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Georgia Department of Human Services

2019 Strategic Plan

Robyn A. Crittenden
Commissioner

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Message from DHS Commissioner
Robyn A. Crittenden

Through each of its programs and services, the Georgia Department of Human Services (DHS) strives to fulfill our vision of building stronger families for a stronger Georgia.

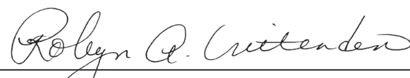
To ensure that the Department's services positively impact individuals who seek to live safer, more independent lives, it is incumbent upon the leaders of the organization to continually develop and evaluate strategies to strengthen Georgia by strengthening its families.

Enclosed is an updated multi-year plan that supports Gov. Nathan Deal's goals for the state of Georgia by improving service delivery to its most vulnerable residents. It also supports the Department's reform effort, called the Blueprint for Change, to develop a robust workforce, strengthen practice models and engage constituents on all levels.

These goals include:

- Ensuring that vulnerable children and adults are safe from abuse and neglect through high program effectiveness, community awareness and stakeholder engagement.
- Increasing the effectiveness and capacity of programs to meet fundamental educational needs.
- Improving access to healthy food options and services that lead to greater independence and healthier lifestyles for vulnerable Georgians.
- Enhancing customer service through modernized processes and effective employee recruitment, training and retention.
- Leveraging public-private partnerships and improving intergovernmental cooperation for successful infrastructure development.

As Commissioner of the Department, I am committed to ensuring each of these goals effectively support the governor's efforts to make Georgia a better place to live, work and play, especially as we seek to improve the lives of the most vulnerable in our state.



Robyn A. Crittenden
Commissioner

June 19, 2018
Date

DHS Accomplishments

The following items are key strategies that were implemented during this strategic plan cycle:

DHS Blueprint for Change: a three-pronged reform effort pioneered by the Division of Family & Children Services and later adopted by the entire Department of Human Services. The initiative creates a framework for how the Department meets its goals, carries out its mission and follows its core values. It serves as the internal road map to improving the lives of vulnerable children and adults. The Blueprint for Change supports a strong practice model, developing a robust workforce and continuous engagement with both internal and external constituents.

Georgia Gateway: an integrated eligibility determination system collaboratively developed and used by various internal and external partners. Georgia Gateway replaces multiple antiquated systems and gives constituents a "one-stop-shop" system to manage their benefits, allow caseworkers greater efficiency to access, review and approve eligibility, reduces duplicative filings, errors, fraud and improves service to customers.

DCSS Mobile App: an industry leading application that allows customers to make child support payments, review their payment history, view scheduled appointments and receive notifications and alerts on important information regarding their cases.

Parental Accountability Court (PAC) program: a joint effort of the Division of Child Support Services and Superior Court judges to offer an alternative to incarceration and to help chronic nonpayers of child support overcome barriers that keep them from making regular payments.

DHS Learning Management System (LMS): allows employees to complete mandatory, annual and new hire training online by simply logging into the LMS. The benefits of DHS LMS organizes eLearning content in one location, provides unlimited access to eLearning materials via desktop and mobile application, easily tracks learner progress and performance, reduces learning and development time, and keeps the organization up-to-date with compliance regulations. The DHS LMS replaced an antiquated system.

DHS Random Moment Sample Study (RMSS): statistical method of a new automated system that determines the activities of a group of employees and the percentage of time a group spends on various work activities. The benefit of the RMSS is to reduce the time it takes to derive a program's share for distributing indirect administrative costs or prorating direct service costs among various benefiting programs on whose behalf the employees are working.

DHS Human Resource Personnel Action Self-Service System (HR PASS): a new electronic system focused on increasing hiring efficiency, enhancing talent selection processes, data integration, and streamlining time-to-fill processes. HR PASS aligns with DHS organizational strategy by decreasing processing times and eliminate existing redundancies.

DHS Vision, Mission and Core Values

Vision

Stronger Families for a Stronger Georgia

Mission

Strengthen Georgia by providing individuals and families access to services that promote self-sufficiency, independence and protect Georgia's vulnerable children and adults.

Core Values

- Provide access to resources that offer support and empower Georgians and their families.
- Deliver services professionally and treat all clients with dignity and respect.
- Manage business operations effectively and efficiently by aligning resources across DHS.
- Promote accountability, transparency and quality in all services we deliver and programs we administer.
- Develop employees at all levels of the agency.

DHS Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis[1]

Strengths

- Knowledgeable staff
- Engaged stakeholders
- Data-driven environment
- Culture of continuous quality improvement

Weaknesses

- Employee and stakeholder training
- No succession plan
- Inadequate resources (staff)
- High turnover rate
- Outdated / manual processes

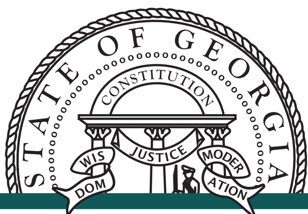
Opportunities

- Create succession plan
- Enhance training via Learning Management System (LMS)
- Re-evaluate and update processes
- Automate contract processes via a Document Management System (DMS)
- Employee recognition and incentives program

Threats

- Scarce manpower
- Data reliability / errors
- Loss of knowledge due to turnover and retirements
- Competitive market
- Overutilization of resources

[1]DHS Conducted a full SWOT analysis in May 2016 that is updated annually.



DHS Goals

Education

1. Promote sustainable community programs to ensure capacity to meet educational needs.
2. Increase programs to improve the successful outcome of fundamental education.

Health

1. Empower individuals and families to pursue and sustain an active and healthy lifestyle.
2. Increase access to healthy food options and services that lead to self-sufficiency.

Responsible and efficient government

1. Ensure that DHS maintains a learning environment to encourage and engage professional development within the organization.
2. Restructure the overall process for hiring, recruiting and retaining DHS employees.
3. Cultivate and maintain a positive relationship with the public and key stakeholders by ensuring agency policy and practice is responsive to constituents' needs.
4. Maintain and increase productivity, efficiency and quality of service through technology and service delivery.
5. Develop support services and job assistance programs which promote self-sufficiency and independence as an alternative to incarceration.

Safety

1. Provide DHS programs and services to protect our most vulnerable clients.
2. Build and maintain community awareness to protect our most vulnerable population.
3. Ensure vulnerable clients and DHS customers are free from abuse, neglect and exploitation.

GOAL 1

Education

Education Goals

1. Promote sustainable community programs to ensure capacity to meet educational needs.
2. Increase programs to improve the successful outcome of fundamental education.

EDUCATION OBJECTIVE 1

Ensure individuals and families served by the Division of Family and Children Services (DFCS) have enhanced capacity to meet their cognitive and educational needs.

Strategies:

- Implement standardized tutoring methods for contracted Education Support Specialists to ensure that youth in care are provided with quality educational support services. For those youths engaged in intensive educational support services, their academic performance will be tracked and monitored (when appropriate) from the initial education assessment through their exit from foster care.
- Develop memoranda of understanding with local school systems to formalize and standardize data sharing processes, as well as educational procedures and processes for children and youth in foster care.
- Provide continuous educational academies to train DFCS staff, caregivers and partners on the Division's educational policies, procedures and entitlements to promote successful educational outcomes for youth in foster care.
- Provide education and support to caregivers regarding the importance of health and wellness screenings for children in care to promote access to the appropriate services for children and youth served by DFCS.

Outcomes:

1. Increase the percentage of youth in foster care who successfully graduate from high school from 17% to 75% by June 30, 2019.[1]

Year	Target	Results
Baseline >> 17%		
SFY 2017	17%	25%
SFY 2018	46%	25% ← As of SFY Q4
SFY 2019	75%	

Data source: The Georgia Department of Education and the Division's Statewide Automated Child Welfare Information System (SHINES)

[1] DFCS will work with the Georgia Department of Education (DOE) to ensure that the DOE is the primary source of all education-related data for children and youth in foster care.

Outcomes:

2. Increase the percentage of educational programming, assessment and consultation (EPAC) referrals for youth in foster care from 46% to 90% by June 30, 2019.

Year	Target	Results
Baseline >> 46%		
SFY 2017	46%	55%
SFY 2018	68%	76.04%
SFY 2019	90%	

As of SFY Q4

Data Source: The State's Automated Child Welfare Information System (SHINES)

GOAL 2

Health

Health Goals

1. Empower individuals and families to pursue and sustain an active and healthy lifestyle.
2. Increase access to healthy food options and services that lead to self-sufficiency.

HEALTH OBJECTIVE 1

Empower older adults to stay healthy by increasing food security and access to healthy food options.

Strategies:

- Increase access to healthy food options for older adults by connecting them to local food systems (farmer's markets and community gardens).
- Implement a person-centered approach to dining options by surveying clients to determine their dining preferences and considering those preferences in meal planning.
- Develop a partner group to support and implement a state Senior Hunger Summit.
- Evaluate the extent of choice of dining options.
- Expand the role of site councils to improve dining choices.
- Provide technical assistance to the Area Agencies on Aging regarding timely and accurate data entry of services provided.

Outcomes:

1. Increase the number of people served through congregate sites from 13,744 to 14,578 by June 30, 2019.

Year	Target	Results
Baseline >>13,744		
SFY 2017	13,744	15,271
SFY 2018	14,153	15,311
SFY 2019	14,578	

As of SFY Q4

Data source: Division of Aging Services Data System

2. Increase the number of people served through home-delivered meals from 12,445 to 13,203 by June 30, 2019.

Year	Target	Results
Baseline >>12,445		
SFY 2017	12,445	12,666
SFY 2018	12,818	13,645
SFY 2019	13,203	

As of SFY Q4

Data source: Division of Aging Services Data System

HEALTH OBJECTIVE 2

Ensure families and individuals that DFCS services have enhanced capacity to meet their physical needs.

Strategies:

- Implement Georgia's Comprehensive Practice Model, inclusive of a trauma-informed approach, throughout the State to ensure timely initial assessment of family and individual needs, as well as connections to relevant supports to meet identified needs.
  - Certify trained staff in our practice model.
  - Increase fidelity of the practice model through fidelity reviews, coaching and live learning.
- Coordinate activities with community partners statewide to facilitate the increase of SNAP participants' access to nutritious food, healthy eating and increased physical activity.
- Implement standardized tutoring methods for contracted education support specialists to ensure that youth in care are provided with quality educational support services. For those youth engaged in intensive educational support services, their academic performance will be tracked and monitored (when appropriate) from the initial education assessment through their exit from foster care.
- Develop memoranda of understanding with local school systems as identified to formalize and standardize data sharing processes, as well as educational procedures and processes for children and youth in foster care.
- Provide continuous Educational Academies to train DFCS staff, caregivers, and partners on the Division's educational policies, procedures and entitlements to promote successful educational outcomes for youth in foster care.
- Train and educate Office of Family Independence (OFI) and Child Welfare case managers on the Medicaid referral and enrollment process for former and current foster care youth (ages 18-21 years old) so that these youth can successfully access healthcare.
- Develop and implement innovative strategies with the Department of Community Health (DCH), Amerigroup and other stakeholders to facilitate youth access to medical, physical and behavioral health services.
- Provide education and support to caregivers about the importance of health and wellness screenings for children in care to promote access to the appropriate medical, physical and behavioral health services for children and youth served by the Division.

Outcomes:

1. Increase the percentage of youth in foster care receiving Medicaid or health insurance, within six months of their 18th birthday, from 45% to 85% by June 30, 2019.

Year	Target	Results
Baseline >>45%		
SFY 2017	45%	94%
SFY 2018	60%	96%
SFY 2019	85%	

As of SFY Q4

Data source: Statewide Automated Child Welfare Information System (SHINES) and the Office of Family Independence (SUCCESS)

2. Increase the percentage of initial wellness screenings for youth in foster care from 16.9% to 75% by June 30, 2019.

Year	Target	Results
Baseline >>16.9%		
SFY 2017	16.9%	20.89%
SFY 2018	45.95%	27.00%
SFY 2019	75%	

As of SFY Q4

Data source: The State's Automated Child Welfare Information System (SHINES)

3. Improve the family Medicaid standard of promptness from 85% to 92% by June 30, 2019.

Year	Target	Results
Baseline >>85%		
SFY 2017	85%	91.28%
SFY 2018	90%	92.06%
SFY 2019	92%	

As of SFY Q4

Data source: The Office of Family Independence Planning, Performance and Reporting Data Management Files

4. Increase the number of SNAP Nutrition Education participants that receive information regarding healthy and nutritious food choices for low income families from 49,184 to 81,058 by June 30, 2019.

Year	Target	Results
Baseline >>49,184		
SFY 2017	53,686	114,803
SFY 2018	67,504	119,645
SFY 2019	81,058	

As of SFY Q4

Data source: The Office of Family Independence's Supplemental Nutrition Assistance Program Unit Data collected annually – September

GOAL 3

Responsible & Efficient Government

Responsible & Efficient Government Goals

1. Ensure that DHS maintains a learning environment to encourage and engage professional development within the organization.
2. Restructure the overall process for hiring, recruiting and retaining DHS employees.
3. Cultivate and maintain a positive relationship with the public and key stakeholders by ensuring agency policy and practice is responsive to constituents' needs.
4. Maintain and increase productivity, efficiency and quality of service through technology and service delivery.
5. Develop support services and job assistance programs which promote self-sufficiency and independence as an alternative to incarceration.

RESPONSIBLE & EFFICIENT GOVERNMENT OBJECTIVE 1

Increase regular child support payments to families by intervening early to build compliance and payment consistency.[1]

Strategies:

- Set income-based orders that reflect the parent's ability to pay with utilizing the agency-initiated Review Modification (Rev-Mod) process. Utilize employer-data reporting tools, such as Department of Labor, The Work Number, and federal interfaces, to identify and target cases where parents' wages and support order amounts have inverse variances which suggest child support amounts are inconsistent with ability to pay.
- Monitor usage and access reports to ensure staff are following processes established in standard operating procedures when using the Data Warehouse report to identify cases that are only paying 0-25% of the current support order amount.
- Develop targeted strategies and procedures for working specialized caseloads.
- Expand our ability to provide outreach services to noncustodial parents who face barriers who may be unemployed or under employed. Individualized service needs will be assessed during initial eligibility interviews with potential participants.
- Work the Undistributed Collections Report to resolve all child support collections held in a pending status. Efforts to resolve pending disbursements will include locating customers, contacting employers and taking other relevant actions depending on the status hold type.

[1] This item was previously listed under Safety Goals

Outcomes:

1. Increase the percentage of current support paid from 61.3% to 63.3% by September 30, 2019.

Current support:

Year	Target	Results
Baseline >>61.3%		
FFY 2017	61.3%	60.29%
FFY 2018	62.3%	60.26% ← As of FFY Q3
FFY 2019	63.3%	

Data source: Office Child Support Enforcement (OCSE) Federal 157 Performance report. Data reported on FFY cycle.

2. Increase the percentage of arrears paid from 65.7% to 67.7% by September 30, 2019.

Arrears:

Year	Target	Results
Baseline >>65.7%		
FFY 2017	65.7%	64.85%
FFY 2018	66.7%	62.51% ← As of FFY Q3
FFY 2019	67.7%	

Data source: Office Child Support Enforcement (OCSE) Federal 157 Performance report. Data reported on FFY cycle.

RESPONSIBLE & EFFICIENT GOVERNMENT OBJECTIVE 2

Increase the number of paternities established for children born out of wedlock.[1]

Strategies:

- Ensure staff are working to reduce cases appearing on the "Requires Establishment" report by researching paternity inquiry, locating tools and targeting cases where paternities are unresolved.
- Continue collaborations between the internal and external customers (state and field office, DFCS, Vital Records, etc.) to identify initiatives and barriers to increase paternity performance.
- Increase genetic testing collections through in-house paternity process by targeting cases from the monthly "Requires Establishment" report.
- Ensure compliance with the locate standard operating procedure to maximize any opportunities for establishing paternity.

Outcomes:

1. Increase the percentage of cases with paternity established from 90.2% to 93.9% by September 30, 2019.

Year	Target	Results
Baseline >>90.2%		
FFY 2017	91.2%	97.18%
FFY 2018	92.7%	76.66% (As of FFY Q3)
FFY 2019	93.9%	

Data source: Office Child Support Enforcement (OCSE) Federal 157 Performance report. Data reported on FFY cycle.

RESPONSIBLE & EFFICIENT GOVERNMENT OBJECTIVE 3

Ensure the Parental Accountability Court (PAC) program continues to serve as an alternative to incarceration for noncustodial parents in their efforts to overcome barriers to self-sufficiency.[1]

Strategies:

- Collaborate with judicial partners to establish new courts in additional judicial circuits in intervals of 10 by promoting PAC program successes and benefits.
- Provide services to noncustodial parents (i.e. substance abuse treatment, job assistance and placement, short term training, coaching and mentoring, educational services and Georgia Work Ready) by conducting individualized assessments during eligibility interviews to prepare them for employment.
- Set income-based orders to decrease recidivism for noncustodial parents and reduce incidences of domestic violence due to misaligned support amounts and arrears accumulation.

[1] This item was previously listed under Safety Goals

- Enhance and maintain relationships with Community Service Boards (CSB) to provide services for parents court-ordered to pay child support.
- Track payments from PAC graduates by utilizing data obtained from the $TARS system, Data Warehouse, and/or Special Query Reports.
- Utilizing the existing $TARS data elements, collaborate with the Office of Information Technology (OIT) to create a new report where comprehensive PAC data can be tracked.
- Encourage child support payment consistency by offering Access and Visitation (AV) services.

Outcomes:

1. Increase the number of PAC from 22 to 49 by June 30, 2019.

Year	Target	Results
Baseline >>22 courts		
SFY 2017	32	33
SFY 2018	42	39 ← As of May 31, 2018
SFY 2019	49	

Data source: Office Child Support Enforcement (OCSE) Federal 157 Performance report

2. Increase the average number of noncustodial parents that participate in the PAC program from 506 to 1078 by June 30, 2019.

Year	Target	Results
Baseline >>506		
SFY 2017	682	713
SFY 2018	924	790 ← As of FFY Q3
SFY 2019	1,078	

Data source: DCSS Data Warehouse

3. Increase collections from noncustodial parents that participate in the PAC program from $547,489 to $1,166,390 by June 30, 2019.

Year	Target	Results
Baseline >>$547,489		
SFY 2017	$737,489	$1,463,013
SFY 2018	$999,763	$1,393,460 ← As of FFY Q3
SFY 2019	$1,166,390	

Data source: DCSS Data Warehouse

RESPONSIBLE & EFFICIENT GOVERNMENT OBJECTIVE 4
Recruit top talent with effective recruitment strategies and processes.

Strategies:

- Establish recruitment strategies based on unique business needs.
- Create and execute recruitment marketing plans.
- Establish DHS as an employer of choice through partnering with colleges and universities, participating in job fairs and community outreach programs, and in support of the federal Title IV-E program.
- Implement an Applicant Tracking System (ATS) – Phase I – to streamline the recruitment documentation workflow processes.

Outcomes:

1. Reduce the process time it takes to fill positions within DHS from 65 days to 55 days by June 30, 2019.

Year	Target	Results
Baseline >>65 days		
SFY 2017	65	54
SFY 2018	60	54 ← As of SFY Q4
SFY 2019	55	

Data source: DHS Office of Human Resources

RESPONSIBLE & EFFICIENT GOVERNMENT OBJECTIVE 5
Retain workforce through personal, professional development and performance management.

Strategies:

- Create strategic organizational plans to optimize workforce skills to align with the vision, mission and core values of DHS in partnership with the Office of Enterprise Development.
- Provide developmental opportunities through skills training via multiple platforms.
- Develop career path initiatives to ensure retention of staff and promote employee satisfaction through all levels of the agency.
- Evaluate and update processes and procedures on performance management.
- Collaborate with leadership on the usage of performance management tools to provide continual and consistent feedback to employees.

Outcomes:

1. Maintain the DHS full-time staff annualized turnover rates of 20.68%.

Year	Target	Results
Baseline >>20.68%		
SFY 2017	20.68%	19.93%
SFY 2018	20.68%	18.14%
SFY 2019	20.68%	

As of SFY Q4

Data source: DHS Office of Human Resources

2. Decrease the DFCS - Child Welfare case management staff annualized turnover rates from 36% to 18% by June 30, 2019.

Year	Target	Results
Baseline >>36%		
SFY 2017	30%	29.14%
SFY 2018	26%	27.47%
SFY 2019	18%	

As of SFY Q4

Data source: DHS Office of Human Resources

3. Decrease the DFCS - OFI case management staff annualized turnover rates from 17% to 11% by June 30, 2019.

Year	Target	Results
Baseline >>17%		
SFY 2017	15%	19.90%
SFY 2018	13%	18.20%
SFY 2019	11%	

As of SFY Q4

Data source: DHS Office of Human Resources

4. Maintain the DAS social service specialist annualized turnover rates of 12.65%.

Year	Target	Results
Baseline >>12.65%		
SFY 2017	12.65%	12.29%
SFY 2018	12.65%	11.70%
SFY 2019	12.65%	

As of SFY Q4

Data source: DHS Office of Human Resources

5. Decrease the DCSS agents annualized turnover rates 15.81% to 9% by June 30, 2019.

Year	Target	Results
Baseline >>15.81%%		
SFY 2017	15.81%	19.87%
SFY 2018	12%	18.04%
SFY 2019	9%	

As of SFY Q4

Data source: DHS Office of Human Resources

RESPONSIBLE & EFFICIENT GOVERNMENT OBJECTIVE 6

Support DHS with the resolution of matters related to DHS programs that affect constituents.

Strategies:

- Seek to identify issues that occur frequently and may reflect systemic problems within DHS.
- Support employees in their efforts to serve constituents by educating the constituent at an enterprise service level.
- Ensure constituents are contacted within one business day of receiving the inquiry and provide resolution within five business days.
- Reinforce written protocol on responding to constituent inquiries.

Outcomes:

1. Increase the resolution rate of constituent legislative inquiries, within five days of receiving the inquiries, from 85% to 95% by June 30, 2019.

Year	Target	Results
Baseline >>85%		
SFY 2017	85%	87.99%
SFY 2018	90%	88.50%
SFY 2019	95%	

As of SFY Q4

Data source: DHS Office of Human Resources

RESPONSIBLE & EFFICIENT GOVERNMENT OBJECTIVE 7

Ensure contracts are produced more efficiently and in a timely manner.

Strategies:

- Establish uniform principles for conducting contract quality reviews.
- Track contract production on a weekly basis to ensure that all contracts are executed and in place when needed.
- Implement an automated contract management system with a lifecycle workflow from creation to execution.

Outcomes:

1. Decrease the average number of days for DHS standard human services contracts within the Office of Procurement and Contracts (OPC) execution cycle from 42 days to 31 days by June 30, 2019.

Year	Target	Results
Baseline >>42 Days		
SFY 2017	42	36
SFY 2018	36	28
SFY 2019	31	

As of SFY Q4

Data source: DHS Office of Procurement and Contracts

2. Decrease the average number of days for DHS non-standard contracts within OPC execution cycle from 30 days to 15 days by June 30, 2019.

Year	Target	Results
Baseline >>30 Days		
SFY 2017	30	39
SFY 2018	22	49
SFY 2019	15	

As of SFY Q4

Data source: DHS Office of Procurement and Contracts

RESPONSIBLE & EFFICIENT GOVERNMENT OBJECTIVE 8

Ensure organizational cohesiveness by understanding and monitoring each strategy that supports DHS' measurable outcomes.

Strategies:

- Instruct divisions and offices to develop a strategic plan derived from their SWOT analysis.
- Assist offices and divisions in developing strategies that align with programs and initiatives within their organizational goals and objectives.
- Review DHS' strategic plan with divisions and offices, and provide guidance on obtaining desired outcomes to ensure that strategies are implemented on time.
- Evaluate strategies that divisions and offices report each month in support of each measurable outcome to ensure strategies align with business objectives.

Outcomes:

1. Support divisions and offices in implementing 95% of planned strategies on time.

Year	Target	Results
Baseline >>50%		
SFY 2018	80%	95%
SFY 2019	95%	

As of SFY Q4

Data source: DHS Office of Strategic Planning and Initiatives

GOAL 4

Safety

Safety Goals

1. Provide DHS programs and services to protect the most vulnerable clients.
2. Build and maintain community awareness to protect Georgia's most vulnerable population.
3. Ensure vulnerable clients and DHS customers are free from abuse, neglect and exploitation.

SAFETY OBJECTIVE 1

Ensure the protection and rights of older and disabled individuals who are victims of abuse, neglect and exploitation.

Strategies:

- Evaluate staffing levels in each region. Adjust staffing levels as necessary to ensure staffing levels meet the need.
- Participate in multi-disciplinary work groups to identify barriers addressing financial exploitation and fraudulent activities to protect at-risk adults from abuse.
- Develop an Elderly Legal Assistance Program (ELAP) plan or protocol to disseminate to targeted groups with targeted issues.
- Target At-Risk Adult Crime Tactics (ACT) training to counties that do not have ACT-certified law enforcement officers.
- Develop a pilot train-the-trainer model to increase the number of ACT trainers without decreasing quality.
- Contact law enforcement agencies statewide to promote ACT training.
- Expand ACT training beyond law enforcement.

Outcomes:

1. Increase the percentage of initial Adult Protective Services (APS) client visits that occur within 10 calendar days of intake from 90% to 95% (5%) by June 30, 2019.

Year	Target	Results
Baseline >>90%		
SFY 2017	93%	94.69%
SFY 2018	94%	94.17% (As of SFY Q4)
SFY 2019	95%	

Data source: DAS Data System

2. Increase the number of At-Risk Adult Crime Tactics (ACT) Certified Specialists from 250 to 300 by June 30, 2019.

Year	Target	Results
Baseline >>250		
SFY 2017	265	267
SFY 2018	285	354 ← As of SFY Q4
SFY 2019	300	

Data source: DAS Data System

SAFETY OBJECTIVE 2

Ensure older adults and adults with disabilities can safely remain independent and in their desired residence.

Strategies:

- Analyze Aging and Disability Resource Connection (ADRC) contact data so Area Agencies on Aging (AAA) can identify and prioritize underserved populations and offer market services.
- Options Counselors and Long-Term Care Ombudsmen (LTCO) collaborate to assist nursing facility residents who have expressed interest in learning more about less restrictive housing options.
- Expand partnerships with Centers for Independent Living for cross support in transition activities.

Outcomes:

1. Increase the number of months non-Medicaid Home and Community Based Services participants delay nursing facility placement from 51 to 57 (10%) by June 30, 2019.

Year	Target	Results
Baseline >>51		
SFY 2017	52	49
SFY 2018	55	46 ← As of SFY Q4
SFY 2019	57	

Data source: DAS Data System

2. Increase the number of individuals that transition from nursing facilities back into the community from 125 to 137 (9%) by June 30, 2019.

Year	Target	Results
Baseline >>125		
SFY 2017	129	218
SFY 2018	133	220 ← As of SFY Q4
SFY 2019	137	

Data source: DAS Data System

SAFETY OBJECTIVE 3

Ensure families and individuals DFCS served have sustainable financial independence, voice, and choice in services, and are self-directed.

Strategies:

- Strengthen and expand the Temporary Assistance for Needy Families (TANF) Employment Job Placement Program and job skills training to promote self-sufficiency.
- Implement the Connected By 21 (CB21) initiatives, the extension of foster care for youth ages 18-21 to ensure that youth in transition are supported and self-sufficient.
- Implement Georgia's Comprehensive Practice Model to provide Child Welfare staff with skills to effectively engage, partner and plan with families, as well as track and celebrate their successes.
  - Certify trained staff in the practice model.
  - Increase fidelity of the practice model through fidelity reviews, coaching and live learning.
- Strengthen the One Caseworker, One Family Practice Model within the Office of Family Independence to effectively improve service delivery, increase accountability for program outcomes and ensure county-based service to customers.

Outcomes:

1. Sustain or increase the percent of TANF participants engaged in a countable work activity from 59% to 60% by September 30, 2019.

Year	Target	Results
Baseline >>59%		
SFY 2017	59%	66.67%
SFY 2018	60%	28.34%
SFY 2019	60%	

(28.34%) As of SFY Q4

Data Source: Independence Planning, Performance and Reporting Monthly Files. National Standard: The federal standard rate set by the Administration for Children and Families (ACF) for Work Participation is 50%

2. Increase family and individual participation in Child Welfare case planning from 42% to 95% by September 30, 2019.

Year	Target	Results
Baseline >>42%		
SFY 2017	59.7%	42%
SFY 2018	77.3%	55%
SFY 2019	95%	

(55%) As of SFY Q4

Data Source: The Division's Child Welfare Quality Assurance Data compiled for the Federal Child and Family Services Review (CFSR). National Standard: The Federal Child and Family Services Review (CFSR) Standard is 95%

SAFETY OBJECTIVE 4

Ensure the families and individuals DFCS serves are healthy and stable.

Strategies:

- Implement the Connected By 21 (CB21) initiatives to allow older Foster Care youth additional time to prepare for a safe and stable transition into adulthood.
- Implement Solution Based Casework throughout the state to ensure quality visits and engagement with parents and children.
  - Certify trained staff in the practice model.
  - Increase fidelity of the practice model through fidelity reviews, coaching and live learning.
- Implement the Partnership Parenting Model to provide support to both Resource and Birth Parents.
- Implement a Kinship Care Continuum - including Voluntary Kinship Care - to ensure that relatives caring for children and youth in foster care are provided the necessary services and supports to maintain placement stability, including continuation of benefits such as TANF and Medicaid.
- Develop and implement processes that ensure timely filing of Termination of Parental Rights in accordance with the Adoption and Safe Families Act (ASFA) to prevent barriers to permanency achievement.
- Implement a statewide foster care recruitment campaign to provide information about Foster Care to prospective foster parents and build awareness about the need.
- Develop partnerships with faith and community-based organizations to recruit and retain foster homes.

Outcomes:

1. Increase the stability of placement for youth in foster care by reducing the rate of placement moves from 5.84 moves (per 1,000 days in care) to 4.12 moves (per 1,000 days in care) by June 30, 2019.

Year	Target	Results
Baseline >>59%		
SFY 2017	59%	66.67%
SFY 2018	60%	92.17% ← As of SFY Q4
SFY 2019	60%	

Data Source: This is a federal data indicator for the Child and Family Services Review (CFSR) pulled from Georgia's Statewide Automated Child Welfare Information System National Standard: The Federal Child and Family Services Review (CFSR) Standard is 4.12 moves (per 1,000 days in care)

2. Increase the percentage of monthly parent visits in child protective services and foster care from 87% to 95% for birth mothers and 80% to 95% for birth fathers by June 30, 2019.

BIRTH MOTHERS

Year	Target	Results
Baseline >>87%		
SFY 2017	87%	90.47%
SFY 2018	91%	91.00% ← As of SFY Q4
SFY 2019	95%	

BIRTH FATHERS

Year	Target	Results
Baseline >>80%		
SFY 2017	80%	87.02%
SFY 2018	87.5%	88.00% ← As of SFY Q4
SFY 2019	95%	

Data Source: The Federal Every Parent Every Month (EPEM) data pulled from the State's Automated Child Welfare Information System National Standard: The Federal Every Parent Every Month (EPEM) Standard is 9

3. Increase the percentage of relative placement for children in foster care from 25.6% to 50% by June 30, 2019.

Year	Target	Results
Baseline >>27.4%		
SFY 2017	27.40%	29%
SFY 2018	38.7%	31.00% ← As of SFY Q4
SFY 2019	50%	

Data Source: The State's Automated Child Welfare Information System (SHINES)

4. Increase the percentage of children in foster care with adoptions that finalize (within 24 months of entering care) from 28% to 52% by June 30, 2019.

Year	Target	Results
Baseline >>28%		
SFY 2017	28%	21%
SFY 2018	40%	25.00% ← As of SFY Q4
SFY 2019	52%	

Data Source: The State's Automated Child Welfare Information System (SHINES)

Fiscal Year 2017 Annual Report

Virginia Pryor | Director

There is power in our story!

When I was first asked to come to Georgia almost four years ago the Division was in a precarious state with numerous challenges and barriers at every turn. But with those challenges came opportunities – an opportunity to change the narrative, an opportunity to change the way we served communities, to chart our own story, and an opportunity to do something BIG.

And so we launched our reform effort, the Blueprint for Change, which emerged from the contents of Senate Bill 138. The Blueprint is a three-pronged approach to service improvement through robust workforce development, consistent practice and intentional engagement of constituents. It also included efforts to engage staff across the Division through a branding and marketing campaign which captured the essence of our humanity and why we do this important work. The strategic plan which followed is the tangible demonstration of the Blueprint in action. And so for the past three years we have focused on implementing the strategies and objectives in the plan.

When Governor Deal recently delivered his final State of the State Address he declared that the current state of our state is good and that the future is bright. I also want to echo this sentiment for the Division. We have made remarkable strides in the past three years and those achievements are reflected in this report. And while we still have a long way to go, we are committed to staying the course and continuing to make improvements. The individuals, children and families we serve deserve our best each and every day.

The next evolution of our work is the journey toward a **State of Hope** — an innovative, collaborative approach which seeks to engage a broad base of stakeholders to design communities in which all members, especially those who are most vulnerable, can thrive as a result of strong safety nets and proactive supports. While the Division does not solely "own" the State of Hope and the transformative work that can only happen within individual communities, we have committed to be the convener of this collective impact approach in partnership with several key stakeholders. No single group or organization alone can raise up strong, healthy, thriving communities. The biggest impact will be made through multiple organizations working together across systems in support of the same goal.

I want to thank Governor and First Lady Deal for championing the work of the Division and demonstrating true servant leadership in action. We are also grateful to the Georgia legislature for their consistent support over these past three years. I then want to thank our former Director, Bobby Cagle, for his strategic vision and leadership. But most importantly, I want to thank our staff for their trust, dedication and perseverance. The road has not always been an easy one, but your commitment to service and hope has inspired me as a leader.

I believe that hope is one of the greatest gifts you can give, particularly when it is the hardest to find. Hope is a light, and where there is just a little bit of light there can be no darkness. My brand is hope. Our brand is hope — hope for safe children, strengthened families and a stronger Georgia.

Thank you for the privilege of being able to serve this great state in partnership with each of you. Indeed, there is power in our story!

Forward in Hope,

Virginia S. Pryor, Director, Division of Family & Children Services

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About the Division of Family & Children Services

About the Division of Family & Children Services

The Georgia Division of Family & Children Services (DFCS) investigates reports of child abuse, finds foster and adoptive homes for abused and neglected children and provides several support services to help families in need, including the Supplemental Nutrition Assistance Program (SNAP), Medicaid and Temporary Assistance for Needy Families (TANF).

VISION

Safe Children. Strengthened Families. Stronger Georgia.

MISSION

We prioritize the safety of Georgia's children in the decisions we make and the actions we take. We partner with families on their path to independence and build stronger communities with caring, effective and responsive service.

GUIDING PRINCIPLES

As the Division of Family and Children Services we...

1. Commit to the safety of our children in the decisions we make and the actions we take.
2. Empower, strengthen and support families on their path to independence.
3. Embrace a servant's heart with compassion.
4. Provide caring, responsive and effective service.
5. Listen and respond to our constituents, communities and each other.
6. Collaborate with our communities to create systems of support.
7. Develop a professional and efficient workforce that never stops learning and growing.

Introduction

The Fiscal Year 2017 Annual Report provides the Georgia General Assembly with information about overall operations of the Division and its service to children and families across the state.

The document that follows includes both state-mandated reports to the General Assembly and an update on efforts to meet six Strategic Goals laid out in the Division's Strategic Plan: Safety, Self-Sufficiency, Permanency, Well-Being, Workforce and Stakeholder Engagement.

The DFCS Strategic Plan sets guideposts for long-term progress following the initial success of the Blueprint for Change reform effort and the ongoing journey of the Division toward a State of Hope.

For each goal area in the Strategic Plan, the Fiscal Year 2017 Annual Report includes quantitative data and details of programmatic strategies that support each goal in the plan.

Reports that must be provided by statute, including a statistical analysis of cases referred to the Child Abuse Registry, are included as part of the report's Appendix.

Our Journey Toward a State of Hope

Since 2014, the Division has sought to improve service to children and families through development of a robust workforce, implementation of an evidence-informed practice model and an aggressive effort to engage constituents on all levels. This three-pronged approach to reform, called the Blueprint for Change, has been instrumental in lowering caseloads, reducing staff turnover and improving outcomes for families served by the Division. As the agency moves beyond plans for stabilization into strategic efforts to build communities with safer children and strengthened families, the Blueprint for Change becomes Georgia's journey toward a State of Hope.

A State of Hope is the Division's ultimate vision. It is a place where people share a vision of safety and success for every child. It is a place where public and private organizations collaborate closely to help achieve that vision. And it is a place where, as a result of this shared vision, children are safer, families are stronger and communities are built to thrive.

Georgia's journey toward a State of Hope is fueled by the belief that families and communities – not systems – are best equipped to raise children and that all families need the support of a caring community to thrive.

This journey is just beginning. In partnership with Casey Family Programs, the Division has embarked on a statewide effort to engage a broad base of community stakeholders in a sustained movement to transform the lives of the most vulnerable residents of the state of Georgia.

Executive Summary

Improved caseloads and response times are among the major goals the Division of Family & Children Services reached or exceeded during the fiscal year that wrapped up in 2017. While the Division continues to strive toward goals that produce better results for children and families, the agency made substantial progress in several service areas.

The Division exceeded several goals set out in the Strategic Plan for the fiscal year, including goals to increase the number of children who enter foster care who are placed with a relative and to recruit more foster parents.

Key outcomes found in the report that follows are:

- A reduction in staff turnover from 36 percent to 29 percent for child welfare staff over a two-year period.
- An increase in employee satisfaction from 66 percent to 71 percent over surveys from 2015.
- A reduction in the number of times foster youth were moved from one foster home or placement to another placement.

The Division continues to work toward goals in other areas, including efforts to have 28 percent of foster children achieve adoption prior to their two-year anniversary in foster care.

In addition, the Division continues:

- Increasing the percentage of children in foster care who achieve permanency within the first 12 months of entering care.
- Increasing the percentage of children in foster care who are placed with a relative.
- Increasing family participation in case planning.
- Increasing the number of finalized adoptions for children who are not reunified with their parents within 24 months of foster care entry.

Strategic Goal 1: Safety

Families & individuals are free from abuse and neglect

GOAL OVERVIEW

The safety of Georgia's children is the top priority of the Division and the foundation for every decision.

The Division has established six measurable objectives (these objectives are outlined based on federal standards included in the annual Child and Family Services Review or CFSR) to demonstrate progress in areas of child safety and systemic readiness to respond to concerns of child abuse and neglect.

In all but one area, Division staff met or exceeded annual objectives for safety set out in the two-year Strategic Plan.

An objective to train all Office of Family Independence staff on requirements to report child abuse was affected by the prioritization of the implementation of Georgia Gateway, a new integrated eligibility system for administration and management of economic assistance programs in Georgia.

Objective 1

Reduce recurrence of maltreatment from 8 percent to no more than 5 percent by July 2019.

[Data is a measure of the number of times a child suffers a confirmed case of abuse or neglect within 12 months of a previous incident.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	8%	8%	6.3%
July 2018		6.5%	
July 2019		5%	

Objective 2

Reduce re-entries into foster care from 7.5 percent to 5 percent by July 2019.

[Data is a measure of the percentage of youth in foster care who were in care for a different reason in the 12 months prior.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	7.5%	7.5%	5.59%
July 2018		6.25%	
July 2019		5%	

Objective 3

Reduce maltreatment of children in foster care from 1.084 victimizations per 10,000 days in care to no more than 0.75 by July 2019.

[Data is a measure of the number of substantiated reports of maltreatment received in a 10,000-day period.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	1.084	1.084	0.28
July 2018		0.92	
July 2019		0.75	

Objective 4

Increase the timely processing of child-care applications resulting from child welfare referrals for eligible foster care children (between the ages of 0-12 years old) by July 2019.

[Data is a measure of the number of child-care applications for children in foster care finalized in a 30-day period.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	85%	85%	88.22%
July 2018		87%	
July 2019		90%	

Objective 5

Train and educate annually all staff in the Office of Family Independence (OFI) on their requirements to report all signs of child abuse.

[Data is a measure of the number of OFI staff who have completed the mandated-reporter training.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	0%	100%	82.5%
July 2018		100%	
July 2019		100%	

Objective 6

Reduce the number of sleep-related deaths for children who are currently receiving or previously received services from DFCS.

[There were a total of 44 sleep-related deaths in 2013, 53 deaths in 2014 and 66 deaths in 2015.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	63	No more than 63 sleep-related deaths (represents a 5% decrease)	49
July 2018		No more than 60 sleep-related deaths (represents a 5% decrease)	
July 2019		No more than 56 sleep-related deaths (represents a 7% decrease)	

Strategic Goal 1: Safety

Families & individuals are free from abuse and neglect

SAFETY STRATEGIES

Through the Blueprint for Change reform effort, the Division has undertaken several initiatives to ensure child safety is at the forefront of each case management decision.

In the last year, child welfare workers adopted a new practice model, called Solution-Based Casework, to guide their approach. The model prioritizes partnerships with families and supports sustainable strategies to create safer, more stable environments for children. All case managers have been trained on the approach and currently are undertaking efforts to achieve certification in the model by the end of Fiscal Year 2018.

The Division has also focused its attention on decision-making related to foster care placements. The initiative, called Safe at Home, seeks to ensure case managers have exhausted all efforts to protect the safety of a child in the home prior to initiating a petition for foster care. The initiative also increases monitoring of foster care cases to ensure no child stays in foster care longer than is necessary for their safety and well-being.

Strategy: Solution-Based Casework

An evidence-informed practice model, Solution-Based Casework (SBC), is the agency's new guide for case managers as they work to address each family's unique situation.

The model supports case managers as they approach their work with families, prioritizing family buy-in for solutions rather than the imposition of a list of requirements based on abstract theory. Using this approach, case managers must be more conscious of speaking in a language the family understands to gain consensus on the problem, tailor solutions to the aspects of everyday family life that threaten child safety, and ensure the proposed solutions support the development of skills that reduce risk and prevent harm.

SBC IN PRACTICE

As of October 2017, 2,900 staff have been trained on the Solution-Based Casework model. Staff are now in the process of becoming certified in SBC, which requires proficiency in the key practices. It is expected that all staff will complete certification by the end of 2018.

SBC provides a common conceptual map for child welfare professionals and families to work together on agreed outcomes. The program builds on the strengths of the family and focuses on behavioral changes rather than prescribed tasks. The success of SBC depends upon the practice of noticing and celebrating change.

SBC combines accepted knowledge from empirical research on family development, clinical research and knowledge regarding behavioral change, and child welfare outcome studies to help staff stay focused on three key elements or tenets. These foundational tenets are:

- to create a partnership based on problem consensus in language the family understands;
- to focus that partnership on the patterns of everyday family life that directly relate to threats to safety, and;
- to target solutions specific to the prevention skills caretakers need to create safety and reduce risk in those family situations.

SBC is associated in research studies with significantly better performance on all 23 federal outcomes in the Child and Family Services Review (CFSR). This performance improvement is predicated upon a high adherence and fidelity to the SBC model.

Tarrick

Tarrick spent the first 16 months of his life in foster care, due to his parents' substance abuse issues and incarceration. His time in care was longer than is ideal for a young infant. And, at one point, Tarrick's parents said they were at rock bottom, and they felt hopeless that he would ever return to them.

But Kristal, a Barrow County case manager assigned to the family, believed in Tarrick's parents and had hope that they could be together again.

Using the skills she learned from Solution-Based Casework (SBC), Kristal worked with Tarrick's parents to build consensus on how their substance abuse affected his safety and to target solutions specific to the skills that would reduce the risk that Tarrick would be in unsafe situations. Practicing other milestones of SBC, Kristal documented successes and celebrated them with the family, sending encouraging messages each time the parents had negative drug screens, for example.

Thanks to her efforts — and those of Tarrick's foster parents and DFCS partners in the judicial system — Tarrick returned home in September 2017. It was an event that Kristal, Tarrick's parents, foster parents and his Court-Appointed Special Advocate celebrated with a shared breakfast.

Tarrick's parents, now sober, say they are glad DFCS intervened on Tarrick's behalf. The thought of losing him had been the driving force behind their efforts to get sober.

They also say they are grateful for Tarrick's foster parents, who took care of him when they could not. Tarrick's foster parents supported his return home to his parents and remain involved in his life. Tarrick's parents say they will let him continue to have overnight visits with his foster family and allow his teenage foster sister to babysit him on occasion.

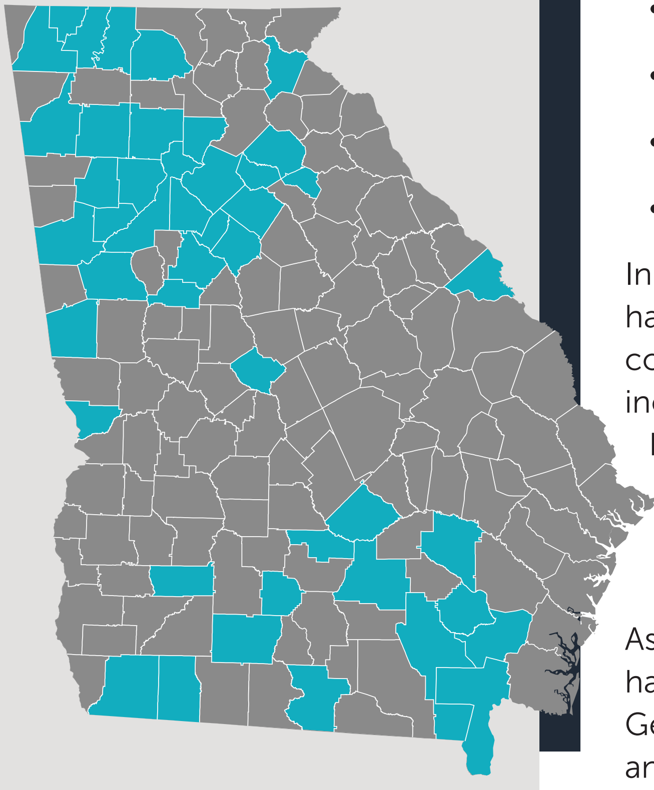
Kristal, Tarrick's case manager, says his successful reunification story is a true example of partnership and the tenets of Solution-Based Casework.

Strategic Goal 1: Safety

Families & individuals are free from abuse and neglect

SAFE AT HOME HOPEFULS WORKGROUP

The 44 counties identified in the map below are responsible for the state's 71% increase in Georgia's foster care population from January 2014 to January 2016.



Strategy: Safe at Home

When the population of Georgia's foster care population swelled by 58 percent after January 2014, the Division took action to ensure only children who needed to be removed from their homes were brought into foster care. In an initiative titled Safe at Home, the Division concentrated efforts to provide support and oversight to families in situations where a child could remain safely at home and avoid unnecessary foster care placement and to speed up reunification of families when the circumstances called for children to enter foster care.

The components of the program include:

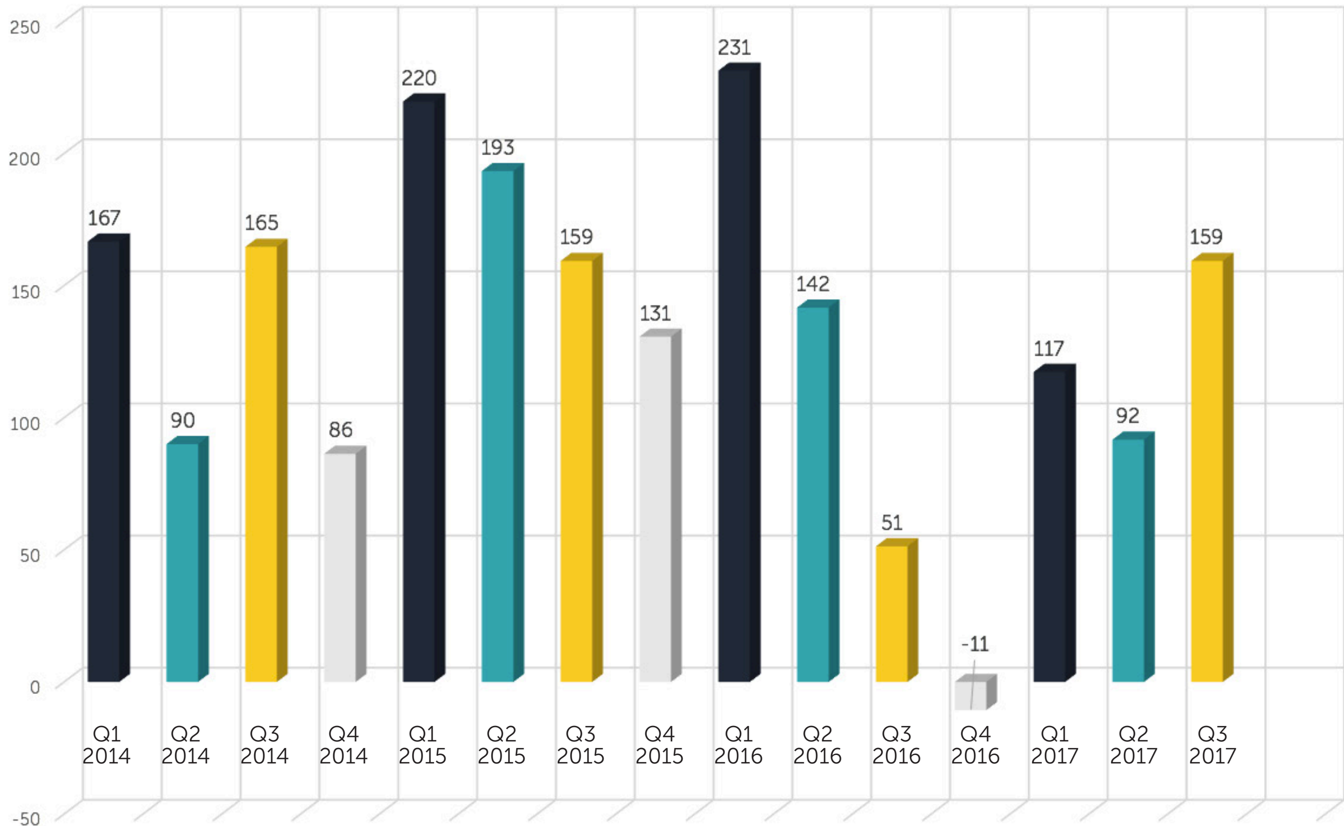
- Strengthening the staffing process for Child Protective Services assessments
- Safely utilizing family preservation services
- Conducting targeted case reviews
- Increasing permanency and adoption efforts
- Increasing the utilization of aftercare services

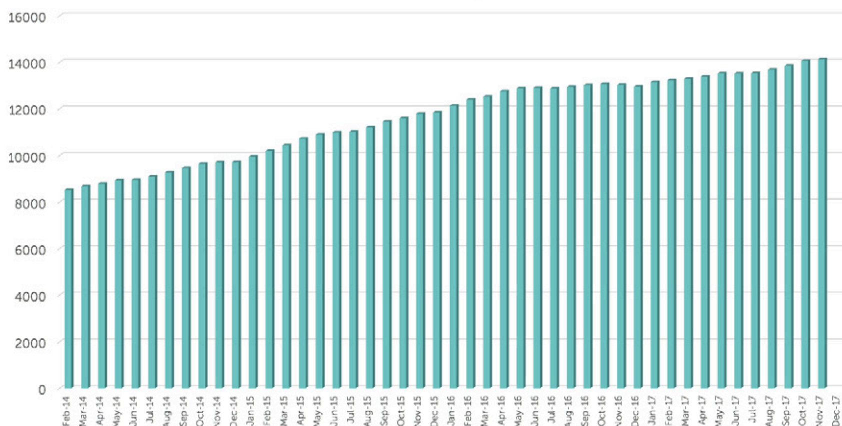
In addition to the Safe at Home initiative, the Division has established a workgroup comprising leaders of 30 county departments where there has been a significant increase in foster care entries. This group, called Safe at Home Hopefuls, serves as a think tank for the Division to create and test hypotheses for reducing foster care entries and speeding the reunification of children in care with their parents.

As a result of the Safe at Home initiative, the Division has begun to slow the growth of foster care entries in Georgia and close the gap between foster care entries and exits, as evidenced in the graphs on Page 12.

Strategic Goal 1: Safety

Families & individuals are free from abuse and neglect





The number of children in foster care increased by 9.6% during the 18-month period between May 2016 (the start of Safe at Home) and November 2017. The previous 18-month period (before Safe at Home) experienced a 32.7% increase.

Strategic Goal 2: Self-sufficiency

Families & individuals have sustainable financial independence, voice and choice in services, and are self-directed.

GOAL OVERVIEW

The Division seeks to help families reach financial and social independence through caring, effective and responsive service. The Division's mission to strengthen families is supported by a guiding principle to empower and support families on their path to success, ensuring each step on that journey is self-directed.

Because strategies to achieve self-sufficiency must reach beyond government to be successful and sustainable, the Division has engaged partner agencies across the state to enhance opportunities for families to build better futures.

The Division has established two measurable objectives based on federal standards included in the annual Child and Family Services Review and set by the Administration of Children and Families to guide the Division's engagement of families in a way that supports their overall and future well-being and self-sufficiency goals.

Tiffney

Tiffney S. found herself jobless and had to turn to the food stamp program for support. Because Tiffney was an "Able-Bodied Adult Without Dependents," she was required to enter job training to maintain her eligibility for the food stamp program. To help get her on her feet, the Cobb County DFCS SNAP Works team referred her to Goodwill of North Georgia for help.

Tiffney was interested in the Highway Construction course and willingly attended the seven weeks of classes offered by Goodwill of North Georgia. There, she learned the basics of highway construction, safety, flagging and operating commercial vehicles. She earned several nationally recognized certifications that would support her in this new career field.

Upon completing the program at Goodwill, Tiffney was thrilled when she was selected for an interview with MARTA. On the day of the interview appointment, however, she received a call that her mother had passed away. Despite her intense grief, Tiffney kept the appointment. Her composure and determination to start a new career so impressed the team at MARTA that they made Tiffney an offer for a job on the spot. But Tiffney faced additional obstacles. Her health had deteriorated and presented specific issues that would have hindered her ability to conduct her job duties for MARTA. Tiffney's determination knew no bounds, however, and despite the additional setback, Tiffney made changes to her diet and lifestyle that allowed her to pass her physical exam and begin her job as a bus operator at MARTA in April 2017.

"Thank you, Goodwill and SNAP for partnering together to create programs to help individuals attain a good job that pays well," she said. "I did exactly what Goodwill asked of me: I was dependable, reliable and motivated to complete the program."

Strategic Goal 2: Self-sufficiency

Families & individuals have sustainable financial independence, voice and choice in services, and are self-directed.

In one of the self-sufficiency objectives, Division staff exceeded standards set out in the two-year Strategic Plan.

An objective to involve families in child welfare case planning should see measurable improvement in Fiscal Year 2018 as staff are more knowledgeable of the tenets of Solution-Based Casework. The Solution-Based Casework practice model holds as a core value engagement of families and prioritizes family involvement in the development of strategies to reduce risk to children and cultivate environments where children are safe.

Objective 1

Increase the portion of Temporary Assistance for Needy Families (TANF) participants engaged in a qualified work activity from 59 percent to 60 percent by July 2019.

[Data is a percentage of eligible adult recipients who participate in work or a work-related activity.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	59%	59%	66.22%
July 2018		60%	
July 2019		60%	

Objective 2

Increase family and individual participation in Child Welfare Case Planning from 42 percent to 95 percent by July 2019. As of the fourth quarter of Fiscal Year 2017, 42 percent of families across the state participated in drafting their plans.

[Data is a percentage of families who actively participate in setting the goals of their case plan, based on Continuous Quality Improvement Reviews or case files.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	42%	59.7%	42%
July 2018		77.3%	
July 2019		95%	

Strategic Goal 2: Self-sufficiency

Families & individuals have sustainable financial independence, voice and choice in services, and are self-directed.

SELF-SUFFICIENCY STRATEGIES

In Fiscal Year 2017, the Division prioritized upgrading its software systems and its support models to ensure families who come to the Division seeking economic or social support are aided on their path to self-sufficiency.

In the last year, Georgia underwent the adoption of a new integrated eligibility system, called Georgia Gateway. The system allows Georgians to manage their accounts for myriad economic assistance programs through a single portal, and improves case workers' ability to verify eligibility for individuals across multiple programs. Georgia piloted the system for most programs in Henry County in February 2017 and gradually implemented it statewide throughout the year.

The implementation of Georgia Gateway has been the most successful integrated eligibility system rollout in the country thus far.

Additionally, the Division expanded efforts to help individuals who come to the Division for support to pursue paths toward sustainable self-sufficiency. The Division's SNAPWorks program supports individuals who receive food stamps in efforts to find a job paying above minimum wage, reducing their reliance on government support. The Division expanded the program to 33 counties in Fiscal Year 2017.

Strategy: Implementation of Georgia Gateway

As the fiscal year concluded June 30, the Division was poised for the September statewide rollout of Georgia's new integrated eligibility system — Georgia Gateway.

Georgia Gateway is a collaborative system between the Division and the departments of Community Health, Human Services, Public Health and Early Care & Learning for determining constituents' eligibility for eligibility-based benefits. Georgia Gateway provides a single point of entry for economic assistance programs that include:

- Medical Assistance through Medicaid, Aged, Blind and Disabled Medicaid, PeachCare for Kids®, Planning for Healthy Babies
- Supplemental Nutrition Assistance Program
- Temporary Assistance for Needy Families
- Special Supplemental Nutrition Program for Women, Infants and Children
- Childcare and Parent Services Program
- Low Income Home Energy Assistance Program to be added in 2019

Strategic Goal 2: Self-sufficiency

Families & individuals have sustainable financial independence, voice and choice in services, and are self-directed.

Georgia Gateway replaced aging computer applications with a modernized, integrated system that enhances fraud-prevention measures, provides real-time eligibility determinations for certain benefit programs, and creates a common portal for customers to apply for and manage their benefits.

Strategy: Expansion of SNAPWorks Program

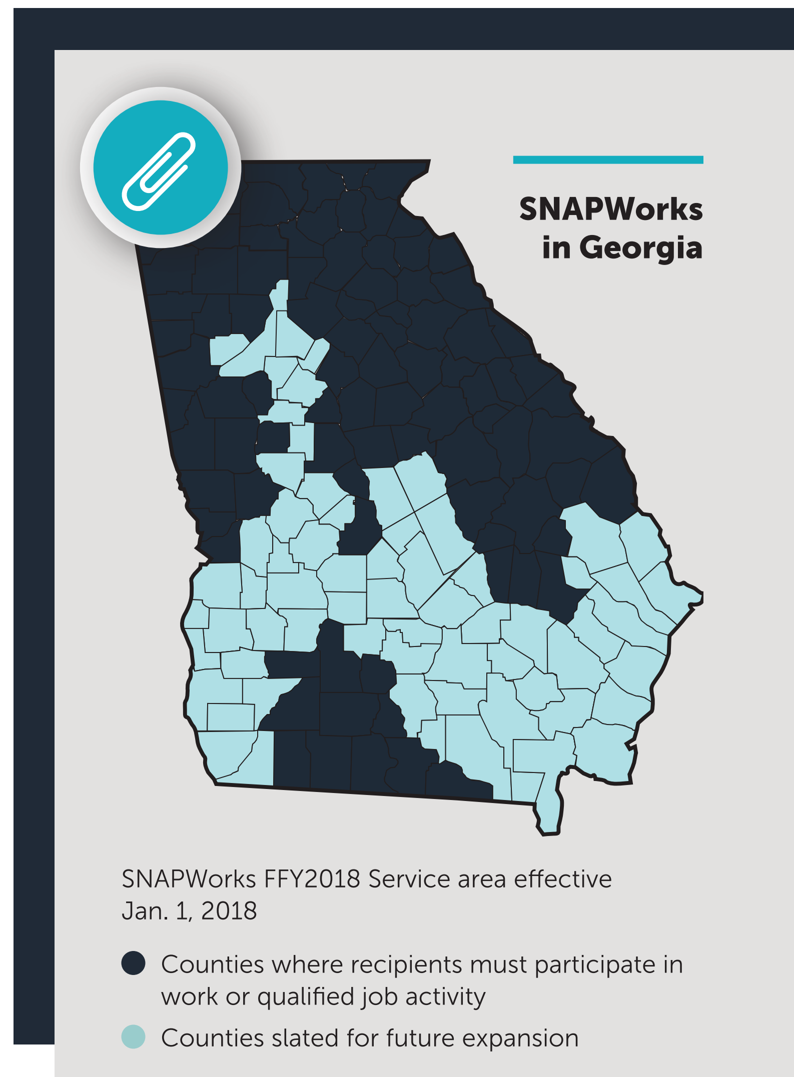
Federal law limits how long able-bodied adults without dependents can receive food stamps, unless they either work or are in a qualified job-training program. However, as Georgia suffered the consequences of reduced private employment following the Great Recession, Georgia, along with most other states, sought and received a waiver from the requirement in counties suffering the highest unemployment rates.

The improving economy of recent years has allowed the Division to reinstate the program and direct recipients to training that helps them access greater employment opportunities.

Beginning with three counties in 2016, the Division reinstated the program and continued with a thoughtful expansion of its efforts to support able-bodied adults without dependents, connecting them with job training programs and partners that help them achieve their goals of self-sufficiency.

During FY17, the Division expanded the program to 24 counties. The program expanded again on Jan. 1, 2018 to a total of 93 counties.

Additionally, in 2018, Georgia will begin a pilot program in Fulton County that allows SNAP recipients who do not fit the definition of able-bodied adults without dependents to receive education and skills training that supports improved employment opportunities.



Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

GOAL OVERVIEW

Children deserve the support and stability that a permanent family offers. It is imperative that the Division focus its efforts toward ensuring children who come to its attention are allowed the opportunity to develop bonds and benefit from relationships that give them their best shot at a successful and fulfilling life.

The Division has established six measurable objectives based on federal standards included in the annual Child and Family Services Review that support the best interest of children who enter foster care. These objectives seek to limit placement moves, maintain children's connection with their families and ensure children do not remain in foster care longer than is necessary for their safety and well-being.

In all but two areas, Division staff met or exceeded annual targets for Permanency set out in the two-year Strategic Plan.

The Division continues to develop and implement strategies that support speedy permanency for children who are eligible for adoption.

The White Family

Lynette White is the paternal grandmother of Chloe, Aleigh, twins Kayden and Jayden, Rico and Bentley, all under age 7.

When the six siblings first came into foster care in 2015, Mrs. White was determined to do anything necessary to ensure her grandchildren remained with family. Initially, she took in three of the children, and another relative stepped up and took in their other three siblings. But Mrs. White, who had previously adopted the siblings' older sister, 9-year-old De'Asia, didn't want the children to live the rest of their lives under separate roofs.

While several family members expressed having the children's best interest at heart in pursuing adoption, none felt they could take all six children.

But Mrs. White, determined to have all of her grandchildren under one roof, moved from a two-bedroom apartment to a three-bedroom home in order to have adequate space for all of the children. She and her partner of 19 years got married in anticipation of the pending adoption. Mrs. White was willing to do whatever it took to have her son's children remain with her.

On April 17, 2017, Mrs. White and her husband made their commitment to the children official, and adopted Chloe, Aleigh, Kayden, Jayden, Rico and Bentley.

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Objective 1

Increase the stability of placement for youth in foster care by reducing the rate of placement moves from 5.84 moves per 1,000 days in care to no more than 4.12 moves by July 2019.

[The intent is to reduce the number of times a youth in foster care changes placement.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	5.84	5.84	4.82
July 2018		5.42	
July 2019		4.12	

Data Source: This is a federal data indicator for the Child and Family Services Review pulled from the state's Automated Child Welfare Information System.

Objective 2

Increase the percentage of birth parents who have monthly visits with their children placed in foster care by July 2019. The intent is to maintain family connections and to facilitate reunification if possible.

[Data is the percentage of birth parents who have monthly visits with their children placed in foster care.]

Month / Year	Baseline	Target Measure [Birth mothers]	Actual Measure [Birth mothers]	Baseline	Target Measure [Birth fathers]	Actual Measure [Birth fathers]
July 2017	87%	87%	90.47%	80%	84%	87.02%
July 2018		91%				
July 2019		95%				

Data Source: The Federal Every Parent Every Month data pulled from the state's Automated Child Welfare Information System

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Objective 3

Increase the percentage of relative placements for children in foster care from 25.6 percent to 50 percent by July 2019.

[Data is the percentage of children (entering foster care) who are placed with a relative.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	19%	27.4%	29%
July 2018		38.7%	
July 2019		50.0%	

Data Source: The state's Automated Child Welfare Information System

Objective 4

Increase the percentage of children in foster care with adoptions that finalize within 24 months of entering care from 28 percent to 52 percent by July 2019. Children eligible for adoption do not wait longer than 24 months from the day they entered care to be adopted.

[Data is a percentage of children eligible for adoption do not wait longer than 24 months from the day they entered care to be adopted.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	28%	28%	21%
July 2018		40%	
July 2019		52%	

Data Source: The state's Automated Child Welfare Information System

The Zacharewicz Family

Unlike the 1980s sitcom, eight wasn't enough for Jenny and Chris Zacharewicz, and this year they adopted 22-month-old Benjamin to add a ninth child to the family.

The family's eight biological children all live at home on six and a half acres in Dallas, ranging in age from seven to 25. Chris says the household runs smoothly, with each child taking on chores as they become old enough.

So, when he and Jenny decided to grow a little more, they weren't particular about a boy or girl.

"We wanted to add another child," he said. "We love kids, and we thought it would be a blessing to have an adopted child."

They trained to become foster parents with a goal of becoming a forever home for a child whose biological parents would not be able to permanently care for him. Benjamin came into their home shortly after he was born, and Jenny and Chris said they grew so attached to him throughout their period as foster parents that it seemed to take forever for the adoption to be finalized.

At one point, a biological relative of Benjamin's from Massachusetts considered taking him in, but Jenny and Chris were the only ones who followed through for Benjamin, adding him to their family by way of adoption.

Now that Benjamin is a part of the family, Chris and Jenny say the door may be open to another adoption and a tenth Zacharewicz, he said.

"We have seriously talked about one more child," he said, adding that they haven't yet decided.

"We love kids, and we thought it would be a blessing to have an adopted child."

Objective 5

Increase the total number of approved foster caregivers (foster and relative) by 20 percent by July 2019 to increase the overall number of placement options for children in foster care.

[Data is the overall number of placement options for children in foster care.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	4,260	4,544	4,685
July 2018		4,828	
July 2019		5,112	

Data Source: The state's Automated Child Welfare Information System

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Objective 6

Increase the percentage of children in foster care who achieve permanency within the first 12 months of entering care from 47 percent to 60 percent by July 2019.

[Data is the percentage of children who are able to safely exit foster care within 12 months of entering care.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	47%	50%	30.84%
July 2018		55%	
July 2019		60%	

Data Source: This is a federal data indicator for the Child and Family Services Review pulled from the state's Automated Child Welfare Information System

PERMANENCY STRATEGIES

Children deserve a permanent place to call home and a family to call their own. With this value in mind, the Division has undertaken several initiatives to ensure that children who must come into foster care are reunified with their families as soon as is safely possible, and that the trauma of entering foster care is limited to the greatest extent possible. For those children who will not return to their parents due to ongoing concerns, the Division works to provide them with an opportunity to receive the love and support of an adoptive family.

To ensure children who come into care are able to maintain connections to their communities, the Division has concentrated efforts to prioritize placement of children who come into care with relatives or close friends of the family. The strategy can support reunification efforts and limit the trauma associated with having to enter foster care.

Additionally, in recognition of the need for children in foster care to be allowed the opportunity for a life with a loving adoptive family, the Division has continued an effort, called There's No Place Like Home, to remove administrative barriers that stand in the way of successful adoption stories. The practice has, for two straight years, increased the number of finalized adoptions of youth in the foster care system.

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Strategy: Kin First

When a child who is at risk of coming into foster care is placed with relatives or close family friends, this is known as kinship foster care. Research confirms that children do best in kinship foster care and that placement with relatives limits the trauma and negative impacts of entering care. Family connections are critical to healthy child development and a sense of belonging. Kinship care also helps to preserve children's cultural identity and relationship to their community.

The Division's Kinship Navigator Program serves as a one-stop shop for information and referral services to grandparents, relatives and other caregivers who are currently raising a child. The Division launched the program in 2015 in direct response to the increasing number of grandparents and caregivers who assumed responsibility for raising another relative's child(ren). The Kinship Navigator Program has 15 kinship navigators located statewide that assist kinship families in identifying and locating resources in their local community. The program's overarching goal is to close the gaps and/or delays in service delivery to kinship caregivers by supporting them however possible.

In 2014, 19 percent of children in care were placed with relatives. The goal is to increase that to 50 percent by 2019. Currently, the percentage of children placed with relatives is at 29 percent.

Strategy: There's No Place Like Home

Through the There's No Place Like Home campaign, the Division has worked to identify barriers to adoption and to remove as many as possible in order to increase the number of children who achieve permanency through adoption. The concentrated effort has improved the path to adoption for children who are seeking permanent, loving homes.

Number of Adoptions
[2013-2016]

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Since 2015, the Division has seen an increase in the number of finalized adoptions, and in FY17, there were 1,190 children who were adopted by their forever families — a roughly 15 percent increase from 2016. The monthly There's No Place Like Home cadence calls allowed staff the opportunity to troubleshoot issues that stand in the way of adoptions, speaking directly with the Division Director.

The initiative has resulted in policy and practice changes that have improved the statewide system of adoptions in Georgia.

The Allen Family

On September 11, 2014, the Allens in Paulding County received a call asking if they would foster two little boys, ages four and five, who had just entered foster care. The Allens decided they would be open to fostering a sibling group, knowing the need for homes in which siblings like Shiloh and Jasper could remain together even though they have been removed from their biological parents. The Allens only had one biological child, so adding two more didn't seem too difficult, they said.

The day after the Allens received the call, the brothers arrived, and their bond was evident and very strong. Shiloh was accustomed to protecting his little brother. And Jasper often translated for Shiloh, since he had a significant speech delay. They had each other, and the Allens respected those roles, which made the boys' transition to their new home a little bit easier.

Almost immediately after the boys arrived, the Allens noticed Shiloh and Jasper would often reference a baby sister. The Allens inquired with their case worker and learned the boys did have a 21-month-old baby sister named Neriah who had been separated from the boys when they were removed from their biological parents' care. When asked if they wanted their sister to live with them at the Allens' home, Shiloh and Jasper's faces brightened, and they screamed, "yes!" The Allens' biological daughter was also ecstatic to add a little sister to the family.

On October 1, 2014, the three siblings were reunited after one of the most difficult times in their lives. Neriah, after weeks without them, was happy to see her brothers.

For three years, the sibling trio became part of the Allen family, each of them handling their baggage in their own way, yet having peace knowing they were all safe and together. On June 19, 2017, Shiloh, Jasper and Neriah became permanent members of the Allen family. The adoptive mother said the experience with Shiloh, Jasper and Neriah, allowed her to see the importance of the sibling bond in the healing process. Through the diligent efforts of their Adoption Case Manager and Regional Adoption Coordinator and the attention their case received through the There's No Place Like Home Program, permanency for Shiloh, Jasper and Neriah was achieved in record time—only seven months after parental rights were terminated.

Strategic Goal 4: Well-being

Families and individuals have enhanced capacity to meet their physical, cognitive and educational needs.

GOAL OVERVIEW

The Division is committed to empowering, strengthening and supporting families on all levels that impact their well-being by providing resources that benefit physical, mental and social development.

The Division has established seven measurable objectives based on federal standards included in the annual Child and Family Services Review that show results of strategies to improve the well-being of families who come to the Division's attention.

In all but two areas, Division staff met or exceeded annual objectives for well-being set out in the two-year Strategic Plan.

The Division continues to work on strategies that will improve the educational outcomes of youth in foster care and support their long-term success.

Objective 1

Increase the percentage of current and former foster care youth receiving Medicaid or health insurance within six months of their 18th birthday from 45 percent to 85 percent by July 2019.

[Data is the percentage of children who have health insurance coverage within the six months following their 18th birthday.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	45%	45%	94%
July 2018		60%	
July 2019		85%	

Data Source: The state's Automated Child Welfare Information System and the Office of Family Independence

Strategic Goal 4: Well-being

Families & individuals have enhanced capacity to meet their physical, cognitive and educational needs.

Objective 2

Increase the percentage of youth in foster care who successfully graduate from high school from 8 percent to 85 percent by July 2019. [1]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	8%	46%	25%
July 2018		60%	
July 2019		85%	

[1] Going forward, the Division will rely on the Georgia Department of Education to be the primary source of all education-related data for children and youth in foster care.

Objective 3

Increase the percentage of Educational Programming and Assessment Consultation referrals for youth in foster care from 46 percent to 90 percent by July 2019.

[Data is the percentage of eligible youth in foster care who have access to the resources and support available from EPAC.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	46%	46%	55%
July 2018		68%	
July 2019		90%	

Data source: The state's Automated Child Welfare Information System

Objective 4

Increase the percentage of initial wellness screenings for youth in foster care from 16.9 percent to 75 percent by July 2019.

[Data is the percentage of youth in care who have a health screening and exam immediately after entering care.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	16.9%	16.9%	20.89%
July 2018		45.95%	
July 2019		75.0%	

Data source: The state's Automated Child Welfare Information System

Strategic Goal 4: Well-being

Families & individuals have enhanced capacity to meet their physical, cognitive and educational needs.

Objective 5

Support the development of executive functioning for children in foster care by increasing the number of these children ages 0–5 who are enrolled in Early Head Start/Head Start, Pre-K, or any other quality-rated child care program by July 2019.

[Data is a percentage of young children in care who participate in Quality Rated Child Care programs.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	32.95%	36.25%	35.12%*
July 2018		60.00%	
July 2019		84.00%	

*Data source: The state's Automated Child Welfare Information System (*Measure as of June 30, 2017.)*

Objective 6

Improve the Family Medicaid Standard of Promptness to 92 percent by July 2019.

[Data is the percentage of families will have their Medicaid application finalized within 45 days.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	85%	85%	87.31%
July 2018		90%	
July 2019		92%	

Data source: The Office of Family Independence Planning, Performance and Reporting Data Management Files

Objective 7

Increase the number of Supplemental Nutrition Assistance Program (SNAP) Nutrition Education participants that receive information regarding healthy and nutritious food choices for low-income families from 49,184 to 81,058 by July 2019.

[Data is the number of SNAP participants who receive educational information regarding the purchase of nutritious foods.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	49,184	53,686	106,614
July 2018		67,504	
July 2019		81,058	

Data source: The Office of Family Independence, Supplemental Nutrition Assistance Program Unit

Strategic Goal 4: Well-being

Families & individuals have enhanced capacity to meet their physical, cognitive and educational needs.

WELL-BEING STRATEGIES

All children deserve their best shot at a good life. The Division must undertake initiatives to ensure that children who enter foster care due to problems resulting in abuse or neglect are afforded the opportunity to thrive, despite their prior circumstances.

In addition, families in economically depressed situations should receive assistance that empowers them to make future decisions that support the health and overall well-being of their families going forward.

With these values in mind, the Division has undertaken several initiatives to bolster families as they seek to improve their social and economic circumstances.

Included is a concentrated effort to improve educational supports and increase the high school graduation rate for children in foster care. This initiative, called Project Graduate, sought to study the effects of placement changes on a young person's educational success and to provide aid and encouragement that would improve a youth's chances of graduating high school. The Division has taken the lessons learned from this year-long initiative and implemented changes in its educational support model for foster youth statewide.

Strategy: Project Graduate

Project Graduate is a collaborative effort between the Georgia Division of Family and Children Services and key stakeholders to improve the graduation rates of Georgia's foster youth by providing coordinated supports while leveraging existing resources available to youth in care. It emerged as a result of then-Division Director Bobby Cagle's participation in the Annie E. Casey Foundation's intensive executive leadership program, and it was developed under the auspices of the Blueprint for Change,

Project Graduate

Jason Livingston and Kenton Pope, both age 19, began the 2016-2017 school year with not enough high school credit hours to be classified as seniors. Each faced challenges with attendance, grades, and repeated moves associated with their stay in foster care. Kenton's long-term foster mom had died earlier in the year, causing him to lose his home and support system. Jason was facing expulsion from school and a threat of being discharged from his foster care placement.

Through much hard work with follow up and a helping hand from the Project Graduate Team, these young men were able to not only become seniors, but both graduated with high school diplomas. Jason is now working with a recruiter to enlist in the U.S. Navy, and Kenton plans to attend a junior college.

Project Graduate is just one example of the Division's efforts to provide caring, responsive and effective service and to champion youth on their path toward independence.

Strategic Goal 4: Well-being

Families & individuals have enhanced capacity to meet their physical, cognitive and educational needs.

Georgia's effort to reform the child welfare system. In its initial phase, Project Graduate served as a demonstration learning project that sought to increase high school graduation rates for a cohort of 41 youth in foster care. Youth from Fulton and DeKalb counties were chosen for the project if they were enrolled in ninth grade in the 2013-2014 school year. The project took place during the 2016-2017 academic year and included youth attending Atlanta Public Schools, Decatur City Schools, and DeKalb and Fulton county schools.

The goal of Project Graduate was for 50 percent of the 41 youth to complete a high school diploma or GED by the end of the 2016-2017 school year. At the conclusion of the project period, the data demonstrated that 41 percent of the cohort successfully completed Project Graduate. If those members of the cohort who ran away, became incarcerated or opted out of foster care during the evaluation period are excluded from the calculation, the completion rate rises to 57 percent.

Project Graduate has allowed Georgia to focus on six strategies that will improve the educational outcomes for all youth in Georgia's foster care system and reconsider the effectiveness of policies and programs aimed at supporting the long-term success of these youth. Statewide implementation will be developed based on the lessons learned in the demonstration project and the successes of each strategy.

Strategic Goal 5: Workforce

The Division's workforce is competent, professional and efficient

GOAL OVERVIEW

To achieve its vision of supporting families and ensuring the safety of children, the Division must develop a competent, professional and efficient workforce that never stops learning and growing.

As part of the Blueprint for Change, the Division's leadership has focused efforts on recruiting quality staff and improving retention rates, which had plummeted in the years leading to 2014. Workforce issues negatively affected the Division's ability to make critical decisions related to child safety and to respond appropriately to the needs of vulnerable Georgians.

The Division has established two measurable objectives to monitor changes in employee retention and satisfaction, which may ultimately impact its ability to serve Georgians. Thanks to efforts to improve retention through market-based salary adjustments and improved supervisory support, the Division exceeded annual objectives for child welfare turnover and employee satisfaction. The Division continues to work to lower turnover rates for Office of Family Independence staff.

Latoya

Latoya came to the Division in 2012 supporting Bulloch County's families in the Temporary Assistance for Needy Families program. While she served some of Bulloch County's neediest families, Latoya was also having a difficult time providing for her own family.

Latoya and her 16-year-old son, Jamari, were living in an area that she said didn't always prove to be the safest or most comfortable place to raise a child. For three years, Latoya said she prayed that she would be able to move somewhere that would be a better fit for her family. But her monthly living expenses and the burden of her medical bills had not yet allowed her to improve her circumstances.

In March, when staff in the Division's Office of Family Independence received a raise to match the market rate, Latoya said she felt like she could finally move her son to a better neighborhood.

"The raise was of great benefit to my family," Latoya said. "The extra income allowed me to purchase a newer vehicle and move to a nicer, safer, more comfortable home. It was a great weight off my shoulders."

Latoya now processes applications for one of the most complex programs the Division administers and says she remains grateful for the raise and the impact it had on her ability to provide for her family.

Strategic Goal 5: Workforce

The Division's workforce is competent, professional and efficient

Objective 1

Decrease the case management staff annualized turnover rates by June 30, 2019. (Baseline OFI – 17 percent, Child Welfare – 36 percent)

[Decrease the turnover rate of staff to: Office of Family Independence – 11 percent; Child Welfare – 18 percent]

Month / Year	Baseline [OFI]	OFI Target Measure	Actual OFI Measure	Baseline [CW]	CW Target Measure	Actual CW Measure
July 2017	17%	15%	19%	36%	30%	29.14%
July 2018		13%			26%	
July 2019		11%			18%	

Data Source: The Office of Human Resources

Objective 2

Increase the percentage of employees highly satisfied with their jobs from 66 percent to 90 percent by July 2019.

[Data is the percentage of staff who participate in an annual survey and indicate they are highly satisfied with their jobs.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	66%	80%	71%
July 2018		80%	
July 2019		90%	

Data Source: The Division's Employee Satisfaction Survey compiled by Georgia State University

Strategic Goal 5: Workforce

The Division's workforce is competent, professional and efficient

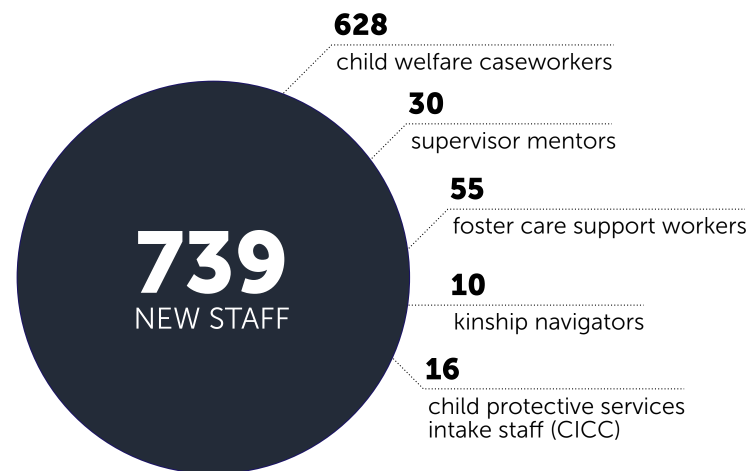
WORKFORCE STRATEGIES

The Division, supported by Gov. Nathan Deal and the General Assembly, has been able to make significant investments in its workforce to improve morale and support safer caseloads for child welfare workers across the state.

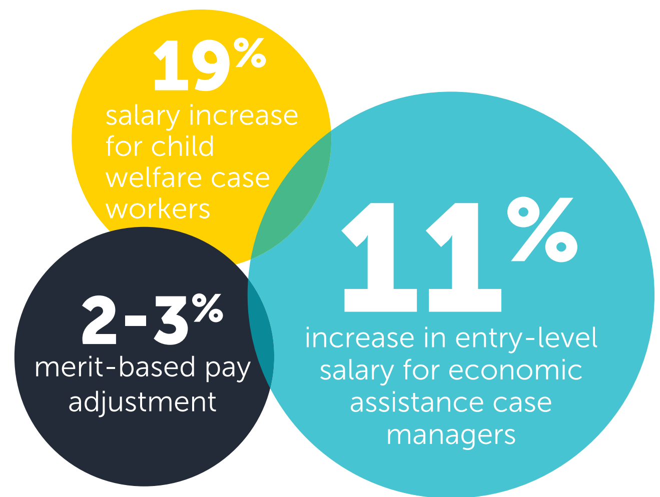
Strategy: Investment in our workforce

SFY 2016 - 2018

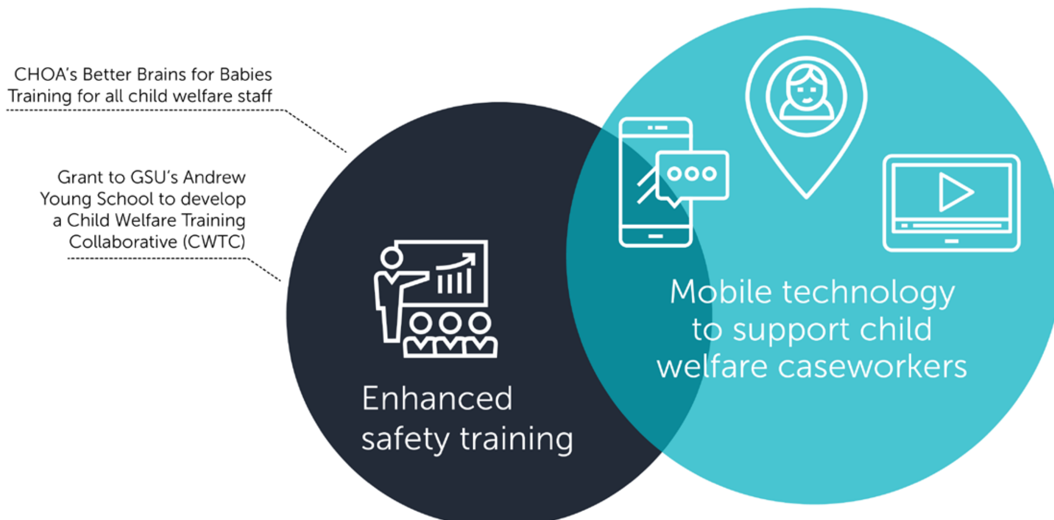
Recruitment



Retention



Training & Technology



Strategic Goal 6: Stakeholder Engagement

The Division and its stakeholders are fully engaged and responsive.

GOAL OVERVIEW

A guiding principle of the Division is to engage, listen and respond to constituents and communities. Another is to collaborate with communities to create systems of support for vulnerable families.

Government can act as a safety net to help families and supplement services available in communities from neighbors, religious and social organizations, and charitable foundations. Where there is a robust network cooperating to support families, there is hope.

In its efforts to support families through community engagement, the Division seeks to foster such communities of hope throughout the state. To do that, it is focusing on developing closer ties to those who have a stake in the success of a State of Hope through better communication and enhanced cooperation.

Launch of Georgia's State of Hope

On May 3, the Division launched its journey to ensure that all of Georgia's children live in communities where they are safe and have the support they and their families need to thrive; this is called a State of Hope.

The event was held at the Georgia Aquarium for the purpose of engaging a broad base of community stakeholders - nonprofits, philanthropies, government agencies, and private businesses – and encourage them to become leaders of this effort. Many signed on as partners and are taking an active role in designing the roll out of the State of Hope for FY18.

DFCS partnered with Casey Family Programs – the nation's largest operating foundation focused on safely reducing the need for foster care and building Communities of Hope across America – for this initiative.

Strategic Goal 6: Stakeholder Engagement

The Division and its stakeholders are fully engaged and responsive.

Objective 1

By July 2019, educate the Division's key stakeholder groups on the Division's revised comprehensive practice model: Solution-Based Casework. Increase the number of stakeholder groups who are knowledgeable about the Division's practice model.

[Data is a measure of the number of stakeholder groups who are knowledgeable about the Division's practice model.]

Month / Year	Baseline	Internal Stakeholder Target Measure	Actual Internal Measure	External Stakeholder Target Measure	Actual External Measure
July 2017	0%	33%	80% staff trained	33%	This will begin November 2017
July 2018		66%		66%	
July 2019		100%		100%	

Objective 2

Reduce the total number of valid complaints received by the Division from 3,687 to 1,796 by July 2019.

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	3,687	2,765	2,284
July 2018		2,212	
July 2019		1,796	

Objective 3

Increase the number of cash match relationships/agreements from 34 to 136 by July 2019.

[Data is the number of positions that are partially funded by local entities.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	34	34	39
July 2018		68	
July 2019		136	

Strategic Goal 6: Stakeholder Engagement

The Division and its stakeholders are fully engaged and responsive.

STAKEHOLDER ENGAGEMENT STRATEGIES

In order to successfully serve its communities and achieve its goal of strengthening families, the Division must seek out partners in this effort and solicit feedback on how to improve service to its constituents. As part of the Blueprint for Change reform effort, the Division has prioritized the cultivation and engagement of stakeholders throughout the state, including known partners in the judicial and nonprofit communities, as well as unlikely stakeholders in the corporate sector.

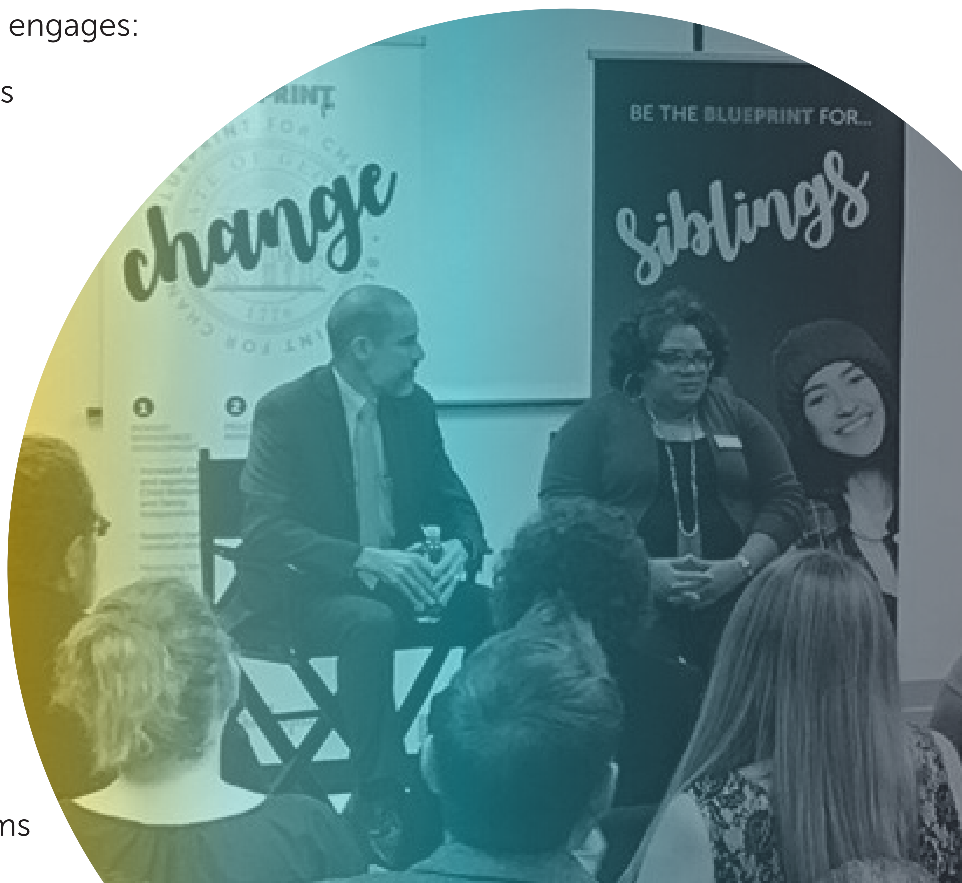
With these values in mind, the Division has made a concerted effort to solicit feedback from local communities, through the Blueprint for Change Roadshow, and initiated an effort to engage communities in strategies that make children safer and build stronger families.

Strategy: Regional Roadshows

The Blueprint for Change Roadshow seeks to gather feedback from staff and stakeholders across the state about agency reform efforts and to build consensus on a plan to make Georgia a safer place for children and a state where vulnerable families can access services that put them on a path to self-sufficiency.

During the roadshow visits, the Division engages:

- Community and civic organizations
- Contracted providers
- Faith-based organizations
- Foster parents
- Foster youth
- General public
- Judges
- Law enforcement
- Legislators
- Media
- Staff
- Superintendents and school systems



APPENDICES

Appendix A: Program Year in Reviews

Field Operations Year in Review
Knowledge Management Year in Review
Office of Family Independence Year in Review
Practice & Program Guidance Year in Review

Appendix B: Funders Briefing

Appendix C: Child Abuse Registry Maltreatment Type Report

Appendix D: Child Fatality Analysis

CY15 Analysis
CY16 Analysis

APPENDIX A

Program Year in Reviews

Field Operations Year in Review

Knowledge Management Year in Review

Office of Family Independence Year in Review

Practice & Program Guidance Year in Review

STATE OF GEORGIA

Division of Family and Children Services

Nathan Deal
Governor

Bobby D. Cagle
Director

DFCS Field Operations Section
Year-in-Review
(FY 2017)

This report contains a list of high-level actions taken by DFCS Field Operations in FY 2017 in support of the "Blueprint for Change" and the Division's leadership vision and priorities. These actions provide a foundation of success for Field Operations to build upon in FY 2018 and beyond.

1. **Roll-Out and Implementation of Solution Based Casework and Georgia's Practice Model**
   Statewide 1,600+ staff have been trained – including 400+ supervisors. Training will be concluded early in the next fiscal year.

2. **Completion of Rebuilding & Reorganization of Regional Field Program Specialists (FPS)**
   The following specific FPS roles were created and filled, with one role assigned per team member:

   - CPS Program Specialist
   - Placement Program Specialist
   - Performance Management Specialist
   - Staff Development / Mentoring Specialist
   - Treatment Coordination and Consultation Specialist

   The Placement Program Specialist team met with their counter-parts within State Office Program and Practice guidance to increase communication and to ensure consistency of focus and efforts. The other teams will follow this example during FY2018.

3. **Continuation of "Safe at Home" Foster Care Campaign**
   Field Operations implemented the "Safe at Home" Foster Care campaign plan consisting of the following best practices:

   - Strengthening the Staffing Process for CPS Assessments – Including a Pre-Removal Staffing and a Second Level Approval Above the Case Manager and Supervisor
   - Safely Utilizing Family Preservation Services
   - Conducting Targeted Case Reviews
   - Increasing Permanency and Adoption Efforts
   - Increasing the Utilization of Aftercare Services

The quarterly average monthly "gap" – the difference between Foster Care entries and exits – decreased in July – September, October – December, and January – March compared to the same periods in the prior fiscal year (see Performance Indicator data).

4. **Continuation of "Safe at Home 'Hopefuls'" Meetings**
As a component of the "Safe at Home" Foster Care Campaign, a monthly meeting was held with counties and regions that experienced the largest percentage of the State's prior Foster Care increase. The meetings included the following topics:

- Role of Leadership
- Mindsets and Bias
- Trauma
- Conditions for Return
- Attachment / Belonging
- Racial Disproportionality
- Poverty – Including a Poverty Simulation Exercise

5. **Collaboration with the Department of Community Supervision**
DFCS and the Department of Community Supervision (DCS) entered into a Memorandum of Understanding (MOU) in an effort to increase inter-agency cooperation and to reduce any redundancies related to families served by both agencies. A joint "kick-off" meeting was held on 2/14/17. The following key areas are included in the MOU:

- Training Opportunities
- Joint Involvement in Family Team Meetings and Multi-Disciplinary Meetings
- Serving as Collateral Contacts for Each Other
- Exploration of Data Sharing Opportunities (Pending Additional Agreement(s))

6. **Emergency Management Activities and Activations**
Emergency Management, under the purview of Field Operations, focused on workplace safety and increasing the number of American Red Cross Shelter Trained staff. A core of 15 Field Operations staff were trained as shelter training trainers during the fiscal year to allow training to be conducted internally. Emergency Management also participated in the 11 State activations of the State Emergency Operations Center, including for Hurricane Hermine, Tropical Store Julia, Hurricane Mathew, forest fires, tornados, and various winter weather events.

7. **Special Investigations Unit (SIU) Expansion**
SIU added several new staff during the fiscal year, including a Quality Assurance team and a Field Program Specialist. SIU also added a team of investigators for Region 12 and Region 5. SIU will continue to expand in the coming fiscal year to provide statewide service provision and targeted, after-hours support.

8. **On-Going Development of Weekly Leadership Development Calls**
   Weekly statewide leadership development calls focused on the fusion of performance, practice, staff retention, and leadership development. The following leadership topics were included, among others, as a part of weekly leadership calls this fiscal year:

   - Leadership Action Series – Think Small to Think Big
   - Leadership Action Series – Lead with Passion
   - Scientific Method
   - Active and Constructive Responding to Good News
   - Partnerships
   - Asking for Help as a Growth Opportunity
   - Mindset Secrets to Achieve Goals Faster
   - Courage Series - Building a Culture of Courage in a Climate of Fear
     - Engage
     - Embolden
     - Inspire
   - The Fearless Leader
   - The Ladder of Inference
   - Interdependence
   - Benevolence
   - Key Leadership Characteristics
   - Year-End Leadership Reflection
   - Affirmations
   - Let Love Inspire your Leadership
   - Self-Compassion
   - Pygmalion Effect
   - Traits of Leaders that do Things Fast and Well
   - Showing Mercy is Your Choice
   - Cultivating Rest and Play
   - Culture of Respect and Civility in the Workplace
   - Problem Solving
   - Critical Incident Stress Debriefing
   - Interactive Series – Conquering the Five Common Fears of Leadership
   - Leadership Series - Introverted Leaders

9. **Statewide CCI Leadership Visits**
   In an effort to increase awareness of the conditions of the CCI facilities and their operations while increasing stakeholder engagement with the CCI directors / managers / owners, Field Operations conducted 135 CCI scheduled visits between September and November 2016. These visits provided an opportunity for a more general assessment of the CCI along with increasing the working relationship between DFCS and the CCI community. These contacts were conducted primarily by Regional, County, and District Directors and other leadership staff.

10. **Implementation of a Standard Operations Procedures (SOP) Processes**
    In an effort to bring consistency to Field Operations, SOP documents were developed for and implemented on the following areas of practice:

    - Child Death, Near Fatality, and Serious Injury Cases
    - Safety Panel Review Process (updated)
    - Monthly "Level Up" CFSR Case Reviews

11. **Initial Safety Assessment Review Project**
    Beginning April 2017, the Field Program Specialists implemented an on-going, statewide review project to assess the quality and fidelity of Initial Safety Assessments.

12. **Leadership Succession Planning**
    Field Operations leadership met with interested County Directors, Field Program Specialists, and State Office staff on 2/14/17 to discuss the Regional Director position and the related duties and responsibilities of the position.

13. **Introduction of Harm Statements, Danger Statements, and Consistent Safety Goal Language**
    Harm statements and danger statements are short, simple, behaviorally based statements about what has happened in the past, why the agency is involved with families, and concerns about may happen in the future. Safety goals are clear statements about what the caregiver will do to ensure the child is safe now and into the future.

14. **Expansion of the Vehicle Lease Program**
    88 leave vehicles were distributed in [pilot] regions 1, 11 and 13.

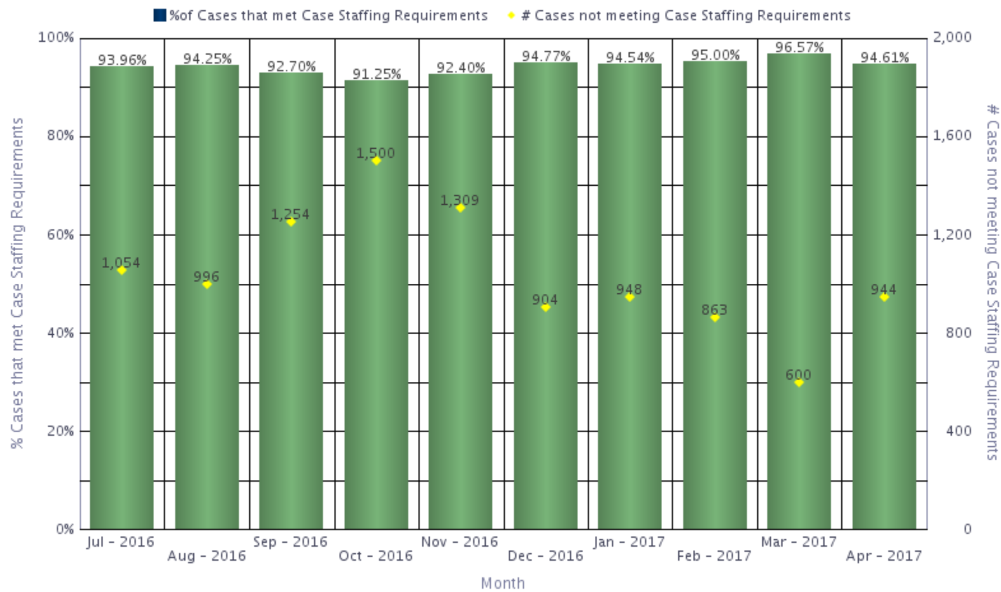
15. **Transition to a Regional Personnel Staffing Allocation and Approval Process**

16. **Creation of a Case Review Interview Component**
    Inclusion of a case review component in the interview process for promotions for Supervisors and above in child welfare to assess the actual quality of a candidate's work.

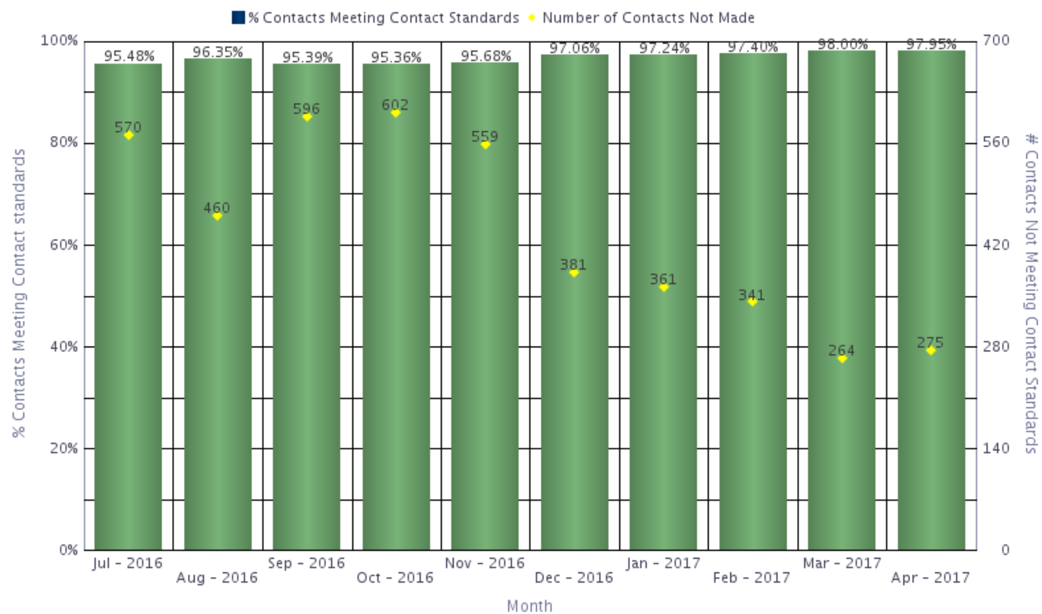
17. **Continued Centralized Intake Call Center (CICC) Efficiency and Service Delivery**
    Over the past fiscal year CICC continued to successfully meet the demands of an increasing call volume while implementing a number of strategic changes to benefit both internal staff and front-line field staff as well as produce better quality work to best serve the needs of the children and families served by the Division. This work included, among other efforts, making changes to the Intake Decision Guide to standardize justification statements and to ensure the most appropriate maltreatment codes are utilized based on reported allegations. CICC also implemented a Transitional Unit to work in tandem with the Training Unit to help improve newly trained Intake worker's skills and ease the burden of the fast-paced world of CICC.

Performance Indicators (July 2016 – April 2017)

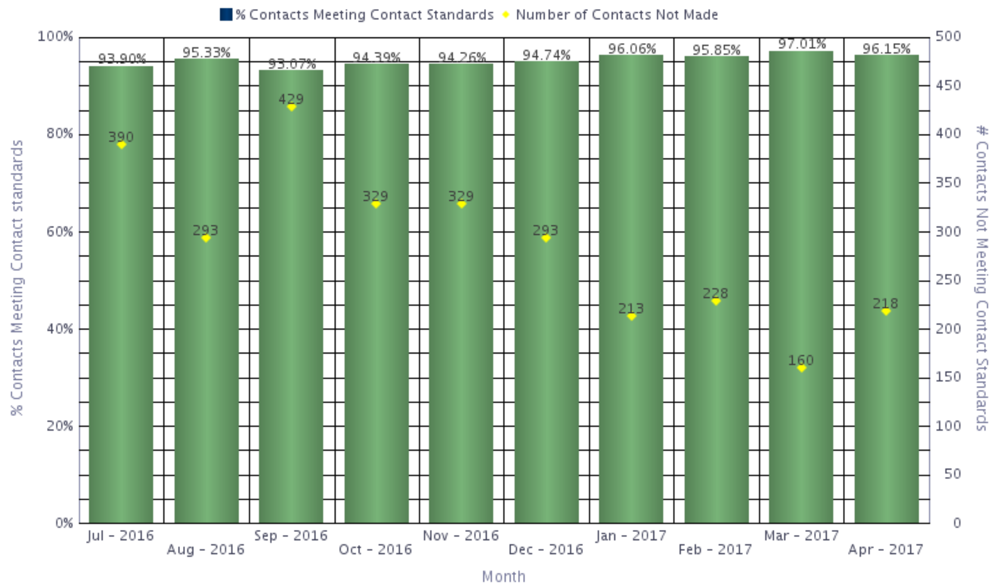
1. Case Staffings



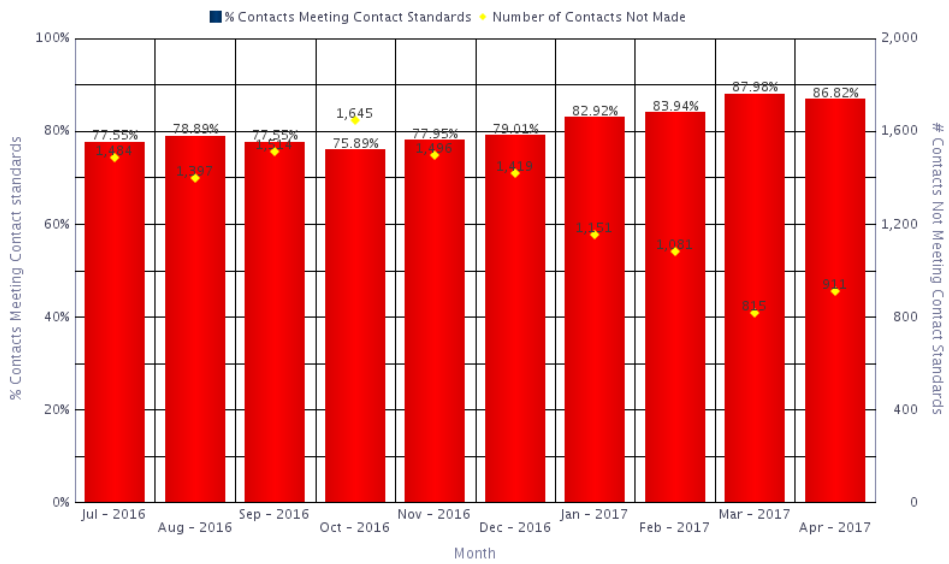
2. Child Visits (Foster Care)



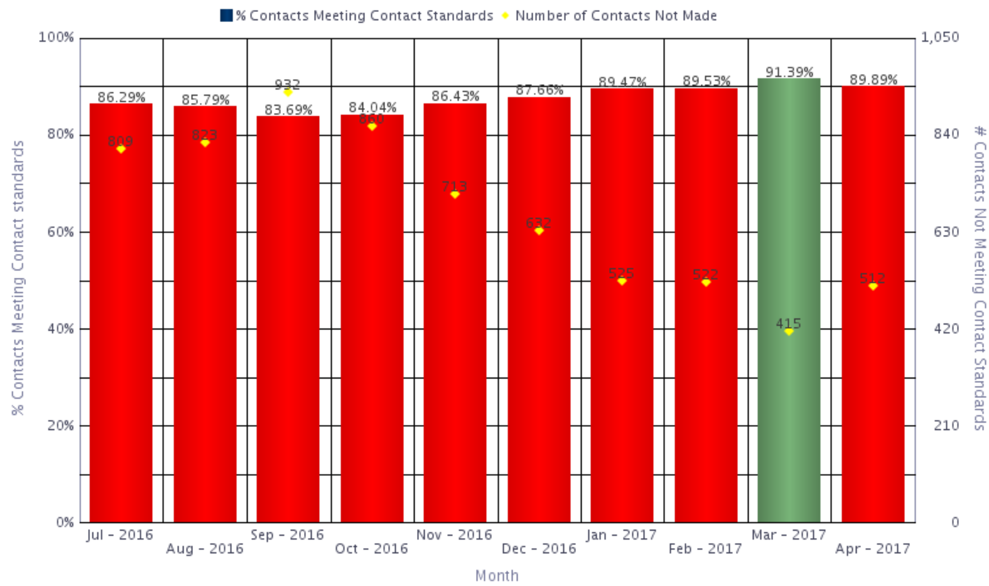
3. Child Visits (CPS)



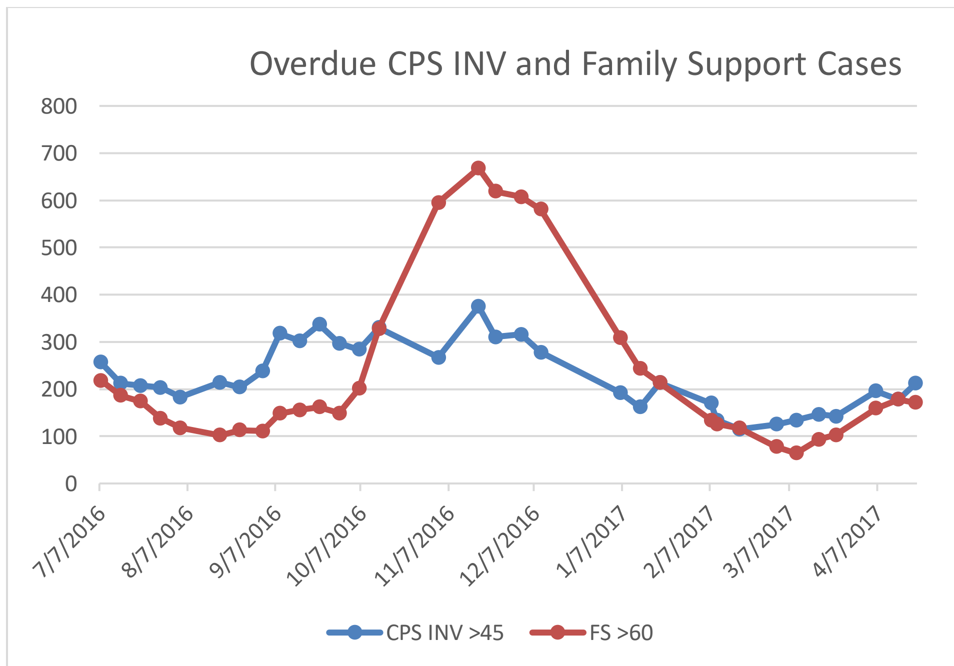
4. Parent Visits (Foster Care)



5. Parent Contacts (CPS)



6. Case Timeliness



Knowledge Management Section

FY-2017 High Level Accomplishments

The following is listing of high-level accomplishments made by the Division's Knowledge Management Section during FY17 and associated with the Division's strategic priorities.

- Administration for Children and Families approved our Program Improvement Plan (PIP) which, when fully executed, will serve to strengthen our practice and service to families. Four of ten quality PIP items were successfully achieve.
- Developed and began piloting our "New Worker Training Academy" which integrates competency-based coursework as well as experiential learning, inclusive of the use of simulation.
- Initiated a year-long project designed to enhance the functioning and impact of our Data Unit. Focused on three main areas; building a data-driven culture across the agency, infrastructure and business need.
- Continued statewide in-class training on Solution Based Casework (SBC) and, for regions that completed training, began facilitation of the certification phase (an on-average six month process during which time trained staff apply learning and develop proficiency in key SBC practice areas).
- Created a fidelity review team dedicated to reviewing the quality of our state-wide implementation of the various structural elements of Georgia's Practice Model.
- Completed development and dissemination of Georgia Practice Model policy.
- Designed and deployed foster care plan in SHINES to support implementation of SBC.
- Presented a workshop on Georgia's Practice Model at Child Welfare League of America's Annual National Conference in Washington D.C.
- Established SHINES interface with Georgia Gateway which allows staff to readily determine if a family is receiving eligible services (i.e. TANF, Food Stamps,Medicaid).
- Enhancements made to SHINES to align with Resource Development policy, thus strengthening safety and permanency-related practice.
- Instrumental in establishing methodology for data collection and review process related to the revised Kenny A. Consent Decree.

- Implemented Performance Improvement Collaborations (PIC) which served to strengthen the process by which results of our internal child and family service reviews are shared, analyzed and, most importantly, put to meaningful use.
.
- Completed evaluation of the agency's Employee Selection Protocol in order to identify frequency and fidelity of use and opportunity to strengthen its effectiveness in identifying viable candidates for front-line positions.

- Planned and held the Section's first annual Knowledge Management Summit, a two-day event that provided opportunity for learning, relationship building and strategic planning.

- Planned and held annual Supervisor Summit.

- Lead planning and facilitation of the Divisions monthly Leadership Development Meetings (joint Social Services and Office of Family Independence).

- Implemented a Policy Advisory Committee to strengthen development, review and dissemination of new child welfare policy.

- Established two SharePoint sites; one to house Federal Regulations and one to house Child Abuse Protocol for easy access.

- Increased Title IV-E Education Program participation from five to seven universities and began placing graduates into full-time agency positions.

- Rolled out Secondary Trauma Training for supervisors and front-line staff in order to educate them on the impact of trauma as well as means to mitigate impact.

- Through persistent and thoughtful advocacy, helped secure $2.5M in funding to develop a Supervisor Mentor Program which will serve to strengthen the agency's workforce.

- Co-founded Georgia PROUD, a multi-agency partnership to identify best practices for interventions with families of infants suffering from Neonatal Abstinence Syndrome.

STATE OF GEORGIA

Division of Family and Children Services

Nathan Deal
Governor

Bobby D. Cagle
Director

DFCS Office of Family Independence Year-in-Review (FY 2017)

This report contains a brief description of high-level accomplishments of the Division's Office of Family Independence (OFI) in FY 2017 in support of the "Blueprint for Change" and the Division's leadership vision and priorities.

1. **New Integrated Eligibility System – Georgia Gateway**

   Together, four Georgia State agencies – Department of Human Services (DHS), Department of Public Health (DPH), Department of Early Care and Learning (DECAL) and Department of Community Health (DCH) – collaborated to design and implement a computer-based integrated eligibility system and business processes across seven State benefit programs. The seven programs include: Medicaid and PeachCare for Kids, Supplemental Nutrition Assistance Program (SNAP, also known as Food Stamps), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), Child Care, and coming in the fall of 2018, the Low Income Home Energy Assistance Program (LIHEAP). The new system is called Georgia Gateway, and will be fully implemented in FY18.

2. **Continued implementation of the One Caseworker, One Family practice model**

   OFI continues to operate under the more locally-driven One Caseworker, One Family model. This model is designed to ensure that customers are served in their local counties whenever possible. This practice model, implemented in FY16, has served as the catalyst for many additional improvements in our overall service to the citizens of Georgia.

3. **Market Based Pay increases for OFI Staff**

   To address staff turnover in the OFI section, leadership reviewed the equivalent Job Market Survey from the Southeast region provided by the Georgia Human Resources Association (HRA), which provided data to support an increase in our entry level salaries for all core staff – front-line staff, supervisors and administrators. These increases were effective March 1, 2017.

4. **Progress made in closing findings on the Food and Nutrition Services (FNS) Management Evaluation.**

   During this fiscal year, OFI was successful in closing 8 of 19 findings. It is anticipated that the eleven additional findings (5 issues) will be closed within the next four months.

5. **SNAP QC Accuracy**

   OFI successfully lowered the SNAP error rate from 4.70% in FFY2015 to 4.04% in FFY2016.

6. **SNAP Time-Limit Able Bodied Adult without Dependents (ABAWD) program operational in 24 counties**

   The ABAWD Time-Limit Program was reinstated in January 2016 in three counties – Cobb, Gwinnett and Hall. The ABAWDs in time-limit counties are required to be in a work or skill-building activity to receive SNAP benefits beyond their initial 3 months of eligibility. This program was successfully expanded to an additional 21 counties in FY17. Staffs are planning to add an additional 69 counties to be added in FY18.

7. **Implemented the SNAP Works 2.0 Grant in ten counties**

   Georgia received a $15 million dollar grant from the USDA Food and Nutrition Services (FNS) to provide a pilot SNAP E&T program for 10 counties. This grant is funded for three years from October 2015 through October 2018. The 10 counties included in the pilot are: Bulloch, Chatham, Cherokee, Clayton, DeKalb, Douglas, Glynn, Gwinnett, Henry and Rockdale. The money was fully approved in January 2016, and the services began being rolled out in late January. The program was implemented in waves, with all counties operational as of the end of June 2016 and continued throughout FY17.

8. **Peach Stars, Quality Stars and Quality Leaders Awards**

   A robust recognition program continued to thrive in OFI, with over 1450 Peach Stars awarded since January 2016. Peach Stars are awarded for demonstrations of superior internal and/or external customer service. Staff are nominated for Peach Stars by peers and management. Quality Stars (Front-line Staff) and Quality Leaders (Supervisors) are awards given for accuracy on Quality Control case reviews. Over 175 Quality Stars and Quality Leader Awards are presented each month.

9. Gateway Training

All OFI staff trained on Georgia Gateway. Child Welfare and other staffs that need inquiry access to Gateway were trained as required.

Additionally, Chief Deputy Division Director, Jon Anderson, held 15 Gateway Overview sessions with a total of 2,331 staff. These user-focused workshops were held from January 10, 2017 through August 16, 2017 in Macon, GA in preparation for statewide implementation of the new system.

10. Performance, Feedback and Enhancement Committee

The Performance, Feedback and Enhancement Committee (PFE) continues to be a source of support to the field across all program areas. During the past year, PFE has implemented the following projects to enhance the performance of OFI staff:

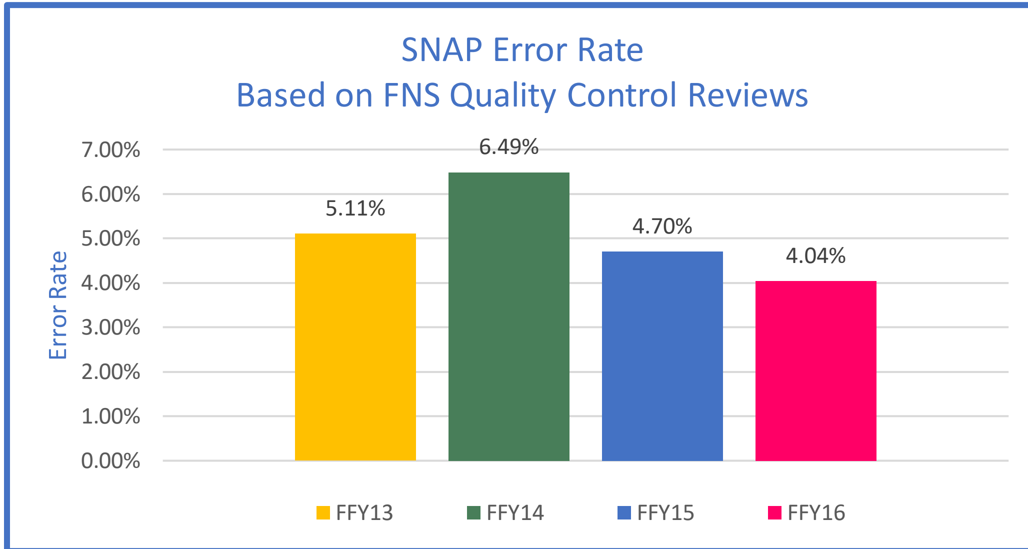
- Quality Checks/Sweet 16 Case Reading Process
- Quality Summit
- Gateway: Crossing the Bridge to Accuracy Training
- Gateway Documentation Requirements Training
- OFI Day 1 Training
- Standardized Unit Meeting Agenda and Supervisor Notes
- Quality Control Corner

11. Community Services Block Grant (CSBG) increases Customer Satisfaction

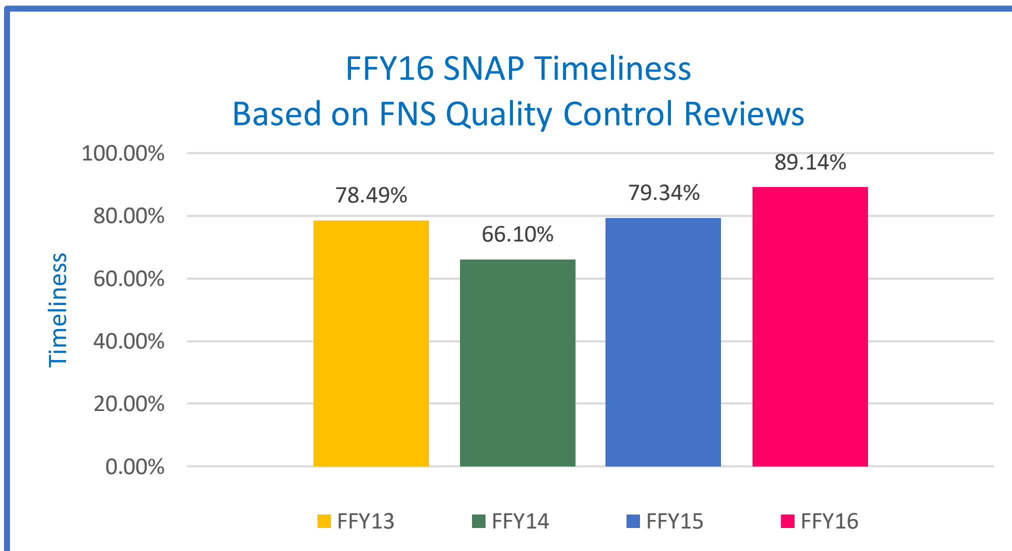
The American Customer Satisfaction Index (ACSI) is the national indicator of customer evaluations of the quality of goods and services available to US residents. The program's objective for CSBG was to measure satisfaction of Community Services Block Grant eligible entities to better understand how well the States are delivering services to the local eligible entities, in which we have 24 in Georgia. During the last year the CSBG program has been working to improve the initial results of a 42% out of 100%. We just received the new results for Georgia and it is now a 66% out of 100%. Increasing our score 24 points is outstanding. The national increase was 5 points and they felt that was a tremendous increase.

OFI Performance Indicators

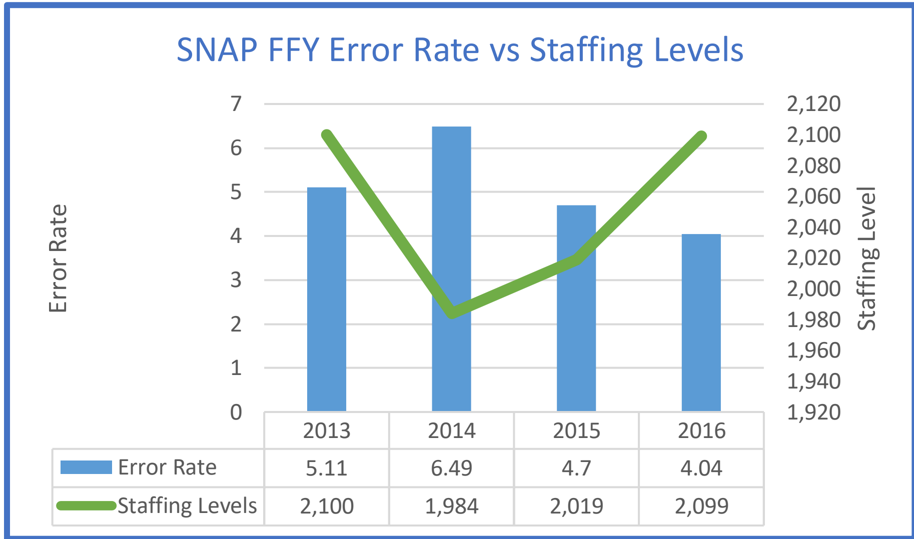
1. SNAP Accuracy



2. SNAP Timeliness



3. Staffing vs Error Rate



	2013	2014	2015	2016
Error Rate	5.11	6.49	4.7	4.04
Staffing Levels	2,100	1,984	2,019	2,099

Georgia Division of Family and Children Services
Practice and Program Guidance SFY 2017 Accomplishments

Well-Being Services Section

Georgia R.Y.S.E. / ILP Accomplishments	
Completed the plan for CB 21 (extended foster care plan)	Plan will be used to present for legislative consideration
Completed 1.5 years of ETV partnership with UGA/Fanning Institute	• Improved financial distribution to college students. • Improved engagement with colleges/universities • Development of electronic database to track and monitor ETV paperwork • Development of website to
Pilot Project with Georgia's Drivers Education Commission (GDEC)	• Provide additional support for youth to complete the driver's education process from beginning to end. • Increased the number of youth able to access resource by 50 youth.
Partnership with Columbus Housing Authority and local case management provider.	Provide housing opportunities for youth in Columbus with intensive support
Orange Duffel Bag educational partnership	Provide educational support and workshops to at least 50 youth to improve academic outcomes for high school students.
MAAC Partnership for ILP Workshops	Per Chafee purposes resources through workshops for youth are provided monthly covering multiple topics (i.e., finances, education, self-esteem etc.)
Early Childhood Collaboration	
Streamline referral process for children in foster care under the age of five to quality early childhood education programming.	• Increased early childhood education program enrollment from 32.95% to 38%. This is a strategy in the Strategic Plan. • Child and Family Service Review – Well-Being Outcome 2 (Meet the Educational Needs of Foster Youth)
Strengthen relationship between child welfare and Head Start/Early Head Start Association	• Facilitated meetings, trainings, and workshops along with Head Start leadership at the federal, state, and local levels targeted at: Foster Parents, DFCS Staff, Head Start Staff, Community Partners • Total-23

<table>
<tr><td></td><td>Child and Family Service Review – Well-Being Outcome 2 (Meet the Educational Needs of Foster Youth)</td></tr>
<tr><td>Strength relationship between child welfare and DECAL.</td><td>Partnered with the DECAL to ensure priority and facilitate enrollment in the following programs:
Georgia Pre-K-
Quality Rated Child Care Programs
CAPS
Child and Family Service Review – Well-Being Outcome 2 (Meet the Educational Needs of Foster Youth)</td></tr>
<tr><td colspan="2">Support and In-Home Services</td></tr>
<tr><td>Paternity Testing Request for Proposal (RFP)</td><td>RFP was administered successfully and a new vendor was selected to begin services October 1, 2017.</td></tr>
<tr><td>Interagency Collaboration: DHS Coordinated Transportation</td><td>Relationships were developed with DHS Coordinated Transportation to begin discussions surrounding transportation issues in rural areas and provide additional resources to children and families in foster care to meet the needs of visitation requirements and reaching educational goals.</td></tr>
<tr><td>Support Services Programs RFPs revised and posted to meet the demands of the families served in Georgia to ensure quality providers are selected.</td><td>Homestead, Early Intervention, Comprehensive Child and Family Assessment (CCFA), WRAP Around Services have posted and are currently under evaluation to increase the pool of qualitative vendors to assist in meeting the mental health needs of families.</td></tr>
<tr><td>Alcohol and Drug Screening Services</td><td>A RFP has been posted for this service and is under negotiation with a final vendor with agreements to train DFCS staff to conduct screenings.
Because of this initiative, the Department should begin seeing a reduction in time for reporting results to court to make decisions on families' futures</td></tr>
<tr><td>Partnership: Timeliness of Payments</td><td>Support Services worked collaboratively with the field leadership and the fiscal department to begin developing a plan to better ensure our external partners are paid in a timely manner.</td></tr>
<tr><td colspan="2">Community Programs</td></tr>
<tr><td>Afterschool Care Program</td><td>Forty (40) community-based organizations and public agencies instituted the Power up for 30 GA Shape program during their afterschool program. Approximately 56,000 youth participate in GA SHAPE activities during the out-of-school time through this partnership.
Initiated through the Governor's Office.</td></tr>
</table>

Afterschool Care Program	Number of youth served: approximately 56,000 youth were supported through DFCS Afterschool Care Program Funding.
Educational Programming, Assessment and Consultation (EPAC)	Increased EPAC referral rate from 48% to 65%
Educational Programming, Assessment and Consultation (EPAC)	Conducted Statewide Education Academies to ensure Case Managers are knowledgeable of the tools, and resources to ensure educational stability for youth on their caseload. • Every Student Succeeds Act • Child and Family Service Review – Well-Being Outcome 2 (Meet the Educational Needs of Foster Youth)
Georgia TeenWork Internship Program	Provide quality job readiness training to youth. Increase the number and breath of job readiness trainings: • Number of job readiness trainings: 15 • Number of Youth Participants: 797 *US Chamber of Commerce: Making Youth Employment Work
Georgia TeenWork Internship Program	Job Readiness Training curriculum was created and provided to 797 foster youth *US Chamber of Commerce: Making Youth Employment Work
Wellness Programming Assessment and Consultation (WPAC)	
Interagency Partnerships	In partnership with PRO Team, created a Hospital Escalation Protocol to improve Agency responsiveness for HealthCare providers
Healthcare Innovations	In partnership with Amerigroup, ensured appropriate counties had Mobile Response Unit, School Clinics, and Court Clinics
Well-Being Services	
25th Celebration of Excellence: ILP and Community Programs	Organized and convened the 25th Annual Celebration of Excellence (COE). This event celebrates high school and post-secondary academic attainment for young people in foster Care. More than 200 young people were recognized
4th Annual Teens R 4 Me Conference: ILP, Community Program, WPAC	Organized and convened the 4th Annual Teens R 4 Me Conference. This event supports positive well-being outcomes for youth in faster care (14-17) and the practitioners that support their trek to adulthood. More than 150 children and 100 adults attend.
Project Graduate	• Project Graduate is a collaborative effort between the Division and key stakeholders to improve the graduation rates of Georgia's foster youth by

	providing coordinated supports while leveraging existing resources. • This initiative spanned the 2016-2017 academic year in DeKalb and Fulton counties. Primarily engaging the four school districts within those counties: Atlanta Public Schools, Decatur City Schools, DeKalb County Schools and Fulton County Schools.
Implementation of new education service delivery model	In partnership with a Lead Education Partner Agency - the Multi-Agency Alliance Children (MAAC) – the Division will ensure the educational needs for children in foster care are met so they can achieve academic success, including improved high school graduation rates and a decrease in negative indicators such as over representation in disciplinary interventions and grade retention. • Beginning August 1, 2017 • Fulton and DeKalb Counties Children/Youth enrolled in the 7th – 12th Grades or pursuing a GED (As of July 15, 2017

Safety Services Section

Safety Accomplishments	
Developed the agency's Comprehensive Addition and Recovery Act implementation plan	Plan will be used to ensure federal compliance by implementing a DFCS Response for infants affected by prenatal exposure or Fetal Alcohol Syndrome AND due to prenatal exposure but the mother's substance use is supervised by a medical professional.
Partnership with Georgia PROUD (Partnership for Recovery Over Using Drugs) Team. Georgia PROUD grew out of the Safety Sections Advisory Committee	• The goal of Georgia PROUD is to identify best practices when developing Plans of Safe Care for infants and their families affected by prenatal substance exposure and to fully comply with all requirements of CAPTA and CARA. • The team is receiving In-Depth Technical Assistance (IDTA) from the National Academy on Substance Abuse and Child Welfare and is ensuring Georgia takes all steps necessary to serve these children and their families and caregivers. • Georgia PROUD was selected to attend the SAMHSA 2017 Policy Academy: Improving

	Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders, and their Infants and Families on February 7-8, 2017
Safe Sleep Initiative	• Decrease sleep related deaths of children known to the department by 5% annually to include the following: • Provided technical assistance and materials to Savannahs Perinatal Initiative Program providers. • Resources provided flip charts and family guides for Latino families to county offices.
Enhanced case review practice of High Risk Cases	In partnership the Safety FPS two additional review levels were included in the Safety Panel Review Process of High Risk Cases.
Georgia's Child Abuse Registry	Maintains a listing of all substantiated cases of child abuse and expanded screening access to the entities, listed below, to prevent maltreators from supervising or caring for children. • Contracted agencies of governmental entities • Any entity licensed by any other state to place children for adoption • A Child-Placing Agency licensed in Georgia to place children in foster homes or for adoption
Completion of Georgia's First Quarter Safety Program Improvement Plans (PIP)	• Developed a substance abuse protocol in partnership with the Courts and Substance Abuse Providers to increase parental capacity and improve safety outcomes. • The Safety Resource Approval Checklist was developed to ensure appropriate practice and compliance with time frames.

Prevention & Family Support Services Section

Prevention Accomplishments	
Safe Sleep Community Educator Training - develop a community educator training program with Clayton and Richmond Counties (two highest risk counties). Partner with DPH to provide the training. The Community Educators will be identified by the county DFCS program managers to be community members such as faith-based organizations, in-home childcare providers, community volunteers, etc. They will then be responsible for providing safe sleep classes to parents of newborns in their	Safe Sleep in strategic plan - safety outcome: reduction in the incidence of babies being killed or injured due to unsafe sleep environments

communities. We will use pack-n-play cribs as incentives for attending the classes.	
Purchase of pack and plays for safe sleep - determine process for purchase of cribs and distribution to DFCS counties/regions.	Safe Sleep in strategic plan
Addition of DFCS C3 Community Resource Guides to Prevent Child Abuse Georgia online resource guide. OPFS provides funding to PCA GA to man a 1-800-CHILDREN Helpline with an online resource directory. We have offered to fund having the DFCS resources from the C3 Coordinators added to the online resource directory. This will also be added into SHINES for a quick link to the map.	Strategic Plan - provide additional resources to families and DFCS staff by providing ready access to local resources to be utilized by staff and/or families and caregivers.
Training of Kinship Navigators in Parent Cafes - we are working with Strengthening Families GA and Tacia Estem to coordinate Parent Café training for the kinship navigators. Trainings will be held in Spring 2018. Planning meetings held in 2017. Parent Cafes are a Strengthening Families initiative based on the World Cafe model where kinship caregivers will be invited to attend, build social connections with other parents or caregivers, and discuss items of relevance to raising their kin.	Strategic Plan - to provide kin placements with more resources
Providing Parentivity as a resource to Kinship Navigators - Parentivity is a web-based application for families of young children. It includes resources about child health and development, child safety, safe sleep, and resources for families. We will be coordinating the use of Parentivity with the Kinship Navigators. Eventually, we intend to expand to all of DFCS.	Strategic Plan - to provide kin placements with additional resources by providing them a web-based application to learn more about child development, parenting skills, safe sleep, and other topics relevant to raising kin.
Strengthening Families - OPFS is the primary funded for the Strengthening Families GA initiative. Works to embed the Protective Factors into work of all family/child-serving agencies, including DFCS.	Agency outcome - SBC and practice model supported by incorporation of SF PFs to help strengthen families.
Essentials for Childhood - a CDC initiative to promote safe, stable, nurturing relationships and environments through a collective impact approach. OPFS provides the funding for the	Agency outcome - CDC's Essentials for Childhood aligns with the State of Hope initiative

initiative and represents DFCS on the steering committee.	
Georgia Family Connection Child Abuse Prevention Cohort - developed a new contract with GA Family Connection Collaborative to develop a cohort of counties to address the prevention of child maltreatment as their primary strategy.	Agency outcome - constituent engagement and aligns with State of Hope
Better Brains for Babies - OPFS is the primary funder for the BBB initiative which provides trainings and expertise on early brain development and the impact of trauma. OPFS sits on the Advisory Board. BBB worked on the Talk With Me Baby brain modules through contract funding from OPFS.	Strategic Plan - offering training to DFCS staff about early brain development.
Child Abuse Prevention Month Activities - coordinated events and activities for the national Child Abuse Prevention month (April). Hosted a CAP Day at 2 Peachtree, coordinated a showing of the Resilience documentary coordinated a Governor's proclamation signing, coordinated resources provided to DFCS Board and DFCS staff throughout counties/regions/districts. Produced a calendar for families and distributed calendars, magnets, pinwheels, and lapel pins to 159 counties/all DFCS staff and providers.	Agency outcome - constituent engagement, prevention
Transition of MIECHV to DPH - the federal Maternal, Infant, Early Childhood Home Visiting grant was officially transferred to DPH. OPFS continues to fund some home visiting sites and First Steps, the screening component of home visiting.	N/A
PREP Adolescent Pregnancy Prevention Program moved under OPFS in April 2017. PREP provided: • 34 New Facilitators Trained in Making a Difference and Making Proud Choices • 1 New Facilitators Trained in Be Proud! Be Responsible! Be Protective! • 6 Professional Development Trainings (3 In-person and 3 Webinars) • 3 Connected Caregiver Trainings for Foster Parents and other Caregivers • Served and graduated 810 youth as of 8/15/2017	Federal grant requirements for PREP grant. PREP grant provides comprehensive sex education to youth throughout the state, both those in and out of care.

Placement and Permanency Services Section

Placement & Permanency Accomplishments	
Formed partnership with private placement providers to further align public and private foster home requirements, develop Flexible Capacity Agreement pilot & further systemic innovations.	The partnership has resulted in the following outcomes thus far: • Modification of program standards for Independent Living Programs (ILPs) and Transitional Living Programs (TLPs), and development of new standards for Personal Care Homes (PCHs). • Flexible Capacity for SMFWO agencies • Assessment of DBHDD Tiered model
Completed SHINES Enhancement/Foster Care Management- Child Placement Referral Form-Universal Application. This allows for one tool to be used by county DFCS offices, all private agencies and the state PRO Team.	• Modifications to existing pages • Three new pages • New system validation/automation • New notice/letter
Completed GA+SCORE Enhancements.	The enhancements resulted in the follow efficiencies: • Modification to existing Referral process for PRO • Allows automated responses and notifications sent between PRO and Field • Allows Providers and Field to know "where they are" in the process by providing system updates • Tracks and keeps record of all correspondence with Field and saves copy of waiver • Decreases timeframe on request
Partnered in the development phase of the Youth Villages Intercept Model pending contract.	The partnership sought to improve outcomes in the following areas: • Crisis Stabilization • Addressing systemic needs of families to move children from state custody to biological family custody
State PRO Team was active in the Children's Freedom Initiative, a collaborative effort to ensure that children who live in facilities are given the chance to live with permanent, loving families.	• The CFI is supported by the Georgia Developmental Disabilities Network, which receives funding from the Administration on Developmental Disabilities, and includes The Georgia Council on Developmental Disabilities (GCDD), the Institute on Human Development and Disability at the University of Georgia (IHDD), The Georgia Advocacy Office (GAO), and the Center for Leadership in Disability at Georgia State University (CLD).

Completed major project to address Non-Contracted Provider Standards and Guidelines and reduce by 85% children who were placed in non-contracted providers.	Accomplishments include: • Cease usage of Non Contracted Providers in 85% of child cases. • Development of Non Contracted Governance Document • Implementation of Non Contracted Monitoring • Onboarding of Non Contracted Agencies • Eliminated Non Contracted providers who do not require licensing
Partnered with MAAC to execute the Crisis Continuum.	• Crisis Stabilization • MAAC has developed a crisis response continuum with partner agencies to decrease the need for hotel "placements". • MAAC will add additional supports for youth referred to this program in order to stabilize the youth and plan for the most appropriate placement DFCS will have 25 "slots" available at any given time to utilize fo1· these youth. MAAC will serve approximately 200 youth over the 12 month period of time. Youth will be place under MAAC's current RBWO contract and receive crisis response services for 30 days
Developed and implemented PRO/OPM Regional Roadshows.	• Engagement with the Field regarding PRO and OPM Units, processes and protocols
Developed FPS/PRO Collaboration, implementation pending.	• Collaborative effort between FPS and PRO to establish a strong partnership. It is further recommended that the scope and authority of the state level PRO Team be refined. Specifically: • Treatment FPS will provide primary education and guidance to field staff regarding the general placement locating process. • Treatment FPS will assist the field in locating base to moderate level placements and serve as a gatekeeper for appropriate high end need referrals to the state level PRO Team. • State level PRO Team Specialists will be assigned to specific Field Operations Districts to better collaboration with specific Treatment FPS and follow District high end children to ensure quality services and placements. • The state level PRO Team will provide direct intervention with high end providers to efficiently secure placements. • State level PRO Team will become more actively engaged in the assessment of available high end placement openings, an understanding of the acuity mix of the placement providers and the negotiation of

	what is needed to secure expedient high end placements. State level PRO Team and Treatment FPS will re-institute "utilization reviews," regularly scheduled meetings with high end placement providers to assess each child's treatment, progress, ability to move to a less restrictive setting and progress towards a permanency plan.
Execution of the National Electronic Interstate Compact Exchange (NEICE) system in Georgia.	• GA ICPC went Live March 03, 2017/ Participating in this cloud-based electronic system that allows the exchange of data and documents necessary to place children across state lines shortens the time it takes to place children across state lines, reduce costs associated with mailing and copying documents, and provide an improved method of tracking ICPC requests.
Developed regional sit visits and training for permanency field staff.	Provided onsite training to all ICPC Liaisons, Region 8, 6, 13, and 3/Increase knowledge and expectation of the ICPC process to the agency as a whole. All regions will receive training and ongoing yearly.
Updated ICPC Policy	• Went over final revisions and waiting on policy unit to provide to all Regions / Reduction of system barriers from the State and Local level
Reduction of and continued focus on overdue cases in the ICPC database.	Accomplishments include: Decreased monthly and currently at 63/Fewer constituent complaints in regards to timeliness of home study request.
Successfully transitioned SSAU to Placement & Permanency Services.	Resulting in the reduction of barriers for families and staff that will improve timely permanency for children.
Completed adoption Re-alignment with specific focus on Adoption Assistance.	Outcome: • Consistency in practice and provision of a continuum of services to adoptive families
Initiated the development of Contracts specific focus and staffing.	• Improved timeliness for contract execution and managing of sections fiscal duties • Improved the quality of contract scope and deliverables.
Completed Gateway transition for Adoption Medicaid.	• Supportive services to adoptive families to ensure finalized adoptions remain stable
PIP Items Finalized for Q1 – Q3	• Improved CSFR outcomes for state and families
State Strategic Plan: Kinship Navigator program provided services and supports to 2700 kinship families. Increased	**State Strategic Plan:** Increasing the stability, identification, and tracking of informal and formal relative placements

engagement of kin caretakers during investigations and family preservation cases.	
The Risk Management section hosts a monthly meeting with various stakeholders and sister agencies to discuss any patterns and trends as it pertains to the providers we contract with.	• During the 2017 fiscal year, representatives from the Fiscal Department, Revenue Maximization Unit and the Dept. of Juvenile Justice Revenue Maximization Unit were included and have initiated participation in the monthly Risk Management roundtable meetings so that all relevant parties are aware of any concerns or identified problematic issues with any of our providers.
The Office of Provider Management have also developed and incorporated various methods in which corrective measures will be implemented with regards to providers that violate any of our policies or procedures.	• Some of these corrective measures include increasing the penalties on provider's PBP scores associated with concerns that were identified to be an ongoing pattern for providers during the year which includes the untimely submission of Policy Violation Assessments, Corrective Action Plans, Significant Events and Performance Improvement Plans. These were concerns that were identified throughout the fiscal year that required immediate resolution.
The Office of Provider Management also initiated meeting with the Policy Unit to provide additional assistance in the development of the RBWO Minimum Standards for the upcoming 2018 fiscal year to ensure that our standards matched and parallel any new or existing changes to DFCS child welfare policy.	Various new policies were also developed and implemented into our existing RBWO Minimum Standards which would address some of the patterns and concerns identified throughout the year.
The Office of Provider Management also provided various trainings to our providers to address the surrounding deficiencies outlined in the PIP which resulted from a recent Title IV-E audit initiated by the federal government.	• 100% Audit was completed on all RBWO providers and this allows course corrections in order for the Division to perform well on our next federal audit.
The Office of Provider Management revised and expanded our New Provider Orientation this year. The Orientation was designed for all newly approved CCI's, CPA's and ILP's and lasted for two days. OPM offered two different Orientation sessions so that all newly approved providers had the opportunity to participate as this has aided the division with moving away from utilizing non-contracted providers.	• The New Provider Orientation is designed to give new providers a full overview of everything that will be expected as a contracted provider. The agenda included a full monitoring overview, a look at contractual obligations, RBWO Minimum Standards and DFCS policy requirements, OPM Training, Fiscal Services overview, accounting and billing process, provider dispute resolutions, waivers and the universal application, risk management, and Caregiver Recruitment and Retention.
The Office of Provider Managements has taken a more active role in monitoring provider Performance Based Placement (PBP) scores. For starters, we began by taking a look at providers	• Providers that fell into this category participated in an Office Conference to discuss their PBP performance, to identify any barriers that may be hindering their performance and for us to provide technical assistance

who had failing PBP scores for two or more consecutive quarters.	in any areas they needed assistance in. OPM met with a total of twenty-one providers between June and July to discuss their PBP performance.
The OPM Leadership Team began conducting technical assistance meetings for contracted providers in October 2016. Different topics were developed into modules for a full day of training. The intent was for providers to be able to participate in an interactive way, with a goal of improving performance. Topics of discussion included DFCS/RBWO Partnership, OPM Structure, Monitoring Reviews, Purposeful Documentation, Individualized Skills Plans, Maintaining GA+SCORE, SHINES Overview, Common Deficiencies, ILPs vs. TLPs, Normalcy for Children, Policy Violation Assessments, and Foster Home Approvals. We conducted successful trainings in Savannah, Macon, Columbus, Thomasville, and several in the Metro Atlanta area. The goal is to continue this project on an on-going basis, however we will update the topics/modules based on the informational needs of each fiscal year.	• OPM received overwhelming positive feedback while travelling the state. However, the one critic that always came up was that DFCS case managers do not seem to be on the same page with what we hold the providers to. As a result, the decision was made to travel once again, but to conduct trainings for a DFCS audience. We sent out an invitation to each of the regions with plans to visit local offices. We received a response from Regions 4, 5, 6, and 11. The response from DFCS employees was also extremely favorable.
With all of the new vacancies that OPM must fill, OPM recognized the need to develop a uniform Unit on-boarding process. All new hires going forward will have to successfully complete the same carefully structured three week orientation, before receiving focused job training in their new OPM role. The OPM New Hire Unit Orientation includes orientation with OHRMD, OPM Structure and Responsibilities, Permanency Section Overview, Unit Overviews, Introductions to GA+SCORE and SHINES, Provider Documentation, Significant Events, Minimum Standards, Risk Management Overview, Provider Relations Overview, Monitoring Tools, Professionalism/Customer Service/Ethics, Monitoring Reviews, RBWO Foundations, and Team Shadowing in Risk Management, Provider Relations, and Monitoring.	• The benefit is that if all new hires understand all aspects of OPM as a whole, it will produce excellence in each specific area of concentration.
Gained SHINES access for Bethany Christian Services for Child Life History completion.	• Reduced work for the field/better quality CLH. • 1,389 CLH completed
Implemented District Adoption Cadence Calls.	• More leadership participation and increase focus and adoptions

Implemented No Place Like Home monthly calls with Director Cagle.	• Leadership participation and drilling down of barriers to improve outcomes. To date 50% of the children in the cohort have been finalized.
Guardianship Waiver Training for waivers to be processed in the Regions.	• Developed and trained FPS on a guardianship decision guide. • Waivers are being processed consistent with State Office meaning better permanency outcomes for children.
Executed the Statewide Adoption Match Meeting.	• 282 Staff attend and received training 227 adoptable children presented, 171 (75%) had at least one potential match.
Executed Adoption Parties throughout the state.	• 195 Children attended Adoption Parties 196 Families 63% Potential Matches made
Contracted CPA (4)	• 150 Adoption placements 130 Finalization
Executed contract for ADOPTS adoption specific counseling & intervention services.	Outcomes: • 741 Family Counseling Sessions 275 Crisis Intervention Hours 530 Parent Coaching Sessions
Initiated the practice of Placement Resource Engagement Meetings between Regional Caregiver Recruitment and Retention (CRR) Teams and Private Agency Providers in their respective Areas.	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement*** – improves the local partnership of Field staff and private agency partners by increasing support from the point of inquiry of prospective caregivers, improve the efficiency of prospective caregiver onboarding buy using all available resources; increases availability of local placements to improve placement proximity.
Hosting Monthly Cadence Calls with Regional CRR Teams – *Began February 2016*	• ***2015-2019 CRR Plan Goal #2 – Improve organizational effectiveness regarding placement resource development, retention, and placement matching -*** Continuous accountability and engagement with field staff to assess adherence to practice and identify performance impediments
Hosting Quarterly Statewide Caregiver Recruitment and Retention Meetings with all CRR staff	• *Same as Item 2*
Weekly Webinar Information Sessions for Prospective Caregivers hosted by state-level team — *average 84% participation rate in webinar sessions.*	• ***2015-2019 CRR Plan Goal #3 – Increase the retention of prospective caregivers during the approval process and once approved, retain caregivers for at least five (5) years*** – Enhance the Foster Georgia Inquiry Line for prospective and fully approved caregivers by creating email materials, improving the website interface, and creating more

	effective communication linkages between the call center and county/regional resource development staff by September 2018
Utilization of caregiver navigators (5 part-time paid foster parents) to support prospective caregivers through the onboarding process Launched and Initiated public awareness of new website www.fostergeorgia.com September 2016 — included web-based inquiry form for prospective caregivers, as well as a chat feature for engagement with site visitors.	• *Same as Item 4* • ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement -*** Enhance the Foster Georgia Inquiry Line for prospective and fully approved caregivers by creating email materials, improving the website interface, and creating more effective communication linkages between the call center and county/regional resource development staff by September 2018
Statewide Recruitment Campaign through contract with vendor that led to the increase of traffic to the inquiry line and new website – September 2016 – February 2017.	• *Same as Item 6*
Launching of the Foster Georgia Inquiry Line manned by a state level team – *formerly outsourced to a vendor.*	• *Same as Item 6*
Resource Development SHINES Enhancements – May 2017	• ***2015-2019 CRR Plan Goal #3 – Increase the retention of prospective caregivers during the approval process and once approved, retain caregivers for at least five (5) years -*** Develop method of tracking prospective caregivers through the approval process by September 2018
Development of LENSE reports and Executive Dashboard for Resource Development	• ***Same as above***
Initiating the training of implementation of the SAFE Home Study	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement*** – establish uniformity in the assessment of caregivers using an evidence-based based assessment of both prospective and approved caregivers.
Launching of Statewide Targeted Recruitment Initiatives – February 2017	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement -*** Develop enhanced recruitment communication methods/distribution and materials to reach prospective caregivers from all communities.
Train-the-Trainer opportunities for RD and CPA staff December 2016 – March 2017 –	• ***2015-2019 CRR Plan Goal #3: Increase the retention of prospective caregivers during the approval process and once approved, retain caregivers for at least five***

Recognizing Developmental Delays in Children Ages 0-5	***years.*** – 2(a) Use information from the caregiver exit surveys to inform pre-service and ongoing training changes and improvements.
Implemented ongoing communication with caregivers via the *Foster Georgia Newsletter*	• ***2015-2019 CRR Plan Goal #3: Increase the retention of prospective caregivers during the approval process and once approved, retain caregivers for at least five years. -*** Increase support by establishing a regular and ongoing communication channel with foster, adoptive and relative caregivers by December 2016.
Implemented Quality Initial Family Assessment training with Foster Home Development Contractors, and established direct communication with vendors via the *Foster Home Development Contractor Newsletter*	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement***
Launching of RD Case Manager Track Training – first course offered September 2017.	• ***2015-2019 CRR Plan Goal #2 – Improve organizational effectiveness regarding placement resource development, retention, and placement matching -*** Implement the Recruit, Prepare and Retain Curriculum for resource development staff by September 2018.
Provided 5 Innovative Recruitment and Retention grants to private Agency Partners	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement***
Held "Think Tank" sessions with Regional RD Teams throughout the state to assess local practice and performance issues impeding work progress, and conducting solution-focused resolutions	• ***2015-2019 CRR Plan Goal #2 – Improve organizational effectiveness regarding placement resource development, retention, and placement matching -*** Utilize data more effectively in developing recruitment plans and training and providing technical assistance to county/regional resource development staff by September 2019

APPENDIX B

Funders Briefing

INVESTING IN HOPE
Philanthropy and Georgia's Children

INVESTING IN HOPE

Philanthropy and Georgia's Children

According to the latest Annie E. Casey Foundation KIDS COUNT assessment, Georgia ranked 42nd among all states in child well-being[1], pointing to a need for greater investment in child welfare. To help address this crisis, Georgia's child welfare system is teaming up with nonprofits, philanthropy, businesses and communities to create a place where people share a vision of safety and success for every child – **a State of Hope.**

Each year, **more than 163,000 children** come to the attention of child welfare officials in Georgia.[2] **Of that number:**

105,900

children receiving services as a result of an investigation.

13,200

children entering the foster care system as of 2017.

Youth in foster care are more likely to **fall behind in school** due to frequent school changes and lack of stability in their home environment. **As a result:**

In Georgia, only 11% of foster youth graduate from high school each year.[3]

Nationally, only half of foster youth graduate with a high school diploma.[4]

On average, 17–18 year-olds in foster care can only read at a 7th grade level.[4]

Foster youth without a diploma are ill-equipped for the job market when they leave the system, hurting not only them but also our state's economy. **Young people who exit out of foster care without a high school diploma typically earn $8,500 less per year in wages.** If foster youth graduated at the same rate as others, they would collectively earn $59,500,000 more per year, require less governmental support and contribute more in income taxes.[5]

Foster care is a direct response to abuse and neglect – **not a solution.**
Yet the number of children in Georgia entering the foster care system is **steadily increasing.**[3]

While the number of children entering foster care is growing, this remains a small share of all children in need of support services. Despite the need for increased programming focused on family preservation, the bulk of federal child welfare funds coming into the state can only be directed toward services related to foster care.[2]

$83.7 million of federal dollars spent on foster care services for **3,500 children.**

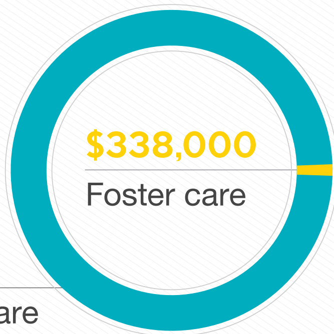
$22.7 million of federal dollars spent on prevention services for **163,000 children.**

*IN*VESTING *IN* HOPE

Philanthropy and Child Welfare in Georgia

Over five years ending in 2014, U.S. foundations awarded nearly $185 million to Georgia-based recipients in grants targeted toward children and youth services. Of that amount, **$40.8 million came in 2014** – the most recent year with available data. Here's a closer look at the funding from that year – where it came from, where it went and how it was targeted toward helping Georgia's children.[7]

In 2014, grants to preventative care services outweighed those going directly toward foster care:



$6.2 million
Preventative care

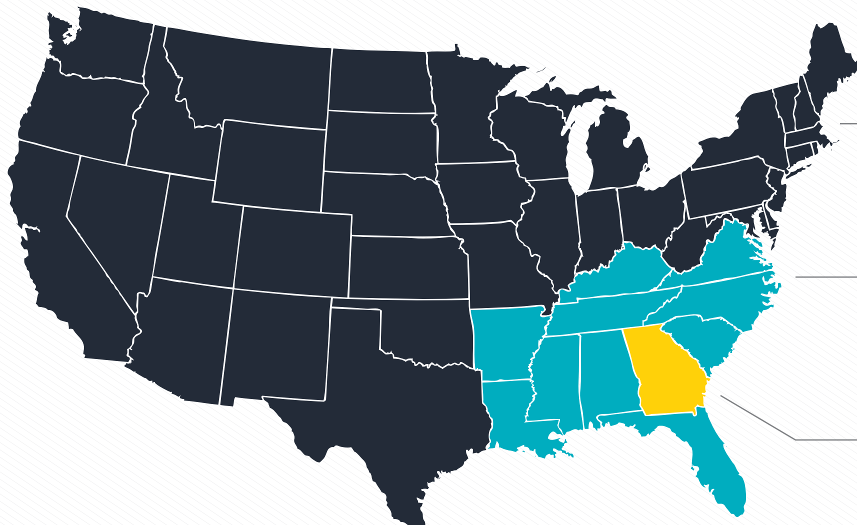
Top funding categories included:

Category	Amount
Youth Services	$20.6 million
Youth Development	$7.2 million
Child Welfare	$3.7 million
Children's Rights	$2.3 million
Child Care	$1.6 million

Particularly in **Georgia**, but also throughout the **Southeast** region, independent foundations led the way for funding in 2014. However, family, community and corporate funders have also invested millions in child welfare.[8]

	Independent	Corporate	Family	Community
Georgia	67.4% $27.5 million	11.5% $4.7 million	10.8% $4.4 million	10.4% $4.2 million
Southeast	$60.3 million 44.4%	$26.6 million 19.6%	$21.8 million 16%	$23.2 million 17%

For every $10 in child welfare grant dollars[6] awarded by foundations to recipients in Georgia in 2014, **$5.70 came from in-state funders**. Most of the remaining funding came from foundations located outside the Southeast.



Non-Southeast U.S.
$16.1 million

Non-Georgia Southeast
$1.6 million

State of Georgia
$23.1 million

INVESTING IN HOPE

Moving Together Toward a State of Hope

The power of partnership:

Public-private partnerships are essential, especially at the local level, and benefit greatly from the expertise of place-based funders like community and family foundations.

Fueling innovation:

Philanthropic investments are more flexible than public funds – this can be leveraged to support creative work in areas like research, training and leadership development.

Helping those in greatest need:

The creativity and flexibility of philanthropic investments would greatly benefit children already in foster care, who are often poorly positioned for success in school, work and life.

Broad impact:

Supporting those in foster care by developing a strategic focus on improving the quality of care-giving and developing a trauma-informed approach to working with families in crisis, the restoration of families can become a reality. This support has the potential to ensure that more children in care graduate from high school, setting them up for greater financial success and allowing them to contribute to our state's economic engine.

Sources & Footnotes:

1) Source: *Annie E. Casey Foundation. (2017). KIDS COUNT data book 2017.*
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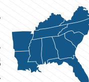
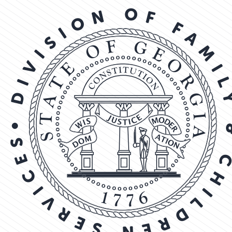
5) Source: *Jim Casey Youth Opportunities Initiative. (2013). Issue brief: Cost avoidance. The business case for investing in youth aging out of foster care.*
Retrieved from: http://www.aecf.org/m/resourcedoc/JCYOI-CostAvoidance-2013.pdf

6) Note: *Data reflected as of August 2017.*

7) Source: *Foundation Center, 2017. Based on all grants of $10,000 or more awarded by a sample of 1,000 of the largest U.S. private and community foundations.*
For community foundations, only discretionary grants are included. Grants to individuals are not included. Grants may benefit multiple subjects, and may therefore may be counted under more than one category.

8) Note: *Other types of foundations accounted for approximately 3 percent of giving to the Southeast. Due to rounding, percentages may not total 100.*





APPENDIX C

Child Abuse Registry Maltreatment Type Report

Georgia Department of Human Services

Division of Family and Children Services

Maltreatment Type Report

Report Parameters

Start Date: 07/01/2016
End Date: 12/31/2016
County: All

Maltreatment Type: All
Relationship: All
Maltreator: Adult

Maltreatment Type	Count
Physical Abuse	401
Sexual Abuse	252
Neglect	4519
Emotional Abuse	933

This section provides the total number of Maltreatment Types received by CPSIS based on the Date, Maltreator and Relationship parameters selected.

APPENDIX D

Child Fatality Analysis

CY15 Analysis

CY16 Analysis

GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES 2015 CHILD FATALITY ANALYSIS

Nathan Deal, Governor

Bobby D. Cagle, Division Director

NOTE FROM THE DIVISION DIRECTOR:

The Georgia Division of Family and Children Services is committed to the safety of Georgia's children in decisions made and actions taken. The death of a child is a matter of very serious concern to the Division as well as to the citizens of Georgia and the greater child welfare community. In accordance with the requirements of state law, the *2015 Child Fatality Analysis* focuses on the deaths for children whose families had been the subject of a report or investigation of maltreatment in Georgia within the last five years.

Each child victim of abuse or neglect should be remembered and mourned, and the circumstances of their deaths studied, so that any citizen in Georgia can understand the factors related to their deaths and apply these sobering lessons toward preventing the deaths of other children. Deaths can result from disease, accidents, unintentional injuries, lack of resources and information, poor judgment, or violence. Some deaths may be foreseeable and others unanticipated. It is our belief that many child deaths are preventable and that we can use data to guide us in accomplishing this overarching aim of prevention. The primary purpose of this report is to examine and make Georgia citizens aware of the multidimensional circumstances surrounding unexpected child deaths. Careful analysis of the causes and contributing factors can lead to recommendations for changes in law, policy, and practice as well as advance organizational learning. We want to improve outcomes for families while they are in our care and learn what might be needed after our involvement has ended.

As Director of the Georgia Division of Family and Children Services, my vision is to build a better future for this state by developing the best child welfare agency in the world. My plan to realize this vision is called the *Blueprint for Change*, a three-pillar approach to reforming Georgia's child welfare system. One pillar includes the establishment and adoption of a practice model that will serve as the foundation to keep children safe and strengthen families. A second pillar focuses on developing a robust workforce for the Division, both in numbers and level of expertise and training. The third pillar is focused on constituent engagement, which is an effort to engage with the public to build consensus and collaboration among partners, staff, and stakeholders. The development of this report speaks to and sheds light on the importance of each of these pillars.

The understanding and prevention of child deaths is a shared responsibility among agencies that serve the children and families of Georgia. I am confident that public reporting of child fatalities, coupled with a thoughtful and intentional review, will support the achievement of our common goals to keep children safe, strengthen families, and build stronger communities.

Bobby D. Cagle, Director
Georgia Division of Family and Children Services

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SECTION 1: PURPOSE OF THE CHILD FATALITY ANALYSIS

As the primary state agency charged with intervening on behalf of vulnerable children in Georgia, the Division of Family and Children Services (henceforth referred to as the Division) must continually review its practice and inform the public of efforts to reduce the risk of child abuse and neglect and mitigate its effects. For this reason, since 2012, the Division has generated an annual report on child deaths among children with any prior child welfare involvement, regardless of the cause of that death. For the purposes of this report, **involvement** is defined as any prior child protective services involvement with the Division within the five years prior to the date of death. Through this report, the Division endeavors to provide information over and above the federal requirement[1] for states to review and analyze child fatalities.

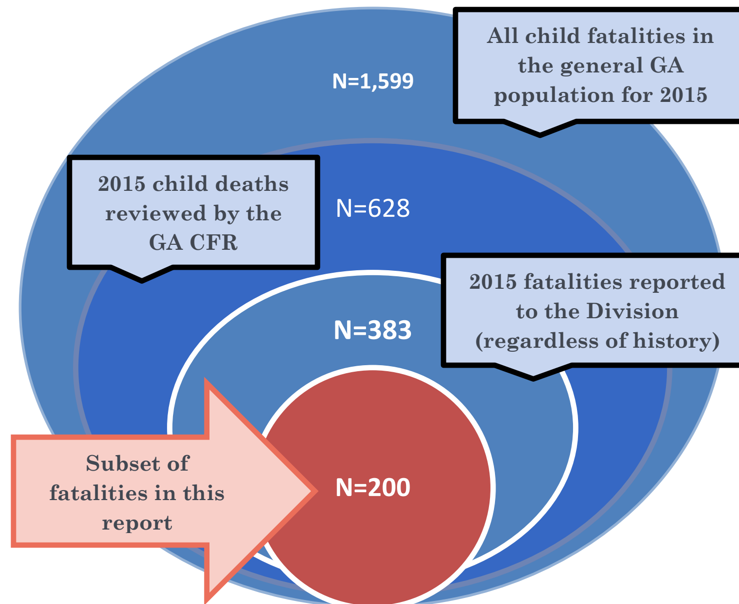
Multiple (and to some extent independent) entities collect data on child deaths in Georgia. The *2015 Child Fatality Analysis* complements the work of the Georgia Child Fatality Review Panel, because it assists the Division and the public in improving intervention efforts and in developing community-based solutions to reduce the risk of harm to Georgia's children. The Division is more closely focused on child deaths in instances where the children and/or their families had prior Division involvement. In contrast, the Georgia Child Fatality Review process (led by the Georgia Bureau of Investigation) has a broader focus that reviews all unexplained, suspicious or unexpected deaths of any minor child in the state.

Therefore, the child deaths reported by the Division in this analysis should be understood as a subgroup of the deaths reported by the Georgia Child Fatality Review, as well as a subset of the overall child deaths reported to the Division during calendar year 2015 (see Figure 1.1). Additionally, data reported from the National Child Abuse and Neglect Data System (NCANDS) are yet another subset of Georgia deaths reviewed by the Division and should be separated from the children identified in this analysis. NCANDS does not distinguish whether prior Division involvement existed.

Ultimately, our ability to understand and prevent deaths among children with child welfare involvement will hinge on our capacity to contextualize these deaths by contrasting them with all child deaths in Georgia. Such context can provide further insight into case characteristics and circumstances surrounding a child's death. As our access to comparison data grows, in the future we will begin to learn whether these circumstances and characteristics serve to predict risk for child deaths.

[1] Per 42 U.S. C. Sec. 5106a (b) (2) (B) (x) of the Child Abuse Prevention and Treatment Act. See: https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap67.htm

Figure 1.1. Child Fatalities Discussed in this Report in the Context of All 2015 Child Fatalities in the General Georgia Population.



Note. The most recent data available for all child fatalities in the general Georgia population are from 2015.[2] In 2015, 1,599 children under the age of 18 years died. In 2015, the Georgia Child Fatality Review Panel reviewed 628 child deaths. For 2015, a total of 383 child deaths were reported to the Division. Of these, 200 children were identified as members of families who had some form of child welfare involvement with the Division within the previous five years.

[2] Georgia Department of Public Health. Online Analytical Statistical Information System (OASIS). Obtained on October 15, 2016 from URL: oasis.state.ga.us.

SECTION 2: METHODOLOGY OF THE DIVISION'S CHILD FATALITY ANALYSIS

This report reflects data collected on child deaths that occurred in Georgia between January 1, 2015 and December 31, 2015 for children whose families had Division involvement within the five years preceding the child's death.[3] For the purpose of this report, a family includes a caregiver and any children included in prior reports, as well as any newborn child or other children who moved into the home after the prior report. This report does not include deaths reported to the Division for children whose families had no prior Division involvement.

Reports of child fatalities in this analysis are classified by cause and manner of death as outlined in Section 3. ***All information presented here is based on data available as of July 22, 2016.***

Since 2011, the Division has sought to improve child death data collection methodologies and strengthen reporting mechanisms. The Division's child death review team has aggressively pursued internal policy requirements regarding the reporting of child deaths. Efforts to engage external stakeholders on the need to provide accurate data have resulted in more consistent reporting of child fatalities. This rigorous process may result in an increase in the number of identified deaths. However, this process has improved the Division's collection of child death data and will result in a more comprehensive analysis of child welfare practice going forward.

Child death data were analyzed by the Division's Data Analysis Unit and by researchers at Georgia State University's School of Public Health. Enhanced collaborations with the Office of the Child Advocate, Child Fatality Review and the Child Abuse and Prevention Treatment Act prevention team also allowed for an additional review of many deaths and offered implications for both prevention and practice enhancements.

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[3] As relates to this sample, *Official Code of Georgia (O.C.G.A.) §15-11-741* defines a child as "an individual receiving protective services from DFCS, for whom DFCS has an open case file, or who has been, or whose siblings, parents, or other caretakers have been, the subject of a report to DFCS within the previous 5 years."

SECTION 3: CLASSIFICATION OF CHILD FATALITIES BY CAUSE AND MANNER

Defining Causes and Manners of Death

Cause of Death refers to a specific forensic finding of how a death occurred (e.g., drowning, gunshot, suffocation, Sudden Unexpected Infant Death, etc.).

Manner of Death is an official classification by a coroner or Medical Examiner of how the cause of death occurred. Five classifications are used to describe the manner of death: *accident, homicide, natural, suicide, and undetermined*. These manners of death are used on death certificates and autopsy reports. Note that for each manner of death, there could potentially be multiple causes of death. Each manner of death included in this report is individually defined below.

Table 3.1. Definitions[4] for Manners of Death.

Manner of Death	Definition	Examples
Accident	An unintended death.	• Drowning • Motor vehicle accident • Accidental asphyxiation while sleeping with an infant
Homicide	The death was caused by the actions of another person.	• Malnutrition and/or dehydration due to neglect • Shooting by stranger or caregiver
Natural	The death was from disease or medical conditions.	• Death due to a medical condition such as Sickle Cell Anemia, Cerebral Palsy, or Cancer • Sudden Infant Death Syndrome (SIDS) is often categorized as natural.
Suicide	A death that is intentionally self-inflicted.	• Hanging • Self-inflicted gunshot • Overdose
Undetermined	There is little or no evidence to establish, with medical certainty, the cause of death.	• When specific details surrounding the death are unclear, it is often categorized as undetermined. • Sudden Unexpected Infant Death (SUID) and sleep-related deaths are often categorized as undetermined.

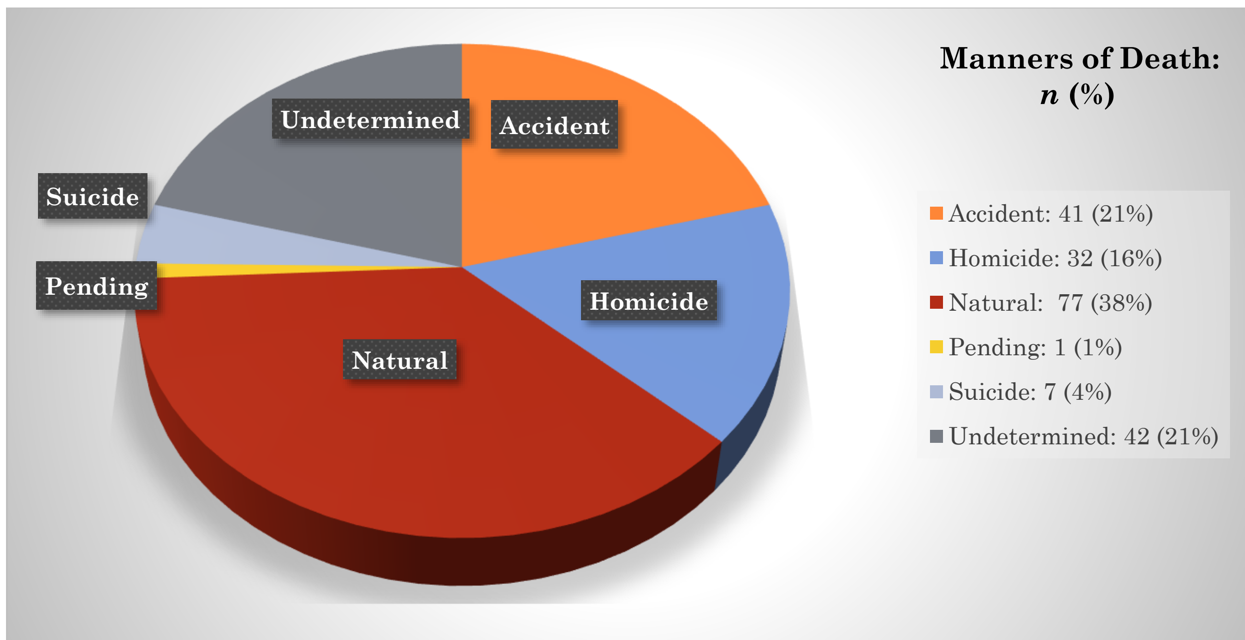
[4] Definitions obtained on September 3, 2016 from https://gbi.georgia.gov/medical-examiners-office.

Of note, many people, confuse the terms homicide and murder. Murder is a criminal charge or the unlawful taking of a human life by another. After the medical examiner determines the manner of death to be a homicide, then law enforcement investigates that death to determine if there is probable cause to bring the criminal charge of murder against the person who caused the death. While all murders are homicides, not all homicides are murders.

An official cause and manner of death is not always associated with a finding of abuse or neglect. For example, a child may die because of an accident (such as a drowning), but maltreatment may also be found in a caregiver's actions (e.g., substance use) or inaction (e.g., lack of supervision), and this may indirectly result in the death of the child. As another example, a death attributed to homicide (i.e., a manner of death) might be at the hands of parents and be abuse-related. Alternatively, the homicide might be at the hands of a non-caregiver, and in that case, there might not be maltreatment by a caregiver.

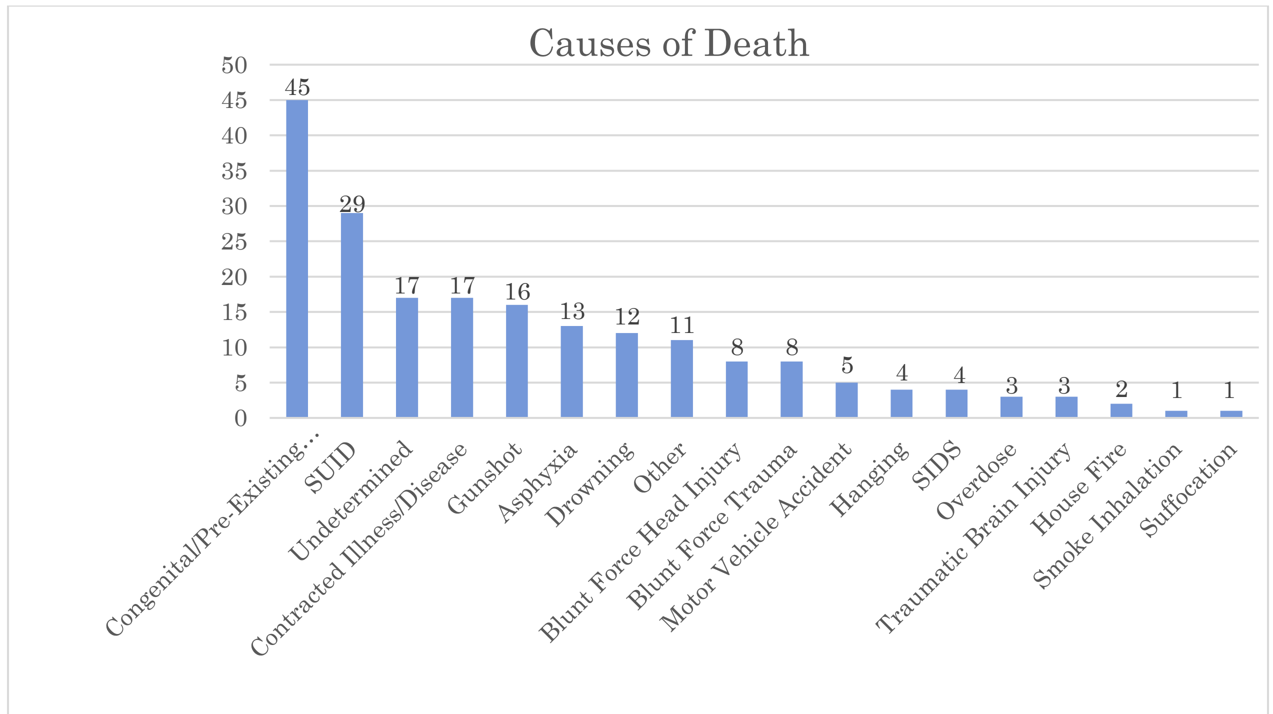
The following figure provides a breakdown of the manner of child fatalities for children with prior involvement for 2015 by percentage. Note that accidental and natural deaths represent 58% (118 children) of the 200 fatalities reviewed in this report. It is noteworthy that 26 of the 118 deaths were substantiated for abuse and/or neglect due to contributing factors that had an impact on the death itself. For example, the drowning death of a child is almost always accidental, but the assessment into the circumstances surrounding the death may reveal inadequate supervision of the child as a contributing factor.

Figure 3.1. 2015 Manners of Death by Percentage for Children with Prior Involvement, $N = 200$.



Next, Figure 3.2 provides information on the causes of death for 2015 fatalities for children with prior child protective services involvement. In building on the data included in the previous figure, for those deaths classified as natural, the leading cause of death was a congenital or pre-existing condition (45 children). The next highest cause of death was Sudden Unexpected Infant Death (SUID; 29 children) which always corresponds to the death of a child less than two years of age, and which most often occurs during a sleep-related event.

Figure 3.2. 2015 Causes of Death for Children with Prior Involvement, *N* = 199**.**



Note. At the time of analysis, cause of death was not known for one child. SUID = Sudden Unexpected Infant Death. SIDS = Sudden Infant Death Syndrome.

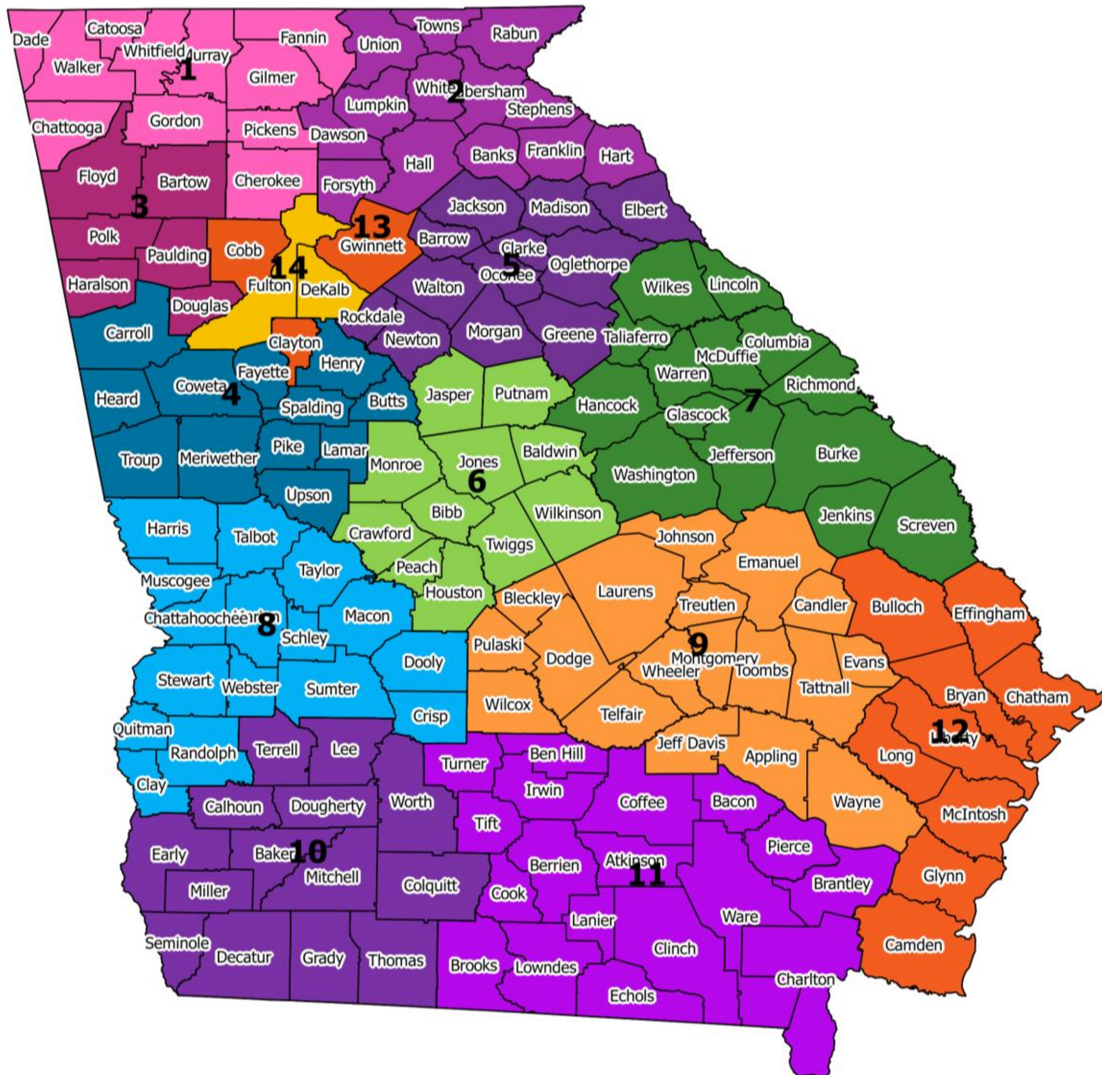
SECTION 4: EXECUTIVE SUMMARY OF DATA FINDINGS

This report reviews the deaths of 200 children who died between January 1 and December 31, 2015, and whose families had prior involvement with the Division. In the past five years, 658,962 children had Division involvement.[5] Below, we provide an executive summary of findings. It should be noted that the following statistics are not mutually exclusive; a death may be represented in more than one of the categories below.

- **47** children (**24%** of the 200 deaths reviewed by the Division) had substantiated findings of child abuse and/or neglect prior to those children's deaths.[6]
- **75** children (**38%**) had substantiated findings of maltreatment in relation to their deaths.
- **77** children (**39%**) were determined to have died because of natural causes.
- **109** children (**55%**) were under the age of one year.
- **74** children (**37%**) had families with open Division cases at the time of their deaths.
- **58** children (**29%**) who died were classified as having special needs.
- **68** children (**34%**) died during a sleep-related event. **61 (31%)** of these children were infants under the age of 12 months.
- **114** children (**57%**) had caregiver(s) who had a history of alleged substance abuse.
- **71** children (**36%**) had caregiver(s) who had a history of alleged mental health issues.
- **76** children (**38%**) had caregiver(s) who had a history of alleged criminal offenses.
- **78** children (**39%**) had caregiver(s) with a history of alleged domestic violence.

[5] There were 236,251 children involved with the Division in 2015.
[6] According to DFCS policy, a substantiated finding is when "an investigation disposition by an abuse investigator concludes that the allegation of maltreatment, as defined by state law and CPS requirements, is supported by a preponderance of the evidence." [Source: *http://www.odis.dhr.state.ga.us/3000_fam/3030_cps/manuals/chapter4/2104_23.doc*]

Figure 4.1. 2015 Map of Division Regions.



Note. Map source: http://dfcs.dhs.georgia.gov/county-offices. The state is divided into 14 regions encompassing all 159 counties throughout the state. Each county office is responsible for providing reports directly to the state office when a child fatality is reported in their county.

Table 4.1. 2015 Child Fatality Numbers/Percentages for all Division Regions.

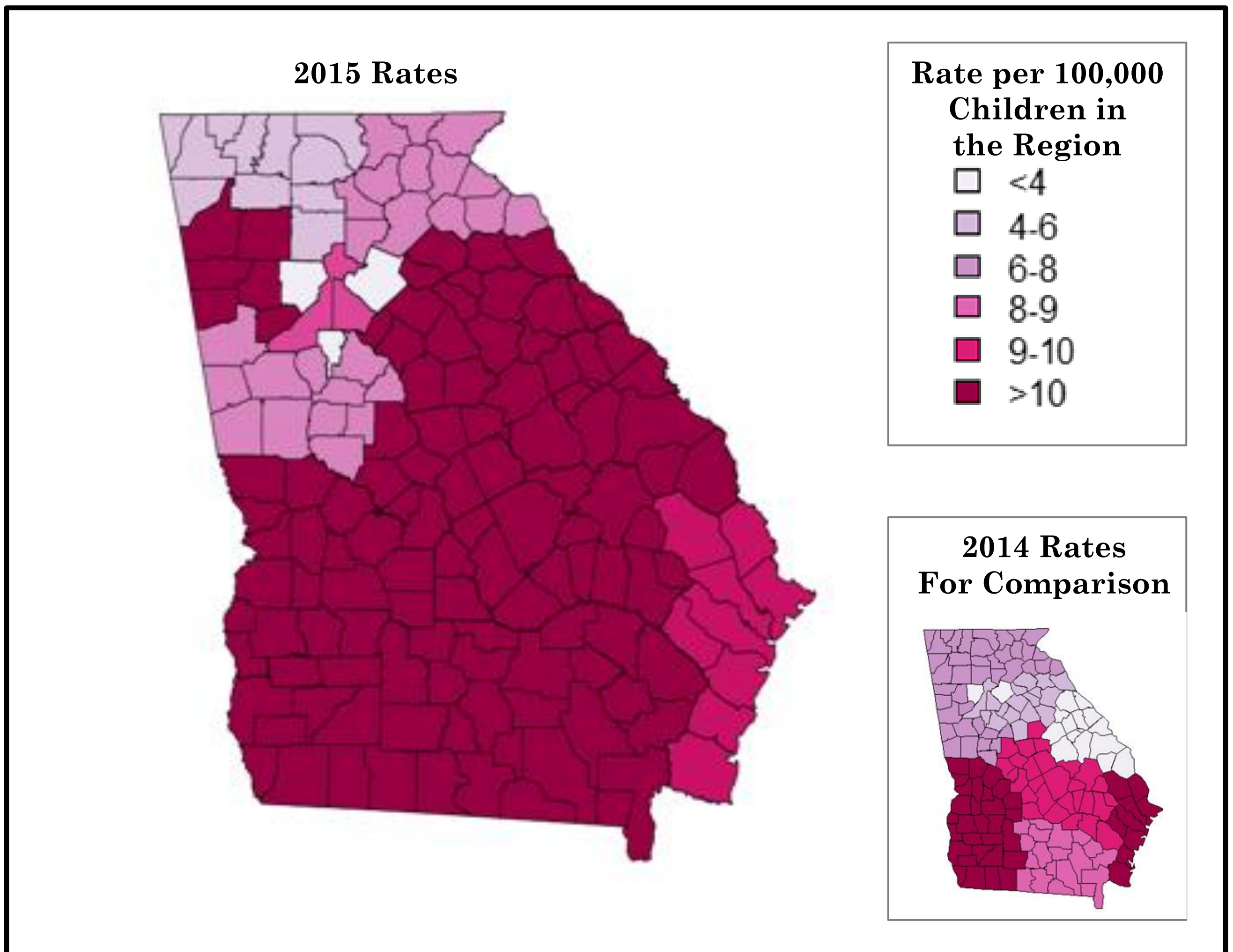
Region	Counties Within the Region	Total Number of Child Fatalities in the Region	Total Number of Children in the Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (N = 200)
1	Catoosa, Chattooga, Cherokee, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	9	168,818	5.33	4.5%
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	12	166,265	7.21	6%
3	Bartow, Douglas, Floyd, Haralson, Paulding, Polk	15	145,240	10.32	7.5%
4	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson	16	206,434	7.75	8%
5	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale, Walton	17	162,709	10.45	8.5%
6	Baldwin, Bibb, Crawford, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	12	117,932	10.18	6%
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	12	116,774	10.28	6%
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	10	86,822	11.52	5%
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	9	72,421	12.43	4.5%

Region	Counties Within the Region	Total Number of Child Fatalities in the Region	Total Number of Children in the Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 200)
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	11	86,559	12.71	5.5%
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	17	101,418	16.76	8.5%
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	15	160,624	9.34	7.5%
13	Clayton, Cobb, Gwinnett	12	506,718	2.37	6%
14	DeKalb, Fulton	33	405,438	8.14	16.5%
Total	Statewide	200	2,504,172	8.0	100%

Note. As noted earlier, as of 2015, there are 14 regions in Georgia (http://dfcs.dhs.georgia.gov/county-offices). There were 15 regions in Georgia in 2014. Population data for regions were obtained from http://wonder.cdc.gov/bridged-race-population.html, on July 25, 2016.

The following heat map of Georgia shows rates of child fatalities with prior Division involvement. Rates are calculated per 100,000 children in each region. While there are contextual concerns underlying this representation (e.g., regions with few children that experienced an incident resulting in multiple deaths could see an elevated rate), it does suggest areas worthy of further investigation and increased collaboration with other state agencies.

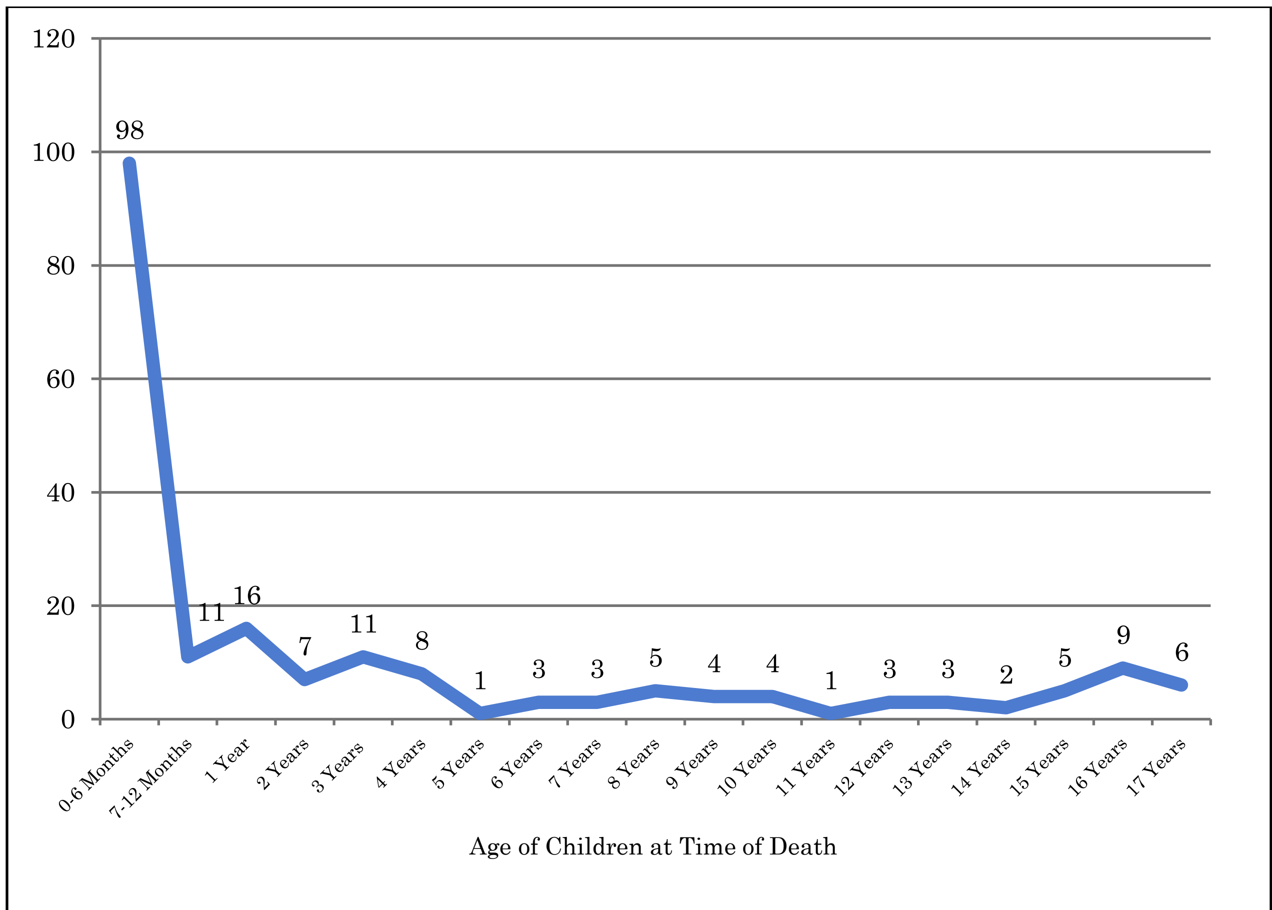
Figure 4.2. 2015 Child Fatality Rates per 100,000 Children by Region.



Note. As a comparison, this map also shows the 2014 heat map for child fatality rates per 100,000 children by region.

The following figure displays the ages of children in this report at the time of their deaths. Children under the age of one-year account for 109 or 55% of the deaths, and 63% (125) of the deaths were children under the age of two years. This conforms to national trends from the Child Trends Databank that show that children are most at-risk in their first year of life.[7] The remaining 37% (75) of the deaths for 2015 comprise children between two and 17 years of age. This data reinforces the vulnerability of infants and young children. Additionally, these outcomes draw attention to the need for greater advocacy and for campaigns that inform new parents and caretakers about risk factors that result in preventable child deaths.

Figure 4.3. Ages of Children at Time of Death for Children with Prior Involvement, $N = 200$.



[7] Child Trends Databank. (2015). *Infant, child, and teen mortality*. Obtained on September 28, 2016 at: http://www.childtrends.org/?indicators=infant-child-and-teen-mortality.

SECTION 5: CHILD FATALITIES AND PRIOR DIVISION INVOLVEMENT

Description of Data

The data included in the *2015 Child Fatality Analysis* detail the manners and causes of death for children whose families had child protective services involvement with the Division within five years from the date of death. As noted earlier, the data included in this report *do not* reflect all child fatalities within the general Georgia child population (see Figure 1.1). When a child's death is reported to a local Division office, it is forwarded to an internal review team that examines the circumstances surrounding the death. The Georgia Office of the Child Advocate and Georgia Child Fatality Review Panel work in partnership with the Division to further understand the events surrounding the deaths of children who have prior involvement and whose death may be maltreatment-related.

In 2015, a total of **383** child deaths were reported to the Division. Of these, **200** children were identified as members of families who had some form of child protective services involvement with the Division within the previous five years.[8] During the same time period, the Division had contact with approximately 658,962 children. This represents a rate of about 30.35 per 100,000[9] children. To place this in context, of the 2,504,172 children living in Georgia, in 2015,[10] 1,599 died from all causes. Thus, the rate of death for children in the general population for 2015 was 63.85 per 100,000, double the rate for children with prior Division history.

In 2015, of the **200** deaths with Division involvement, there were **126** fatalities that occurred after the Division had ended its involvement with the family. In **74** of the fatalities, the Division had an open case with the family at the time of death.

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[8] In comparison, for 2014, the deaths of 169 children whose families had prior Division history were reported to the agency.

[9] This estimate is unadjusted for the number of new births in families, number of unreported children in the family, or recurrent reports for the same child during the 5-year period.

[10] Population data for total number of children was obtained on September 15, 2016 from http://wonder.cdc.gov/bridged-race-population.html, on July 25, 2016.

The following data provide a snapshot of the Division's overall Child Welfare caseloads for 2015:

- The total number of reports to the Division: **109,794**
    - Screen-Outs: **27,368**
    - The total number of reports assigned to Child Protective Services (CPS): **82,426.** Of the 82,426:
        - **36,083 (44%)** were assigned to Family Support Services
        - **46,343 (56%)** were assigned to Investigations
- The total number of children in Foster Care at some point in 2015: **18,251**
- The total number of Family Preservation Services cases: **11,546**

Child Fatality Review Process

Once a death has been reported to the agency, a review of circumstances surrounding the death is warranted. Although any preventable death deserves attention, deaths due to maltreatment are of special concern and require additional scrutiny because the Division is charged with investigating child abuse and neglect.

Specific causes and manners are typically determined by a coroner or Medical Examiner. Findings of maltreatment are not only based on physical indicators; experts often rely on additional information obtained by the Division, first responders, and law enforcement. As a result of more in-depth reviews, the Division may identify maltreatment-related concerns that were not initially apparent at the time of the death. This additional level of investigation and detection may increase the number of deaths attributed to maltreatment. Because states can differ substantially in their data collection methods and maltreatment definitions, state-to-state comparisons of maltreatment death rates are generally difficult to interpret or potentially misleading. Also, as states increase their scrutiny and improve their data systems, the number of maltreatment-related deaths may appear to rise, even if actual incidences are stable or declining.

Intervention by the Division involves a broad spectrum of potential services. For example:

- A report that was screened-out because it lacked an allegation of abuse or neglect.
- Family Support cases where the allegation does not necessarily involve immediate child safety.
- Investigations where the Division confirmed an allegation of abuse or neglect.
- Family Preservation cases where allegations of maltreatment or abuse may have been substantiated, but the removal of the children was not necessary to ensure safety.
- Prior or current Foster Care services.

Closed Cases

In 2015, 126 of the fatalities reviewed in this report (i.e., 63% of 200 deaths reviewed) were for children from families with closed cases at the time of the child's death. This includes 52 children (26% of 200 deaths in 2015) who were born after the last case closure. In other words, the child who died was born after the completion of the Division's most recent involvement with the family. In looking at child fatalities and prior Division involvement, the length of time between the most recent involvement and the death of the child is noteworthy. It has been shown that evidence-informed programs have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.[11]

For homicides, 12 homicides occurred less than 12 months after case closure, and 10 homicides occurred more than 12 months after case closure. The homicide rate in the general Georgia population for 2015 was 3.54 per 100,000.[12] The children examined in this report include the 658,962 children with Division involvement in the last five years. This constitutes a rate of 3.34 per 100,000 children (i.e., 22 homicides among 658,962 children with Division involvement in the last five years).

The following figure displays the length of time between prior Division involvement with the family and the child's death (for cases closed at the time of death), delineated by the five official manners of death.

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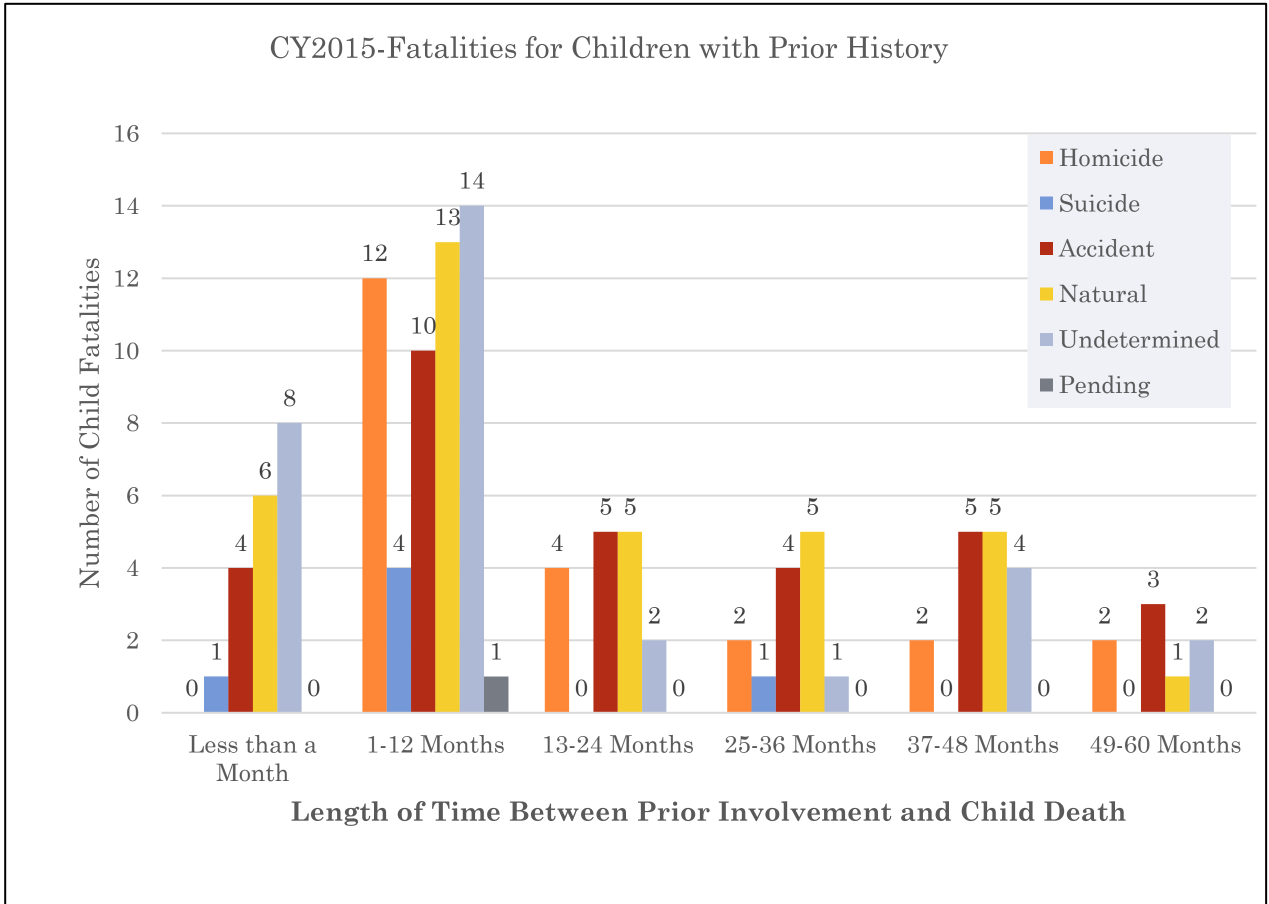
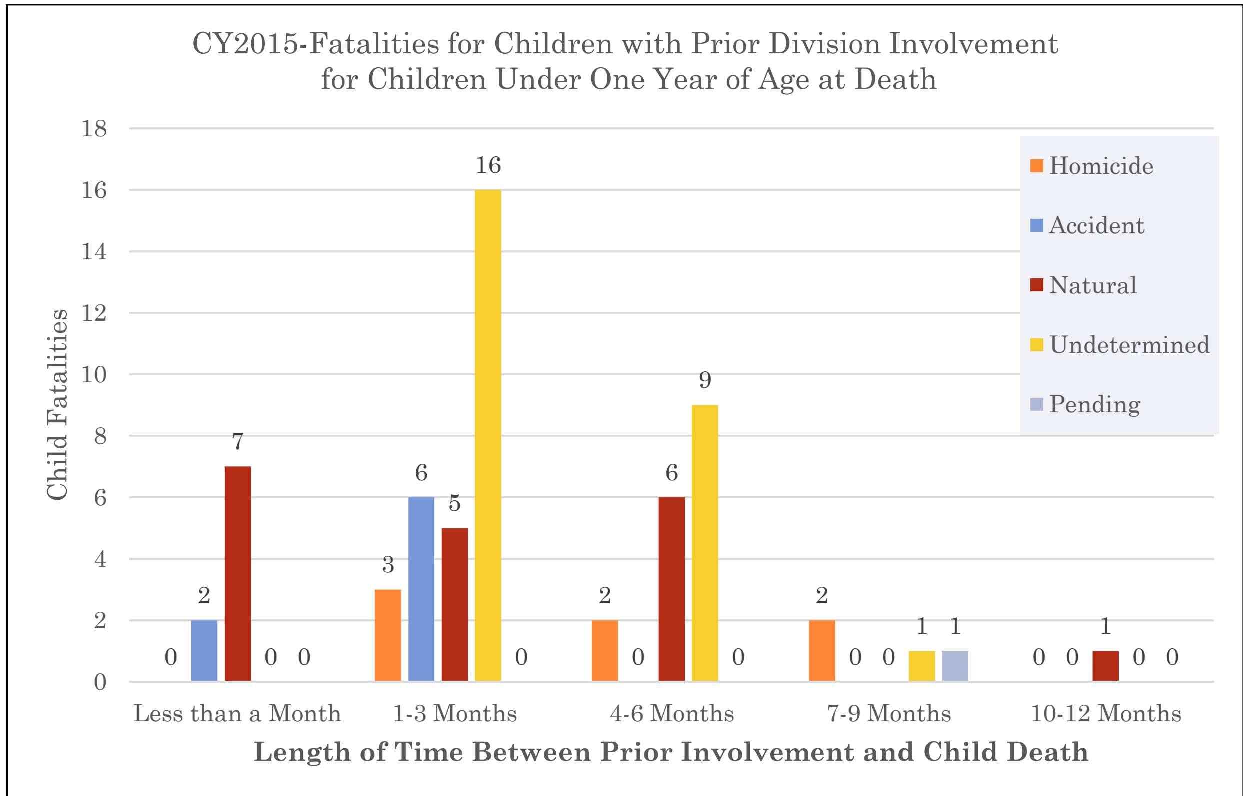
[11] Reynolds, A. J., & Robertson, D. L. (2003). School–based early intervention and later child maltreatment in the Chicago longitudinal study. *Child development*, *74*(1), 3-26.
[12] Data source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (September 2016). Accessed on September 20, 2016 from URL: www.cdc.gov/injury/wisqars

Figure 5.1. Length of Time Between Prior Involvement and Child Death for Those with Closed Cases at Time of Death, Delineated by Manner of Death, $N = 126$.



The next figure provides more detailed information about the subset of children with closed cases who were under one year of age at the time of their death.

Figure 5.2. Length of Time Between Prior Division Involvement and Child Death for Those with Closed Cases Who Were Under One Year of Age at the Time of Death, Delineated by Manner of Death, $N = 61$.



Note. There were 61 children aged 0-12 months in 2015 who had closed cases at the time of death.

Open Cases

An open case indicates active Division involvement with a child or family. In 2015, there were 74 fatalities with an open case at the time of the child's death.

Of these 74 open cases; 32% of them (24 children) had substantiated findings of maltreatment in the children's deaths. Of those 24 children, 6 also had substantiations prior to their deaths. Of the 24 child death substantiations, 6 of those were open due to the incident that resulted in the death. Fifteen (20%) of the 74 open cases were opened due to the incident that resulted in the death.

The next table breaks down these 24 fatalities by case type and whether the case was open prior to the death or due to the incident that caused the death.

Table 5.1. Number of 2015 Substantiated Fatalities with Open Cases at the Time of Death (with Case Type) for Children with Prior Involvement, *N* = 24.

Substantiated Fatalities with Open Cases at the Time of Death	Investigation for Abuse or Neglect	Family Preservation	Family Support Services	Foster Care/ Placement	Total Number (%)
Case Open Prior to Incident that Led to the Death	7 (29%)	4 (17%)	3 (12%)	4 (17%)	18 (75%)
Case Open Due to Incident that Led to the Death	4 (17%)	0	0	2 (8%)	6 (25%)
Total Number and Percentage of Open Cases at the Time of Death	11 (46%)	4 (17%)	3 (12%)	6 (28%)	24 (100%)

The following table (Table 5.2) provides a breakdown for open cases with a substantiated finding of maltreatment in the death and is broken down by the official manner of death. *Again, note that as of July 22, 2016, one case is still awaiting an official finding from the Medical Examiner and therefore had a manner of death considered "Pending." This death is not included in the table below.*

Table 5.2. Number of 2015 Substantiated Fatalities with Open Cases at the Time of Death (with Manner of Death) for Children with Prior Involvement, $N = 24$.

Substantiate Fatalities with Open Cases at the Time of Death	Homicide	Accident	Natural	Undetermined	Total *N* (%)
Case Open Prior to Incident that Lead to Death	6 (25%)	1 (4%)	5 (21%)	6 (25%)	18 (75%)
Case Open Due to Incident that Led to the Death	4 (17%)	1 (4%)	1 (4%)	0	6 (25%)
Total (%)	10 (42%)	2 (8%)	6 (25%)	6 (25%)	24 (100%)

Note. All children with cases open due to the incident that led to the death also had cases open prior to the incident that led to the death.

13 foster children died in 2015:

- **8** of those deaths were ruled natural due to complications from medical conditions or due to congenital or pre-existing conditions.
- **4** children died due to homicide: 3 children died due to blunt force head injury and 1 child due to blunt force trauma.
- **1** child died due to an undetermined cause.

Two of the four homicides were the result of the child being fatally injured while under the care of a relative caregiver or Fictive Kin. The other two homicides involved children that were placed in foster care because of the injury that then led to their death. The undetermined cause of death had to do with an infant who was swaddled and sleeping on an adult bed. The coroner was unable to determine the exact circumstances that led to the death.

Implications for Practice

Deaths of children with Division contact may occur in multiple ways and, therefore, have different implications for understanding, learning, and improving practice. One of the most disconcerting manners of death for the Division is when a child suffers a violent death at the hands of a caregiver where the risk was pre-existing, and the interventions offered failed to shield the child or to reduce the risk. In these cases, maltreatment is the proximal cause of death. These types of incidents raise service improvement questions about risk assessment (e.g., was the risk detectable?), provision of services (e.g., were the services appropriate?), decision-making (e.g., was maintaining the child in their existing home a reasonable decision?), and management of aftercare needs (e.g., were post-termination services adequate?).

Other manners of death may be caused by complex circumstances in which parental negligence plays a partial, but not a proximal, or even necessary role. For example, a child may die in a vehicular accident in which the child was not properly secured in a car seat, or a child may die from an illness complicated by delayed medical care. These types of cases may alert case managers about possible future maltreatment if other children are present in the home.

However, in some situations the Division may end its involvement with a family after it has ensured the safety of existing children in the home, but the parent(s) may later bear other children who are not known to the Division. For example, a drug addicted mother may have all her children removed from her care and her parental rights later terminated. As a result, the Division would close its case because she has no other children under her direct care. The mother may later have additional children and a report is made because she has given birth to a drug exposed infant; the infant has medical complications and dies due to those complications. The implications for practice under these types of scenarios would focus on strategies involving Georgia's maternal and child health system and community supports. For 2015, there were 52 children born after the Division's last involvement with the family, and, therefore intervention efforts for these children were improbable.

The Division continuously reviews its practices at many levels. Whenever there has been prior involvement with a family, there is an opportunity to review its response and potentially the responses from other agencies that may have been involved in the family's life. Division intervention in a family's life can be crucial and have lasting effects. Open and effective communication between all parties who have a responsibility to ensure a child's safety is critical to having successful outcomes for children.

SECTION 6: VULNERABLE POPULATIONS

Children under the Age of One

In 2015, 109 deaths of the 200 deaths reviewed in this report were children under the age of one year. The primary manner of death (see Table 6.1) was natural causes (50 children), and the secondary manner was Undetermined (35 children). This corresponds to the leading two causes of death for this age group (see Table 6.2) which were congenital or pre-existing conditions (31 children) and Sudden Unexpected Infant Death (29 children). Additionally, 72 of the 109 children (66%) in this age group had caregivers who were alleged to have been engaging in substance use at some time during the Division's involvement with the family.

Unsafe sleep practices have also been identified as a major factor contributing to death among children who died during a sleep-related event. Being placed on a soft surface and/or sharing sleep surfaces with adults or siblings remain factors in sleep-related deaths. This is a recognized public health problem nationwide and underscores the need for educating parents and caregivers about infant safe-sleep practices not only used during night time sleeping, but also during any sleep-related event throughout the day.[13]

Table 6.1. Manners of Death in 2015 for Children Under the Age of One for Children with Prior Involvement, *N* = 109.

Age	Accident	Homicide	Natural	Un-determined	Pending	Total *N* (%)
0-6 Months	11	8	45	34	0	98 (90%)
7-12 Months	1	3	5	1	1	11 (10%)
Total	12 (11%)	11 (10%)	50 (46%)	35 (32%)	1 (1%)	109 (100%)

[13] The Centers for Disease Control and Prevention report that in 2014, the leading causes of infant deaths were: birth defects, preterm birth (birth before 37 weeks gestation) and low birth weight, maternal complications of pregnancy, sudden infant death syndrome (SIDS), and injuries (e.g. suffocation).

Table 6.2. Leading Causes of Death in 2015 for Children Under the Age of One for Children with Prior Involvement, *N* = 109.

Causation	Age 0-6 Months	Age 7-12 Months	Total *N* (%)
Asphyxia	10	0	10 (9%)
Blunt Force Head Injury	2	0	2 (2%)
Blunt Force Trauma	1	1	2 (2%)
Congenital/Pre-Existing Condition	28	3	31 (28%)
Contracted Illness/Disease	6	1	7 (6%)
Drowning	0	2	2 (2%)
Other	5	2	7 (6%)
Overdose	1	0	1(1%)
SIDS	4	0	4 (4%)
SUID	28	1	29 (27%)
Suffocation	1	0	1 (1%)
Traumatic Brain Injury	1	0	1(1%)
Undetermined	11	0	11 (10%)
Pending	0	1	1 (1%)
Total	98 (90%)	11 (10%)	109 (100%)

Prenatally Substance-Exposed Children

There were 36 children (18% of 200 children) who had a history of prenatal exposure to drugs. Of these children, 33 were under the age of 7 months at the time of their deaths. While it is difficult to link deaths exclusively to prenatal exposure, the effects of prenatal exposure to substances may put infants at risk. Prenatal exposure to substances is associated with low birth weight, extreme prematurity, and other factors that may create complications for children.[14]

Even after an infant is born, substance use by an adult caregiver may place infants at risk. A parent or caregiver in a compromised state, places children at risk, especially when the caregiver is unable to provide and recognize what is a safe environment for the child. In addition, addicted parents may live in households rife with violence and instability. Addiction is treatable, but recovery is neither quick nor easy, and lapses back into substance abuse are not uncommon. Addiction recovery is best viewed as a long-term task, extending well beyond the time frame of involvement of a child welfare agency. Deaths associated with caregivers' abuse of methadone, alcohol, prescription medication, and illegal substances have been reported to the Division and continue to be a challenging characteristic of the child welfare population. When substance use is coupled with bed-sharing or a special needs child, the risk of harm or death is even higher.

Of the **36** prenatally-exposed children there were **21** born prematurely. Of those, many had complex medical issues. Fourteen died before they left the hospital.

Table 6.3. Prenatal Drug Exposure and Manner of Death, *N* = 36.

Exposure History	Accident	Homicide	Natural	Undetermined	Total *N* (%)
Prenatal Drug Exposure	6 (17%)	2 (6%)	18 (50%)	10 (27%)	36 (100%)

[14] Brady, J.P., Posner, M., Lang, C., Rosati, M.J. (1994). Risk and Reality: Implications of Prenatal Exposure to Alcohol and Other Drugs. Washington, D.C.: U.S. Department of Health and Human Services & U.S. Department of Education. Accessed at http://eric.ed.gov/?id=ED397986

Children/Families with Multiple Risk Factors

Often families who have prior involvement with the Division and have experienced a child death are affected by multiple risk factors, including, but not limited to, substance use, domestic violence, mental health issues, and/or criminal history. The greater the complexity of the issues within a family, the more challenging it can be for professionals to assess the ongoing safety of the children. Naturally, families are not always comfortable or willing to expose areas they may find embarrassing or difficult to address, making safety assessments even harder to thoroughly complete. Nevertheless, the Division recognizes the crucial need to consistently assess and address these multiple risk factors for such cases. The following table describes caregiver risk factors by manner of death.

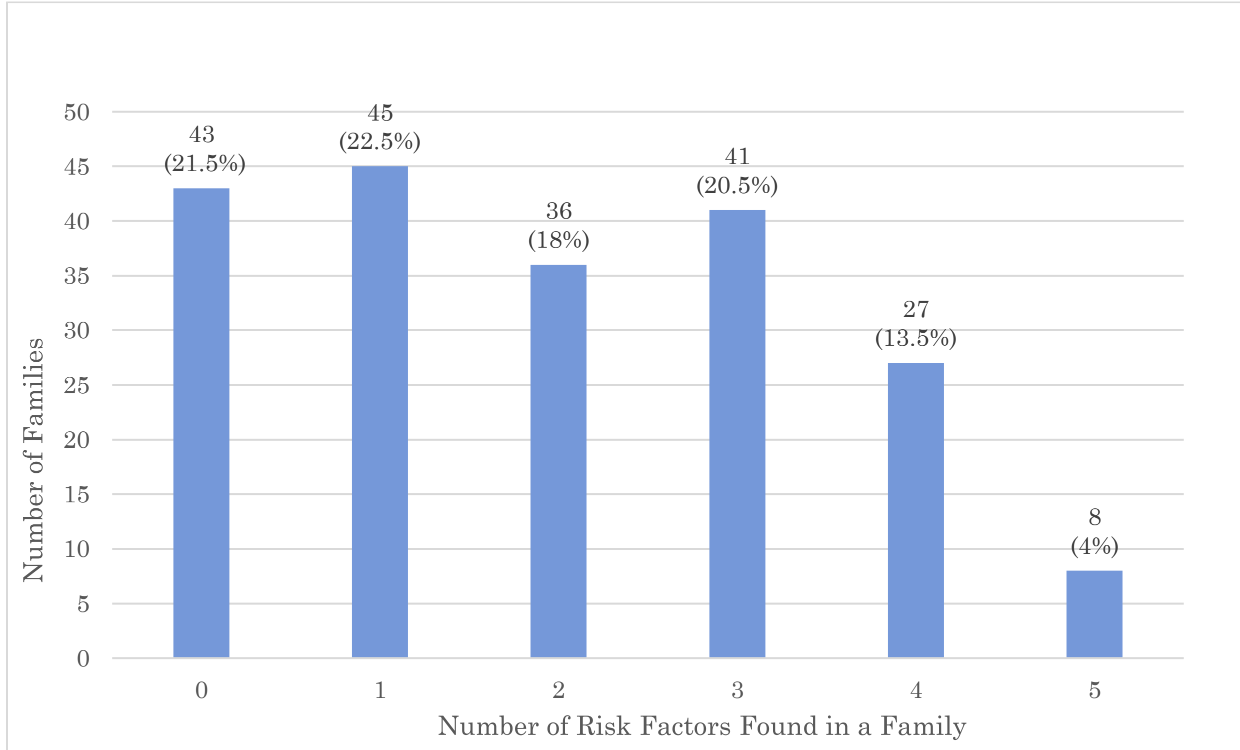
Table 6.4. Risk Factors of Caregivers and Manner of Death.

Caregiver Risk Factors	Accident	Homicide	Natural	Suicide	Undetermined	Total
DFCS History as a Child: Yes (*N* = 48)	7 (14%)	5 (10%)	20 (41%)	1 (2%)	15 (31%)	48
Alleged Substance Use History: Yes (*N* = 114)	23 (20%)	14 (12%)	43 (38%)	3 (3%)	31 (27%)	114
Alleged Criminal History: Yes (*N* = 76)	16 (21%)	11 (14%)	32 (42%)	2 (3%)	15 (20%)	76
Alleged Mental Health History: Yes (*N* = 70)	14 (20%)	14 (20%)	21 (30%)	3 (4%)	18 (25%)	70
Alleged Domestic Violence History: Yes (*N* = 78)	14 (18%)	17 (22%)	30 (38%)	2 (3%)	15 (19%)	78

Note. Caregivers may have met criteria for more than one risk factor.

The next figure highlights the number of risk factors (i.e., Caregiver had DFCS History as a child, Caregiver Substance Use History, Domestic Violence History, Criminal History, and Mental Health History) that were found in each child's family.

Figure 6.1. Number of Identified Risk Factors Found in a Child's Family, *N* = 200.



Note. Caregivers may have met criteria for more than one risk factors.

Table 6.5 provides a breakdown of 2015 deaths based for children with prior involvement and caregivers with alleged substance use and/or domestic violence. Note that **56** (**28%**) of the total deaths for children with prior Division involvement involved the exposure of the child to ***both*** domestic violence and substance use.

Table 6.5. Causes of Death in 2015 for Children with Prior Involvement and Caregivers with Alleged History of Substance Use and/or Domestic Violence, *N=114 and N=78*

Causes of Death	Caregivers with Alleged Substance Use History	Caregivers with Alleged Domestic Violence History
Asphyxia	9	3
Blunt Force Head Injury	1	1
Blunt Force Trauma	3	4
Congenital/Pre-Existing Condition	24	18
Contracted Illness/Disease	9	7
Drowning	6	5
Gunshot	8	9
Hanging	3	2
House Fire	2	2
Motor Vehicle Accident	2	1
Other	9	5
Overdose	1	1
SIDS	2	1
SUID	22	10
Smoke Inhalation	1	1
Suffocation	1	1
Traumatic Brain Injury	0	1
Undetermined	11	6
Total *N*	114	78

Note. At the time of analysis, cause of death was not known for one child. Some children may be captured in both categories. Thus, the total reflects the category of exposure and not the number of children. SIDS = Sudden Infant Death Syndrome. SUID = Sudden Unexpected Infant Death.

Special Needs Children

Table 6.6. Manners of Death in 2015 for Special Needs Children with Prior Division Involvement, *N* = 58.

Manner of Death	Accident	Homicide	Natural	Suicide	Undetermined	Total *N* (%)
Total Number	4 (2%)	7 (3%)	45 (23%)	1 (1%)	1 (1%)	58 (29%)

Teen Deaths

2015 identified **25** teenagers between the ages of 13 and 17 who died and had prior involvement with the Division.

- **6** committed Suicide**:** **2** by Hanging, **3** by self-inflicted Gunshot wounds, and **1** by Overdose.
- **7** died due to Accidental causes: **2** died in Motor Vehicle-related incidents, **1** by Blunt Force Head Injury, **1** by Blunt Force Trauma, **1** by Gunshot wound, and **2** by other causes.
- **5** died due to Homicide: All **5** deaths were due to Gunshot wounds; **2** of the Homicides were committed by a direct caregiver.
- **6** died due to Natural causes: **4** by a Congenital Pre-Existing Condition, **1** by Contracting Illness/Disease, and **1** due to Other cause.
- **1** died in an Undetermined Manner due to Blunt Force Trauma.

For suicide, 5 suicides occurred less than 12 months after case closure, and 1 suicide occurred more than 12 months after case closure. In Georgia, the suicide rate for the general Georgia population was 2.0 per 100,000 for children aged 0-17 years.[15] It is difficult to identify a comparison rate. If we consider the 236,251 children that had Division involvement in 2015, the rate would be 2.54 per 100,000 (i.e., 6 suicide deaths among 236,251 children). However, the children examined in this report include the 658,962 children with Division involvement in the last five years, which constitutes a rate of .91 per 100,000 children (i.e., 6 suicide deaths among 658,962 children with Division involvement in the last five years).

[15] Data source: Georgia Department of Public Health. Online Analytical Statistical Information System (OASIS). Obtained on October 15, 2016 from URL: oasis.state.ga.us.

SECTION 7: UNSAFE SLEEP ENVIRONMENT

Many of the sleep-related deaths involved incidents where there was a combination of bed-sharing and an overall unsafe sleep environment. To illustrate, in the case of bed-sharing, caretakers falling asleep with infants in chairs, couches, and adult beds was a factor in 32 of the 68 sleep-related deaths. It is always recommended that infants sleep alone, on their backs, and in a safe sleep setting such as a crib. For the infants who died in 2015, many of the causes of death were either ruled as SUID (Sudden Unexpected Infant Death) or Undetermined. Review of these fatalities has uncovered other mitigating factors not readily observed at the time of death, such as substance use, mental health needs of a caregiver, and/or caregivers placing children on soft sleep surfaces (e.g., blankets, pillows, etc.). Circumstances surrounding sleep-related deaths continue to be explored to identify underlying contributing factors. In this report, 61 of the 68 children with sleep-related deaths were under one year of age at the time of their death. In 48 of the 68 sleep-related deaths, caregivers had a history of alleged substance use. The Division believes the majority of these deaths were preventable.

Figure 7.1. 2015 Sleep-Related Death Rates per 100,000 Children by Region.

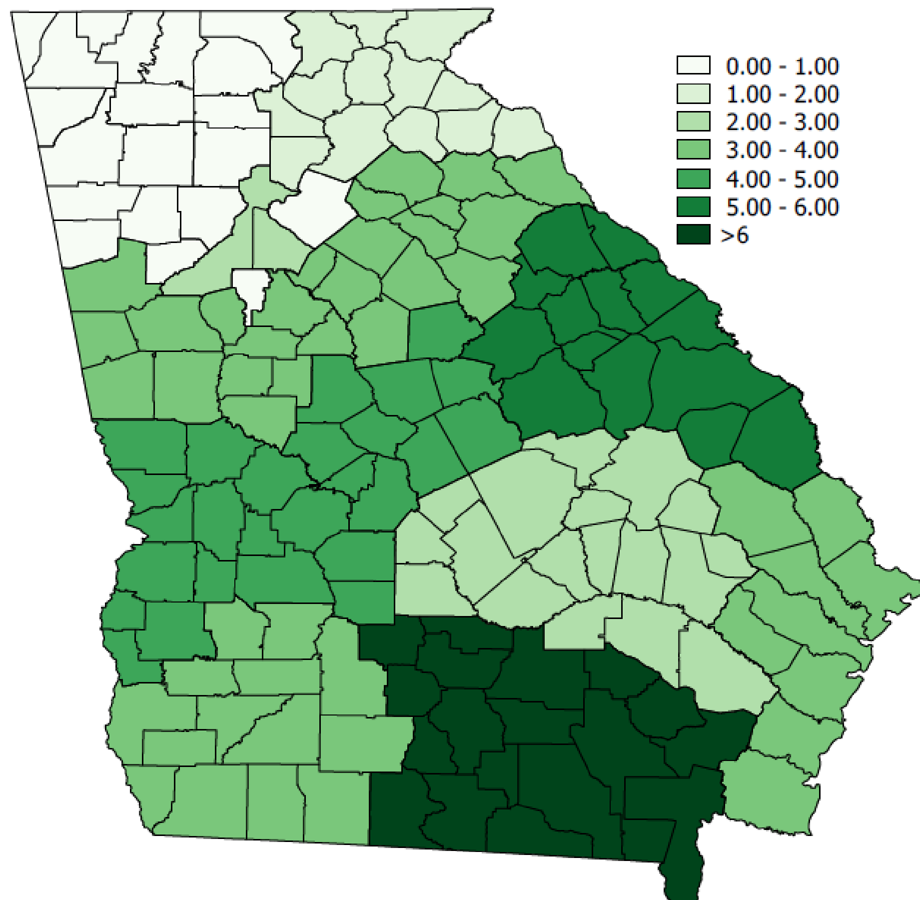


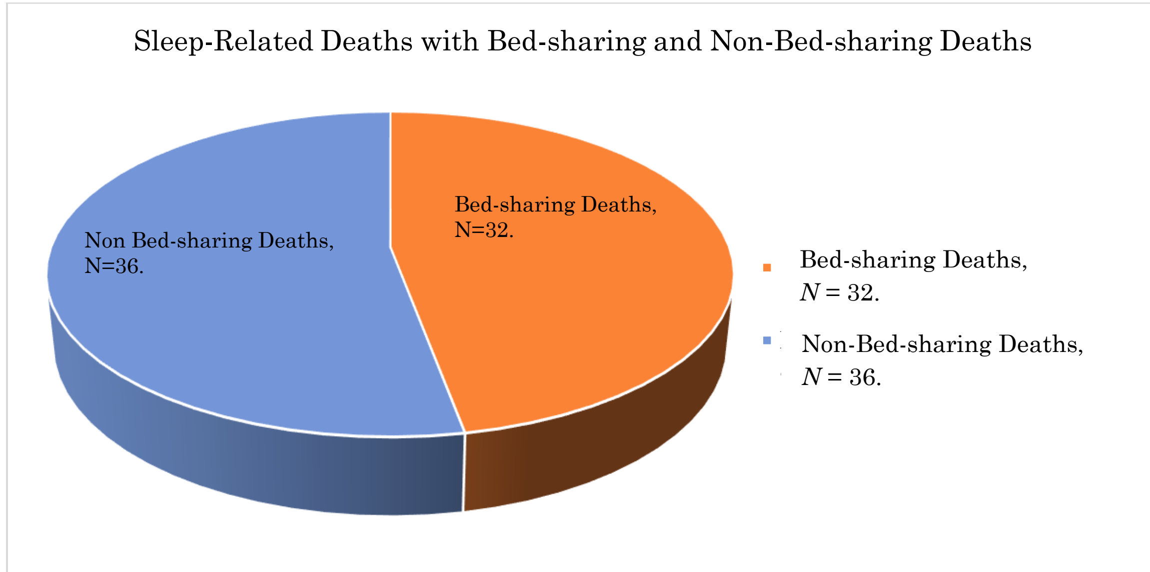
Table 7.1. Fatality Numbers/Percentages for Sleep-Related Deaths for All Division Regions, $N = 68$.

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in the Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (N = 68)
1	Catoosa, Chattooga, Cherokee, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	2	168,818	1.18	3%
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	4	166,265	2.41	6%
3	Bartow, Douglas, Floyd, Haralson, Paulding, Polk	1	145,240	0.69	1%
4	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson	8	206,434	3.88	12%
5	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale, Walton	6	162,709	3.69	9%
6	Baldwin, Bibb, Crawford, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	5	117,932	4.24	8%
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	6	116,774	5.14	9%
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	4	86,822	4.61	6%

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in the Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 68)
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	3	72,421	4.14	4%
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	3	86,559	3.46	4%
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	7	101,418	6.90	10%
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	5	160,624	3.11	8%
13	Clayton, Cobb, Gwinnett	3	506,718	0.59	4%
14	DeKalb, Fulton	11	405,438	2.71	16%
Total	Statewide	68	2,504,172	2.72	100%

At the time of analysis, 68 deaths were found to be sleep-related. Of these 68 deaths, 32 involved bed-sharing. *Bed-sharing is a preventable risk factor.*

Figure 7.2. Breakdown of Sleep-Related Deaths by Bed-sharing or Non-Bed-sharing Arrangements, $N = 68$.



Note. Most literature uses bed-sharing for describing infants sleeping on the same space.

SECTION 8: CONCLUSIONS

The following conclusions are drawn from the 2015 child fatality analysis:

Very Young Children

In 2015, 125 (63%) of the 200 children who died were two years old or younger. Additionally, 49 (39%) of the 125 children had a substantiated finding of maltreatment in relation to their death. Further, 45 (36%) of the 125 children in this cohort were under twelve months old. These statistics demonstrate that very young children are at greatest risk of maltreatment. They are more likely to spend their time out of public view and are less likely to encounter mandatory reporters (in contrast to school-aged children who interact daily with teachers, who are mandatory reporters).

Substance Use

Caregiver substance use continues to be a contributing factor in child safety. Effectively assessing whether a substance-using caregiver is adequately equipped to care for a child is challenging for case managers. Denial of drug use by caregivers may affect the assessment process and influence case outcomes. Gathering supportive evidence, including drug testing, and collecting collateral information from family and friends that may either support or negate allegations remains a critical component of ensuring child safety.

When substance use is coupled with caring for a child under the age of two or a child with complex needs, assessing the safety of the child may be even more challenging. Nonverbal children are not able to communicate effectively about their safety. Caregivers using substances can be effective at concealing their usage, and brief encounters with a family may not reveal significant information about substance use and its potential impact on the safety of children. Very young children who live with substance using caregivers are at high risk of maltreatment.

Teen Deaths

Research indicates teens who have suffered rejection or trauma, such as those who have experienced abuse and/or neglect, are at an increased risk for suicidal behavior.[16] Parenting any teen requires continuous monitoring; however, for youth who have experienced rejection and trauma, caregivers need to be even more diligent regardless of whether the youth is in state custody or living with family or friends.
The effects of social influence on teens is great and additional oversight for children who have experienced social isolation and/or rejection or bullying should be taken into consideration when assessing children in this age group.

Safe Sleep and Impaired Sleeping

While the Division and partner agencies continue to educate families and the public about what constitutes a safe sleep environment, challenges remain around the perception of a shared sleep surface and bed-sharing. Often these challenges involve intergenerational family beliefs and/or cultural practices[17]. For example, some caretakers believe bed-sharing with a child increases the bond between a parent and their child. Thus, they may overlook contributing factors to child safety. Additionally, substance use may play a contributing role. Caregivers who are impaired by alcohol or drugs (both prescription and non-prescription) continue to increase the risk of death to children under the age of one when coupled with bed-sharing and by placing children on unsafe sleep surfaces.

Unsafe sleep surfaces can be detrimental to newborns and especially premature infants. Children should sleep on their backs, alone and on a firm surface. Placing blankets, pillows or other soft materials under an infant can lead to an unexpected death.

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[16] Miller, A. B., Esposito-Smythers, C., Weismoore, J. T., & Renshaw, K. D. (2013). The Relation Between Child Maltreatment and Adolescent Suicidal Behavior: A Systematic Review and Critical Examination of the Literature.*Clinical Child and Family Psychology Review*, *16*(2), 146–172. http://doi.org/10.1007/s10567-013-0131-5
[17] Moon, R. Y., Hauck, F. R., & Colson, E. R. (2016). Safe Infant Sleep Interventions: What is the Evidence for Successful Behavior Change? *Current Pediatric Reviews*, *12*(1), 67–75. http://doi.org/10.2174/1573396311666151026110148.

Domestic Violence

Domestic violence impacts child safety through its effect on both the adult victim and the perpetrator of the abuse. Adult victims in abusive relationships must be ever vigilant for their own safety and therefore, may not be as well equipped to ensure the safety of minors in their care. Many adult victims and perpetrators use substances to help address underlying emotional issues. When coupled with the frustrations, fear and impaired thinking a domestic event can trigger, adults may make poor decisions that negatively impact a child.

Blueprint for Change

The Division must have a strong community approach. The work of child welfare, and the Division's charge, involves the heavy responsibility of ensuring safety from abuse and neglect, which cannot be done in silos. Working collaboratively is good for children, child welfare staff, external partners, and the community in general. There must be a unified approach and open communication in working to protect and ensure children's safety.

To that end, the Division's Blueprint for Change encourages constituent engagement that strives for each community partner to understand the factors negatively affecting their most vulnerable citizens; and to share in knowledge, service delivery needs, and support and prevention efforts.

The Blueprint for Change also mandates a robust workforce, which plays a critical role in terms of retaining quality staff who can make informed decisions for children. This necessitates enhanced systemic respect for those on the front-lines, evidenced by an investment in competitive salaries, and ongoing support to strengthen our workforce. It includes a work environment where career opportunities are available and where informed, quality supervisory support is delivered. Community and legislative advocacy at all levels is needed to secure the funding required to continue improving Georgia's child welfare system.

The Blueprint for Change utilizes Solution Based Case Work (SBC), a component of Georgia's Comprehensive Practice Model, to strengthen service delivery. A practice model provides guidance regarding interaction with families. At its core, SBC addresses the needs of the family, and provides an evidence-informed framework to address the needs of families.

SECTION 9: GLOSSARY

Child Abuse. (A) Any non-accidental physical injury or physical injury which is inconsistent with the explanation given for it suffered by a child as the result of the acts or omissions of a person responsible for the care of a child; (B) Emotional abuse; (C) Sexual abuse or sexual exploitation; (D) Prenatal abuse; or (E) The commission of an act of family violence as defined in Code Section 19-13-1 in the presence of a child. An act includes a single act, multiple acts, or a continuing course of conduct. As used in this subparagraph, the term "presence" means physically present or able to see or hear. (OCGA § 15-11-2).

Closed Case. Division involvement with a child or family has concluded.

Collateral Contacts. Individuals who can provide reliable information about the family and are not meant to be "character references."

Family Preservation Services (FPS). This term is described by the Family Preservation and Support Services Act of 1993 (PL 103-66) as a continuum of family-focused services for at-risk children and families. Services include activities designed to assist families in crisis, often where a child is at risk of being placed in out-of-home care because of abuse and/or neglect. Support services include preventive activities, typically provided by community-based organizations designed to improve the nurturing of children and to strengthen and enhance the stability of families.

Family Support Services (FSS). Intake reports that are assigned to Family Support Services contain an allegation of child abuse or neglect and there is no preliminary indication of a present danger situation or an impending danger safety threat. Family Support Services are designed to ensure child safety and prevent future involvement in the child welfare system through the use of formal and informal services to strengthen and support families and enhance caregiver protective capacity to ensure the protection and care of children. (Georgia Child Welfare Policy Manual, 7.0).

Foster Care. The Foster Care program provides temporary out-of-home care for children who cannot legally remain safely in their home. Foster Care services are also provided for eligible Foster Care youth ages 18-21 through the Extended Youth Support Services program unless they opt out of participation.

Intake (Report). Any information received by the Division, alleging known or suspected instances of child abuse and/or neglect. The intake assessment begins the process of comprehensively assessing child safety by gathering information to assist in locating the problems and behaviors in the everyday life of the family that led to the maltreatment concerns; as well as information that will help to build partnerships with families in identifying solutions to address child safety.

Investigation (INV). Assigned when a report indicates a present danger situation, an impending danger safety threat, or the reported maltreatment allegations fall into specific

categories requiring the assignment to investigation. An investigation is a non-voluntary intervention with families during which DFCS determines the validity of the child maltreatment report, assesses the risk of maltreatment, determines if the child is safe, develops a safety plan, if needed, to ensure the child's protection and determines services needed.

Involvement. All current and prior involvement with DFCS. This includes, but is not limited to, Intakes that were screened out, Family Support Services, Investigations and Foster Care.

Neglect. (A) The failure to provide proper parental care or control, subsistence, education as required by law, or other care or control necessary for a child's physical, mental, or emotional health or morals; (B) The failure to provide a child with adequate supervision necessary for such child's well-being; or (C) The abandonment of a child by his or her parent, guardian, or legal custodian. (OCGA § 15-11-2).

Screen Out. A report is screened out when there are no allegations of maltreatment based on an analysis of the information gathered. (Georgia Child Welfare Policy Manual, 3.0).

Substantiated. The allegations of maltreatment, as defined by Georgia statute and DFCS policy, are supported by a preponderance of the evidence. A preponderance of evidence means the evidence gathered, makes it more probable than not that the abuse and/or neglect occurred. (Georgia Child Welfare Policy Manual, 5.3).

Unsubstantiated (not substantiated). The allegations of maltreatment, as defined by Georgia statute and DFCS policy, are not supported by a preponderance of the evidence. A preponderance of evidence means the evidence gathered, makes it more probable than not that the abuse and/or neglect occurred. (Georgia Child Welfare Policy Manual, 5.30).

Georgia division of family and children services 2016 child fatality analysis

Nathan Deal, Governor

Bobby D. Cagle, Division Director

NOTE FROM THE DIVISION DIRECTOR:

The Georgia Division of Family and Children Services is committed to the safety of Georgia's children in all aspects of its operation. The death of any child is a matter of serious concern to the Division, the citizens of Georgia, and the greater child welfare community. As required by state law, the *2016 Child Fatality Analysis* includes the deaths of children whose families had been the subject of a report or investigation of maltreatment in Georgia within five years prior to their death.

The primary purpose of this report is to examine the complex circumstances surrounding the deaths of children with prior Division involvement and to make these findings available to the general public. Careful analysis of the causes and contributing factors in these deaths can lead to recommendations for changes in law, policy, and practice. We want to improve the long-term outcomes for families both during their involvement with the Division and afterwards.

Any death of a child is a tragedy and circumstances of any child's death should be reviewed, so that lessons can be learned and applied towards protecting other children from similar fates. Children's deaths can result from disease, violence, neglect, unintentional injuries, or even lack of sufficient parental training. Some deaths may be foreseeable and others unanticipated. It is our belief that many child deaths are preventable and we can use our analysis to improve efforts to protect the children of Georgia.

As Director of the Georgia Division of Family and Children Services, my vision is to build a better future for this state by developing the best child welfare agency in the world. My plan to realize this vision is called the *Blueprint for Change*, a three-pillar approach to reforming Georgia's child welfare system. One pillar includes the establishment and adoption of a practice model that will serve as the foundation to keep children safe and strengthen families. A second pillar focuses on developing a robust workforce for the Division, both in numbers and level of expertise and skill. The third pillar is focused on constituent engagement, which is an effort to engage with the public to build consensus and collaboration among partners, staff, and stakeholders. The development of this report speaks to and sheds light on the importance of each of these pillars.

The understanding and prevention of child deaths is a shared responsibility among agencies that serve the children and families of Georgia. I am confident that public, meaningful review of child deaths will support our common missions of keeping children safe, strengthening families, and building stronger communities.

Bobby D. Cagle, Director
Georgia Division of Family and Children Services

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SECTION 1: PURPOSE OF THE CHILD FATALITY ANALYSIS

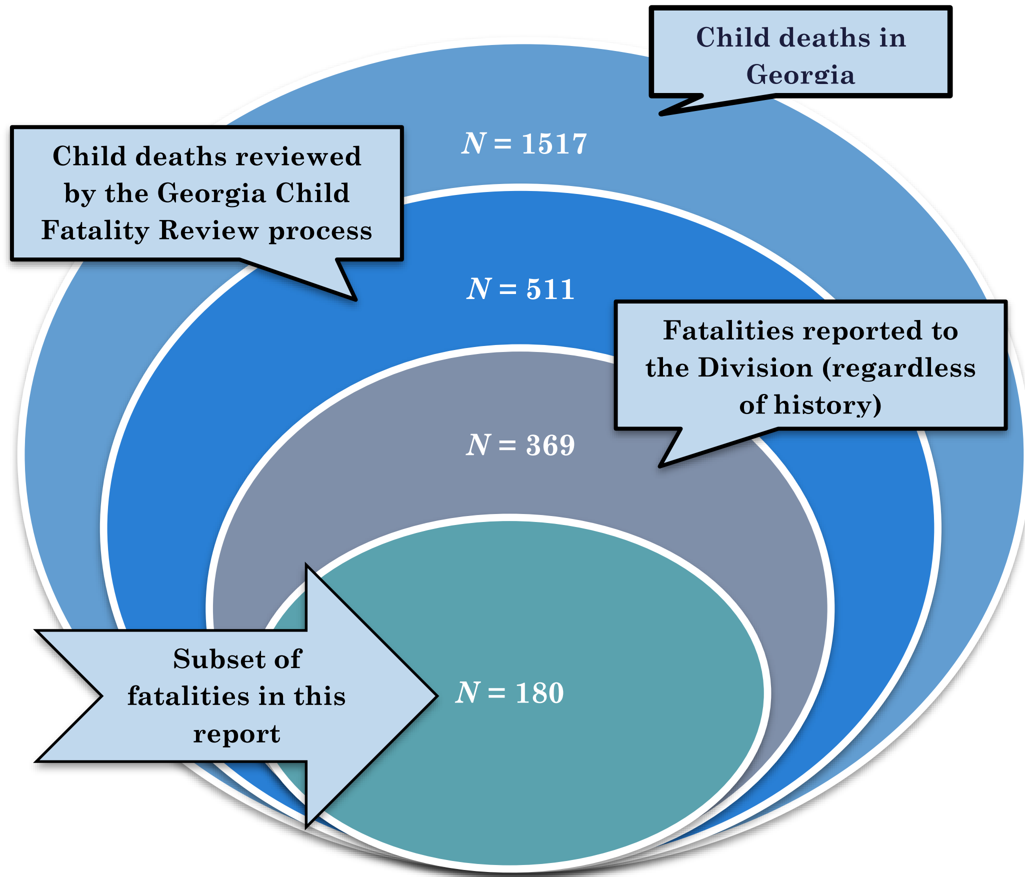
In Georgia, the Division of Family and Children Services (henceforth referred to as the Division) is the primary state agency charged with intervening on behalf of vulnerable children and investigating allegations of abuse or neglect. The Division must continually review its practices and inform the public of efforts to reduce the occurrence and harm of child abuse and neglect. Since 2012, the Division has generated an annual report on child deaths among children with prior child welfare involvement, regardless of the cause of death. For the purposes of this report, **involvement** is defined as any prior child protective services report made to the Division within five years preceding the date of death for either the child or a member of their immediate family. The Division endeavors to provide information above and beyond the state's requirement to report and analyze child fatalities under federal law.[1]

Multiple independent entities collect data on child deaths in Georgia. Complementing the work of the Georgia Child Fatality Review Panel, the *2016 Child Fatality Analysis* assists the Division in improving intervention efforts and in developing community-based solutions to reduce the risk of harm to Georgia's children. The Division closely focuses on child deaths in instances where the children and/or their families had prior Division involvement. In contrast, the Georgia Child Fatality Review process (led by the Georgia Bureau of Investigation) has a broader focus that reviews all unexplained, suspicious, or unexpected deaths of any minor child in the state.

As shown in figure 1.1, the cases in this study are a subset of the cases reported to the Division, which are in turn, a subgroup of all cases reviewed by the Child Fatality Review Panel. Additionally, data reported from the National Child Abuse and Neglect Data System (NCANDS) are yet another subset of Georgia deaths reviewed by the Division and should be separated from the children identified in this analysis. NCANDS does not distinguish between children based on prior Division involvement and highlights the deaths of children with a substantiated finding in relation to their death. Our ability to prevent deaths among children with prior child protective services involvement may be dependent on our capacity to identify common factors in the circumstances of these deaths. Such analysis will allow for the development and implementation of targeted interventions. By endeavoring to deepen our understanding of actions taken and decisions made in these cases, and to apply that knowledge to practice in the field, we anticipate improving the outcomes of Georgia's most vulnerable children.

[1] Per 42 U.S. C. Sec. 5106a (b) (2) (B) (x) of the Child Abuse Prevention and Treatment Act. See: https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap67.htm

Figure 1.1. Child Fatalities Discussed in this Report in the Context of All 2016 Child Fatalities in the General Georgia Population.



Note. In 2016, 1,517 children under 18 years of age died in Georgia (Georgia Department of Public Health, 2017). In 2016, the Georgia Child Fatality Review Panel reviewed 511 child deaths. For 2016, a total of 369 child deaths were reported to the Division. Of these, 180 children were identified as members of families who had some form of child protective services involvement with the Division within the previous five years. In 2015, 200 children met the same criteria.

SECTION 2: METHODOLOGY OF THE DIVISION'S CHILD FATALITY ANALYSIS

This report covers child deaths that occurred in Georgia between January 1, 2016 and December 31, 2016 for children whose families had some form of Division involvement within the *five years* preceding the child's death.[2] For these purposes, a family includes any caregivers, any children included in prior reports, and any newborn children or other children who moved into the home after the prior report. Deaths of children whose families had no prior Division involvement within the five years prior to their death were not included in this report.

Fatalities in this analysis are classified by cause and manner of death as outlined in Section 3. ***All information presented here is based on data available as of June 12, 2017.***

The Division has sought to improve child death data collection methodologies and strengthen reporting mechanisms since 2011. The Division's child death review team has aggressively pursued internal policy requirements regarding the reporting of child deaths. The accuracy of reported data has improved following concerted efforts to engage with stakeholders on the need for more consistent reporting of child fatalities. This process has improved the Division's collection of child death data and will result in a more comprehensive analysis of child protective services going forward. It is worthwhile to note this improved reporting process may result in an increased number of relevant child deaths being identified by the Division, as a function of improved data collection procedures.

Researchers at Georgia State University's School of Public Health analyzed the child death data. Effective collaboration with the Office of the Child Advocate, Child Fatality Review Panel, and CAPTA allowed for an additional review of many deaths and offered implications for both prevention and practice enhancements.

DFCS/GSU Protocol

The Child Fatality Analysis created by the Division includes a subset of children who had a history with the Division in the past five years. This report excludes children who did not have a history with the Division in the past five years.

Child death data were collected and provided by the Division's Data Analysis Unit and the Child Death, Near Fatality, and Serious Injury Review Team. Based on the data obtained, researchers at Georgia State University's School of Public Health analyzed the data to create data elements such as tables and figures; the Georgia State University team also edited this report. A glossary of terms is available in Section 9.

[2] As relates to this sample, *Official Code of Georgia (O.C.G.A.) §15-11-741* defines a child as "an individual receiving protective services from DFCS, for whom DFCS has an open case file, or who has been, or whose siblings, parents, or other caretakers have been, the subject of a report to DFCS within the previous 5 years."

SECTION 3: CLASSIFICATION OF CHILD FATALITIES BY CAUSE AND MANNER

Defining Causes and Manners of Death

Cause of Death refers to a specific forensic finding of how a death occurred (e.g., drowning, gunshot, suffocation, Sudden Unexpected Infant Death, etc.).

Manner of Death is an official classification by a coroner or medical examiner of how the cause of death occurred. Five determinations are used for manner of death: *accident, homicide, natural, suicide,* and *undetermined*. These manners of death are used on death certificates and autopsy reports. Note that for each manner of death, there could potentially be multiple causes of death. Each manner of death included in this report is individually defined below.

Table 3.1. Definitions[3] for Manners of Death.

Manner of Death	Definition	Examples
Accident	An unintended death.	• Drowning • Motor vehicle accident • Accidental asphyxiation due to an unsafe sleep environment
Homicide	The death was caused by the actions of another person.	• Malnutrition and/or dehydration due to neglect • Shooting by stranger or caregiver
Natural	The death was from disease or medical conditions.	• Complications stemming from Sickle Cell Anemia, Cerebral Palsy, or Cancer • Sudden Infant Death Syndrome (SIDS) is often categorized as natural
Suicide	A death that is intentionally self-inflicted.	• Hanging • Self-inflicted gunshot • Overdose
Undetermined	There is little or no evidence to establish with medical certainty, the cause of death	• When specific details surrounding the death are unclear, it is often categorized as undetermined • Sudden Unexpected Infant Death (SUID) and sleep-related deaths are often categorized as undetermined

[3] Definitions accessed on September 9 2017 from https://gbi.georgia.gov/medical-examiners-office.

Of note, many people, as well as the media, confuse the terms homicide and murder. Murder is the unlawful taking of a human life by another. After the medical examiner determines the manner of death to be a homicide, law enforcement investigates the death to determine if there is probable cause to bring the criminal charge of murder against the person who caused the death. While all murders are homicides, not all homicides are murders.

An official cause and manner of death is not always associated with the Department's finding of abuse or neglect. For example, a child may die because of an accident (such as a drowning), but maltreatment may be found in the caregiver's actions (e.g., substance use) or by their inaction (e.g., lack of supervision), and this may indirectly result in the death of the child. As another example, a death attributed to homicide (i.e., a manner of death) may occur at the hands of a caregiver and be abuse-related. Alternatively, the homicide may occur at the hands of a non-caregiver, and in that case, there may not be maltreatment by a caregiver (e.g., a teenager shot by a stranger).

The following figure provides a breakdown of the manner of child fatalities in 2016 for children with prior involvement by percentage. Note that accidental and natural deaths represent 57% (102 children) of the 180 fatalities reviewed in this report. It is noteworthy that 52 of the 102 deaths were substantiated due to contributing factors that had an impact on the death itself. For example, the drowning death of a child is almost always accidental, but the assessment of the circumstances surrounding the death may reveal inadequate supervision of the child as a contributing factor. In 80 of the deaths classified as accidental or natural, maltreatment was not substantiated.

Figure 3.2. Manners of Death by Percentage

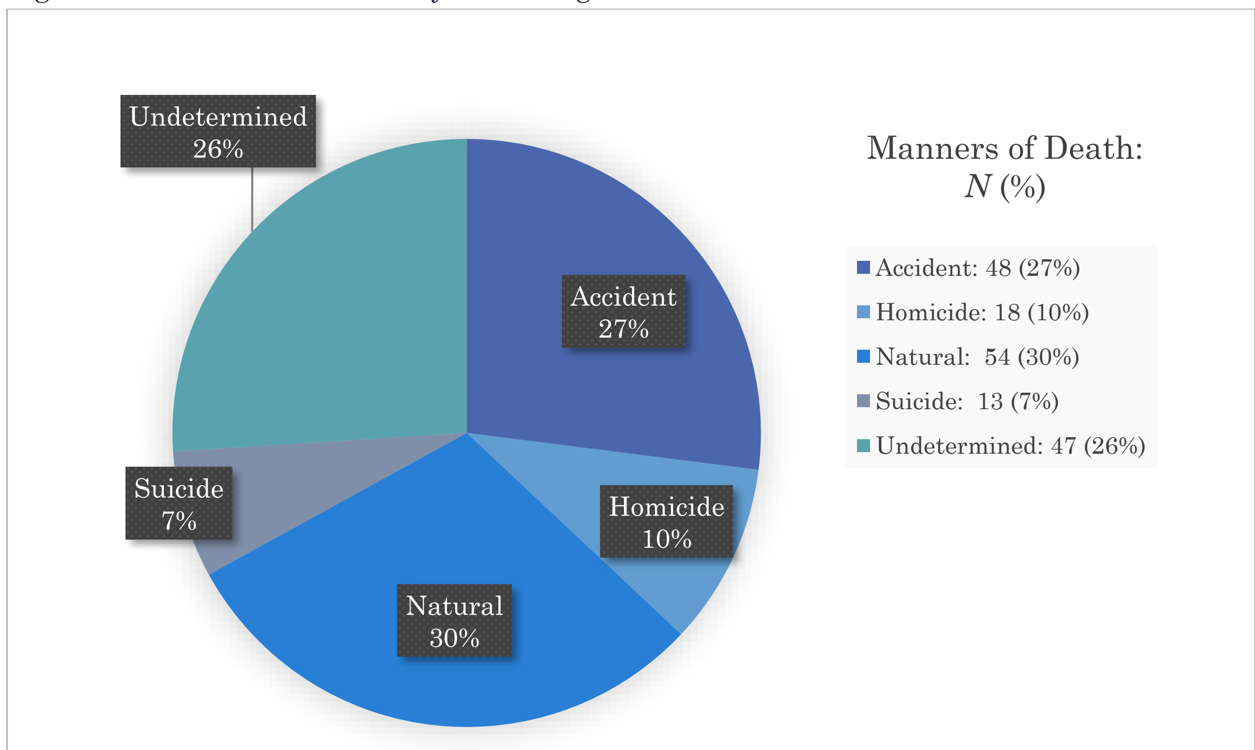
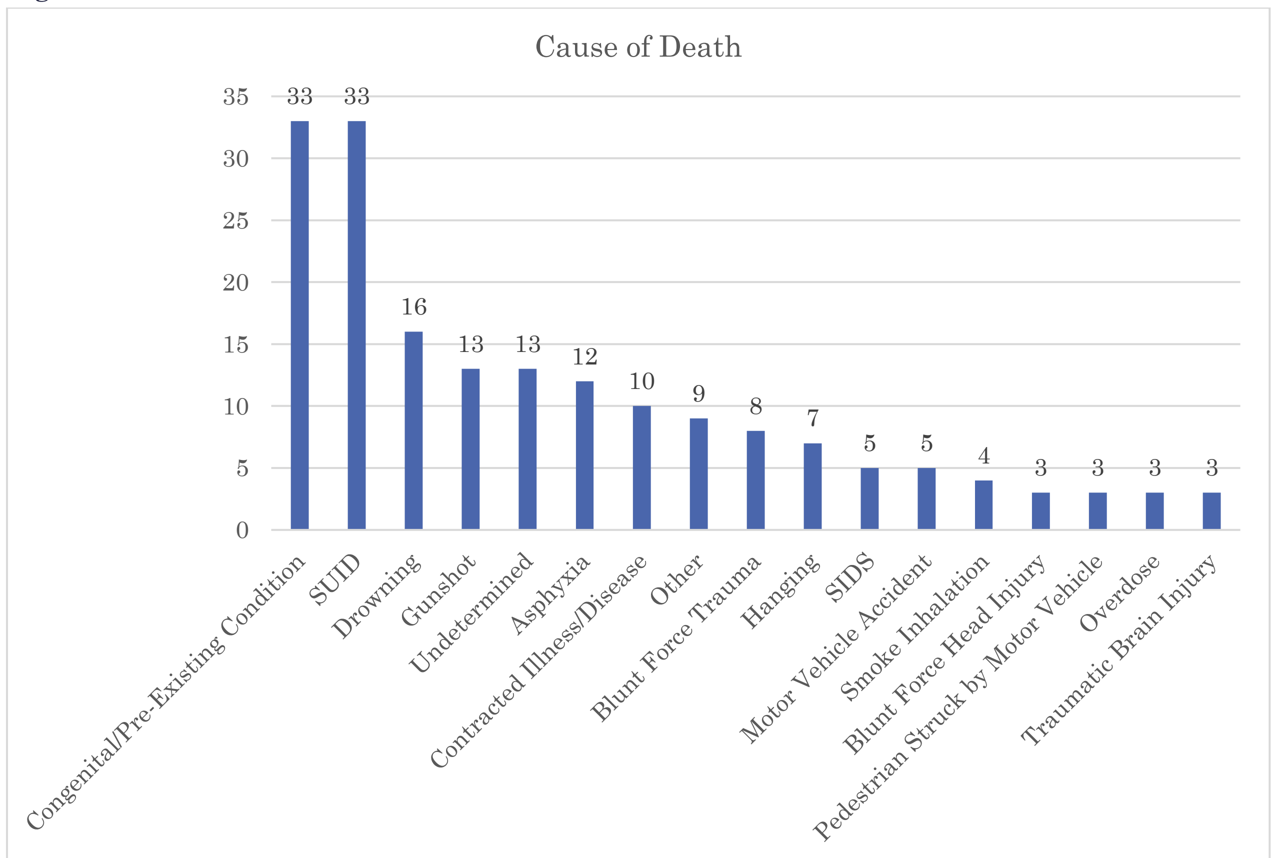


Figure 3.3 provides information on the causes of death in 2016 for children with prior child protective services involvement. In building on the data included in the previous figure, for those deaths classified as natural, the leading cause of death was a congenital or pre-existing condition (33 children) and Sudden Unexpected Infant Death (SUID; 33 children) which always corresponds to the death of a child fewer than two years of age, and which most often occurs during a sleep-related event. The second leading cause of death was drowning (16 children).

The analysis of cause of death is based on causes as they were officially recorded and reported to the Division. Because of differing approaches to investigation and classification in sleep-related deaths of very young children, there is often ambiguity regarding Sudden Unexpected Infant Death (SUID), which is a broad category including SIDS, accidental suffocation and strangulation in bed, and death by unknown causes. While there have been efforts to standardize the reporting of these cases, the cause may be officially reported differently depending on the investigation and examiner (CDC, 2017a).

Figure 3.3. Causes of Death for Children with Prior Involvement

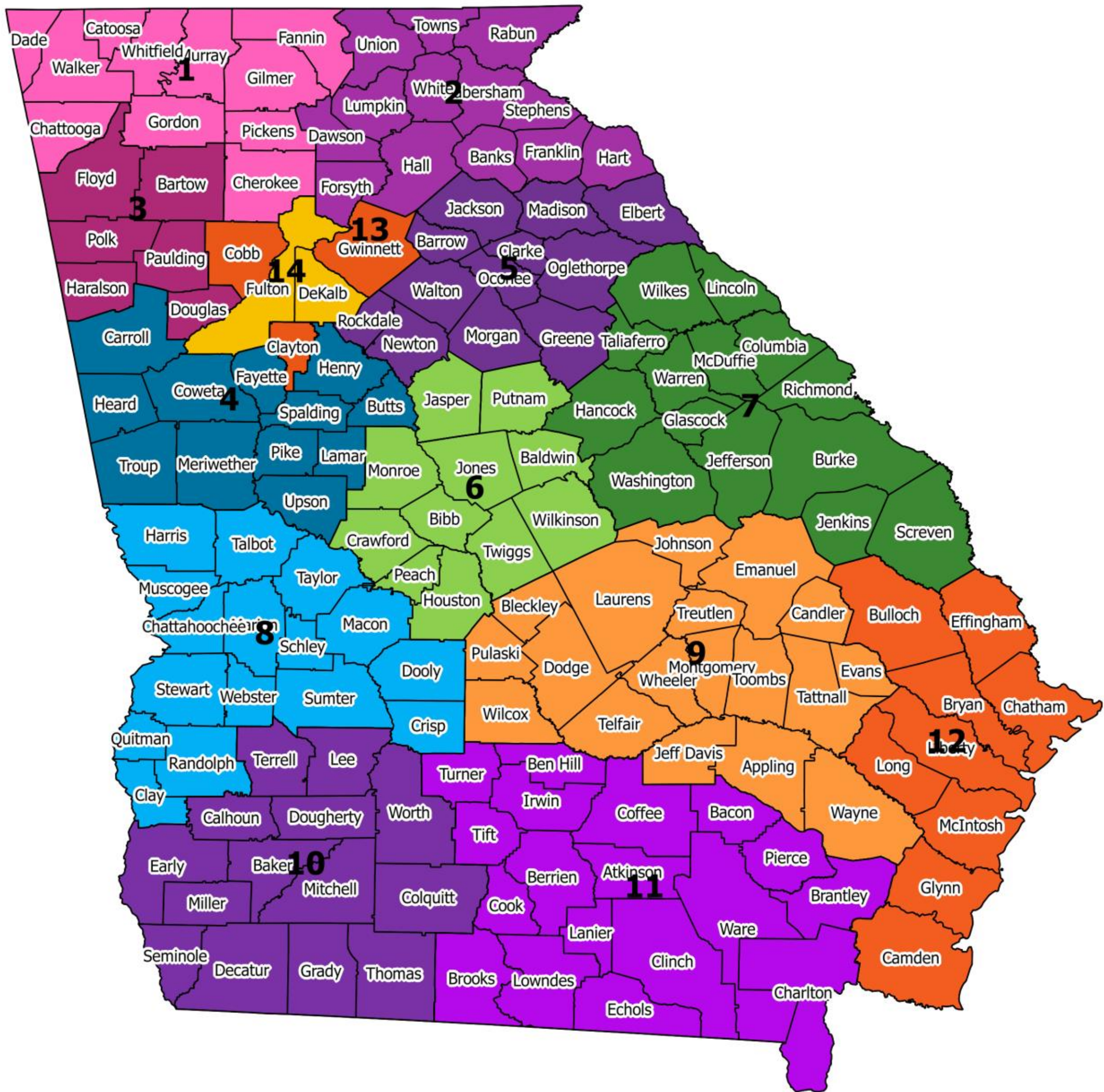


SECTION 4: EXECUTIVE SUMMARY OF DATA FINDINGS

This report reviews the deaths of 180 children who died between January 1 and December 31, 2016, and whose families had prior involvement with the Division. In the past five years, 684,664 children had Division involvement. Below, we provide an executive summary of findings. It should be noted that the following statistics are not mutually exclusive; a death may be represented in more than one of the categories below.

- **40** children **(22% of the 180 deaths reviewed by the Division)** had substantiated findings of child abuse and/or neglect prior to those children's deaths.
- **52** children **(29%)** had substantiated findings of maltreatment in the circumstances resulting in their deaths.
- **8** children **(4%)** had both substantiated findings of maltreatment prior to their deaths and substantiated findings in relation to their deaths.
- **54** children (**30%**) were determined to have died as a result of natural causes.
- **84** children (**47%**) were under the age of one year.
- **71** children (**39%**) had families with open Division cases at the time of their deaths. 9 of the 71 were open due to the incident that led to the death.
- **41** children (**23%**) were classified as having special needs.
- **56** children (**31%**) died during a sleep-related event, **40** of which involved co-sleeping.
- **84** children (**47%**) had caregiver(s) who had a history of alleged substance abuse.
- **57** children (**32%**) had caregiver(s) who had an alleged history of mental health issues.
- **76** children (**42%**) had caregiver(s) who had a history of alleged criminal offenses.
- **69** children (**38%**) had caregiver(s) who had a history of alleged domestic violence.

Figure 4.1. Map of Division Regions.



Note. Map source: http://dfcs.dhs.georgia.gov/county-offices. Each county office is responsible for providing reports directly to the state office when a child fatality is reported in their county.

Table 4.2. DFCS-involved Child Fatality Numbers/Percentages for all Division Regions.

Region	Counties Within the Region	Total Child Fatalities in Each Region	Total Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 180)
1	Catoosa, Chattooga, Cherokee, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	14	169,036	8.28	8%
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	6	168,188	3.57	3%
3	Bartow, Douglas, Floyd, Haralson, Paulding, Polk	13	145,481	8.94	7%
4	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson	16	207,261	7.72	10%

Region	Counties Within the Region	Total Child Fatalities in Each Region	Total Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (N = 180)
5	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale, Walton	11	164,024	6.71	6%
6	Baldwin, Bibb, Crawford, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	8	118,218	6.77	4%
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	13	116,928	11.12	7%

Region	Counties Within the Region	Total Child Fatalities in Each Region	Total Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 180)
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	17	85,654	19.85	9%
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	3	71,741	4.18	2%
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	8	85,676	9.34	4%

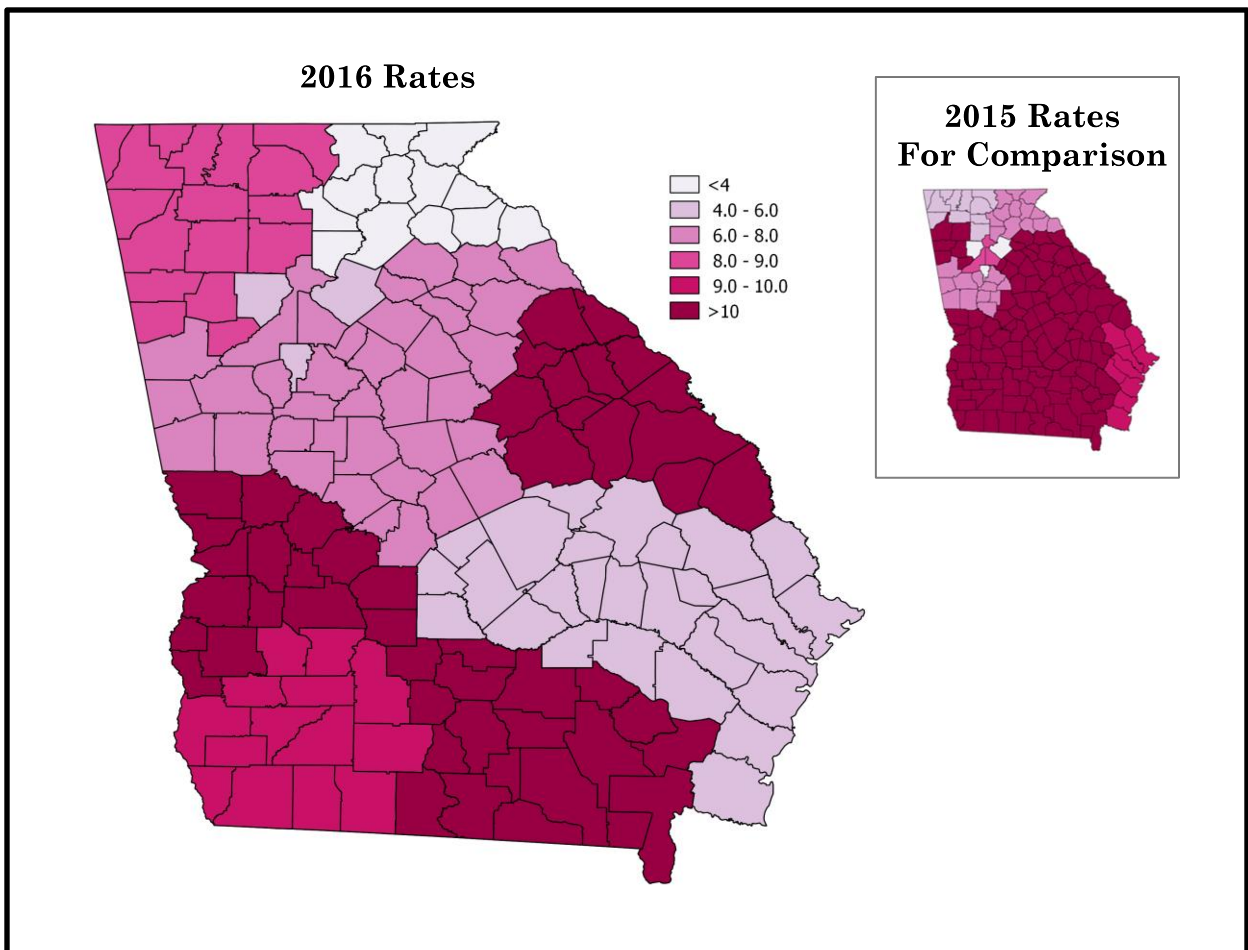
Region	Counties Within the Region	Total Child Fatalities in Each Region	Total Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 180)
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	12	100,152	11.98	7%
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	7	161,854	4.32	4%
13	Clayton, Cobb, Gwinnett	21	510,236	4.12	12%
14	DeKalb, Fulton	31	407,095	7.61	17%
Total	**Statewide**	**180**	**2,511,544**	**7.17**	**100%**

Note. Population data for regions were obtained from http://wonder.cdc.gov/bridged-race-population.html, on June 30, 2017 (CDC, 2017b).

The following heat map of Georgia shows rates of child fatalities with prior Division involvement. Rates are calculated per 100,000 children in each region. While there are contextual concerns underlying this representation (e.g., regions with few children that experienced an incident resulting in multiple deaths could see an elevated rate), it does suggest areas worthy of further investigation and increased collaboration with other state agencies.

Regions 7, 8, and 11 each have rates higher than 10 per 100,000 and may benefit from targeted intervention strategies and efforts to ensure access to quality healthcare. Combined, these three regions contain 12% of the population of children in Georgia (302,734 out of 2,511,544), but account for 23% (42 out of 180) of deaths in this report. It should be noted that the manners and causes of death in these regions follow similar patterns to the entire state and only 26% of the deaths have substantiated findings of maltreatment, compared to 29% statewide.

Figure 4.3. Child Fatality Rates per 100,000 Children by Region.

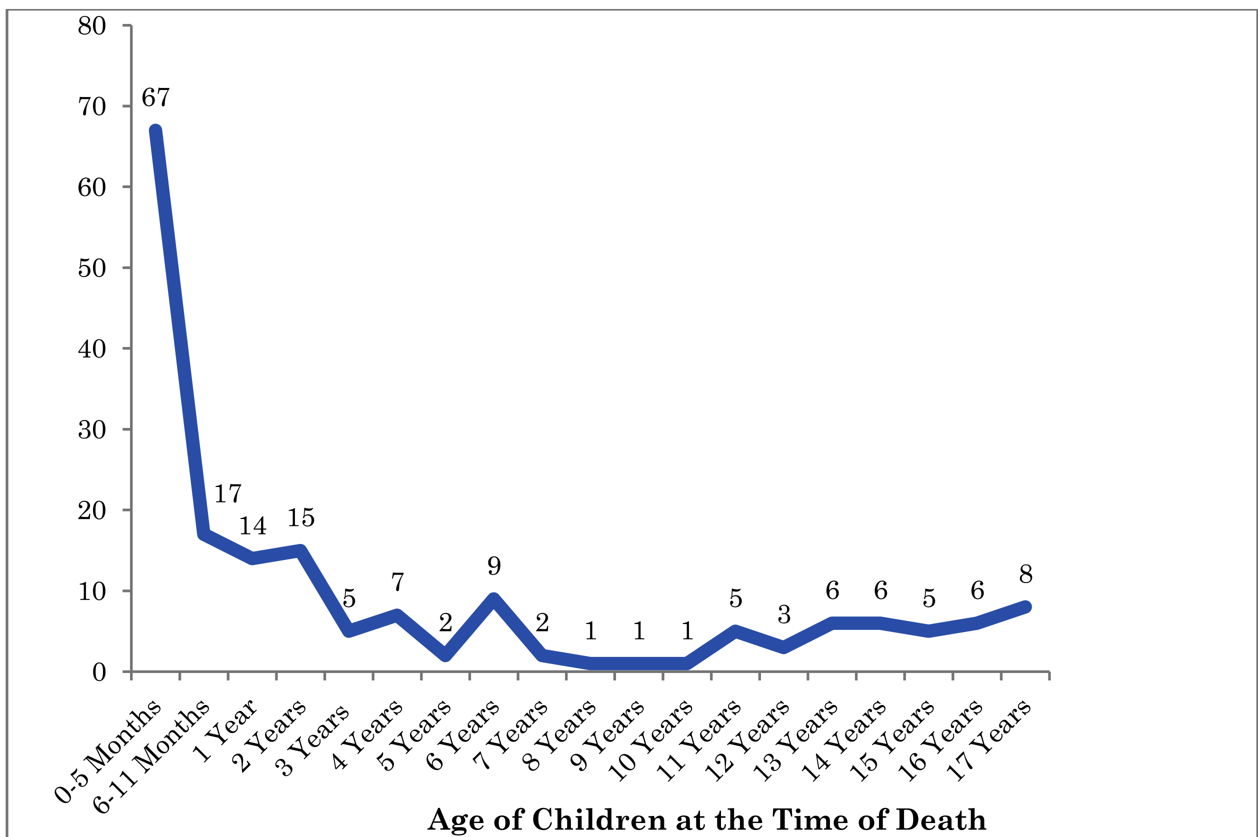


Note. As a comparison, this map also shows the 2015 heat map for child fatality rates per 100,000 children by region.

Figure 4.4 displays the ages of children in this report at the time of their deaths. Children under the age of one year account for 47% (87) of the deaths, and 54% (98) of the deaths were children under the age of two years. This conforms to national trends from the Child Trends Databank showing that children are most at-risk in their first year of life (Child Trends Databank, 2016). These data reinforce the vulnerability of infants and young children, but also draw attention to the need for greater advocacy and for campaigns that inform new parents about risk factors that may result in preventable child deaths.

The remaining 46% (82) of the deaths for 2016 comprise children between 2 and 17 years of age. Of those 82, 27 (32%) children had special needs. Thirteen (16%) of the 82 deaths between 2 and 17 years old were ruled suicides.

Figure 4.4. Ages of Children at Time of Death for Children with Prior Involvement.



SECTION 5: CHILD FATALITIES AND PRIOR DIVISION INVOLVEMENT

Description of Data

The data included in the *2016 Child Fatality Analysis* detail the manners and causes of death for children whose families had child protective services involvement with the Division within five years prior to the date of death. As noted earlier, the data included in this report *do not* reflect all child fatalities within the general Georgia child population (see Figure 1.1). When a child's death is reported to a local Division office, it is forwarded to an internal review team that examines the circumstances surrounding the death. The Georgia Office of the Child Advocate works in partnership with the Division to further understand the events surrounding the deaths of children who have prior involvement and whose deaths may be maltreatment-related.

In 2016, a total of **369** child deaths were reported to the Division. Of these, **180** children were identified as members of families who had some form of child welfare involvement with the Division within the previous five years.[4] During the same time period, the Division had contact with approximately 684,664 children. This equates to **180** deaths in 2016 among 684,664 children with any family involvement with DFCS in the past five years, a rate of about 26.29 deaths per 100,000[5] applicable children. To place this in context, 1,517 children died from all causes in Georgia in 2016. In 2016, there were **2,511,544** children living in Georgia (CDC, 2017b). Thus, the mortality rate for Georgia children for 2016 was 60.40 per 100,000.

In 2016, of the **180** deaths with Division involvement, **109** occurred after the Division had ended its involvement with the family. In **71** of the fatalities, the Division had an open case with the family at the time of death, **9** of which were opened due to the circumstances that led to the death.

The following data provide a snapshot of the Division's overall Child Protective Services caseloads for 2016:

- The total number of reports to the Division: **118,730**
    - Screen-Outs: **27,622**
    - The total number of reports assigned to Child Protective Services (CPS) workers: **91,048**
        - **46,168 (51%)** were assigned to Family Support Services
        - **44,880 (49%)** were assigned to Investigations
- The total number of children in DFCS custody at some point in 2016: **19,080**

[4] In comparison, for 2015, the deaths of 200 children whose families had prior Division history were reported to the agency.
[5] This estimate is unadjusted for the number of new births in families, number of unreported children in the family, or recurrent reports for the same child during the 5-year period.

- The total number of Family Preservation Services cases: **9,989**

Child Fatality Review Process

Once a death has been reported to the Division, a review of circumstances surrounding the death is warranted. Deaths due to maltreatment are of special concern and require additional scrutiny because the Division is charged with investigating child abuse and neglect. It should be noted that not all deaths in this report are due to abuse or neglect; in fact, most were due to circumstances beyond any responsibility of the Division. The Division reviews the deaths of children with prior DFCS history due to the desire to improve practice whenever possible.

Specific causes and manners are typically determined by a coroner or Medical Examiner. Findings of maltreatment are based on physical indicators, as well as additional information obtained from the Division, first responders, and law enforcement. This additional level of investigation and detection may increase the number of deaths attributed to maltreatment, and the number of maltreatment-related deaths may appear to rise, even if actual incidences are stable or declining.

Intervention by the Division involves a broad spectrum of potential services. For example:

- Prior or current Foster Care services.
- A report that was screened-out because it lacked an allegation of abuse or neglect.
- Family Support Services cases in which the allegation does not necessarily involve immediate child safety.
- Family Preservation Services cases in which allegations of maltreatment or abuse may have been substantiated, but the removal of the children was not necessary to ensure safety.
- Investigations in which the Division may have confirmed an allegation of abuse or neglect.

The Division forwards data from both types of reports (with and without prior Division involvement) to the National Child Abuse and Neglect Data System (NCANDS). In 2016, **189** child deaths without prior child protective services involvement, were made to the Division. Those deaths are excluded from this analysis. NCANDS does not distinguish whether or not the Division had prior involvement and thus only includes children whose deaths were a) reported to the Division and b) determined to be related to maltreatment.

Closed Cases

Of the 180 fatalities reviewed in this report, 109 (61%) were for children from families with closed cases at the time of the child's death. This includes 52 children (29% of 180 deaths in 2016) who were born after their family's last case closure. In other words, the child who died was born after the completion of the Division's most recent involvement with the family. In looking at child fatalities and prior Division involvement, the length of time between the most recent involvement and the death of the child is noteworthy.

The 109 deaths occurring after case closure include 8 suicides and 8 homicides. Three suicides occurred fewer than 12 months after case closure, and 5 suicides occurred more than 12 months after case closure. For homicides, 4 homicides occurred less than 12 months after case closure, and 4 homicides occurred more than 12 months after case closure.

Figure 5.1 displays the length of time between prior Division involvement with the family and the child's death (for cases closed at the time of death), delineated by the five official manners of death.

Figure 5.1. Length of Time between Prior Involvement and Child Death for Those with Closed Cases at Time of Death, Delineated by Manner of Death, *N* = 109.

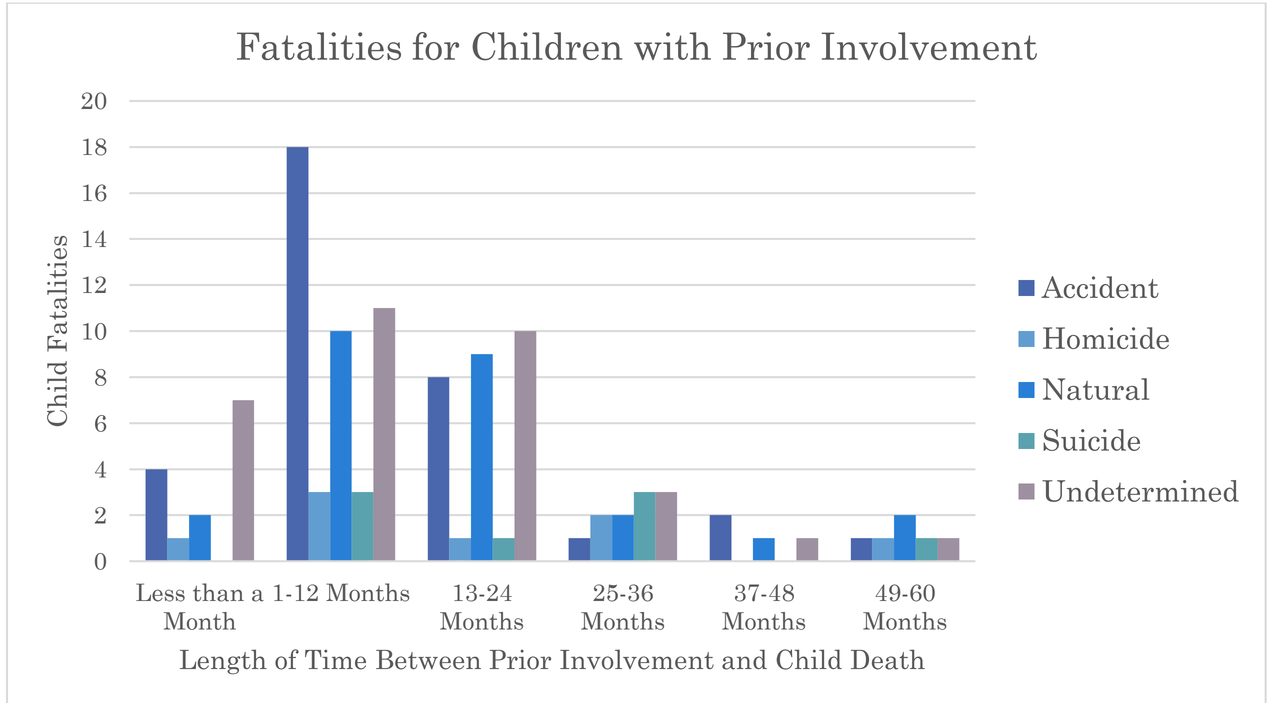


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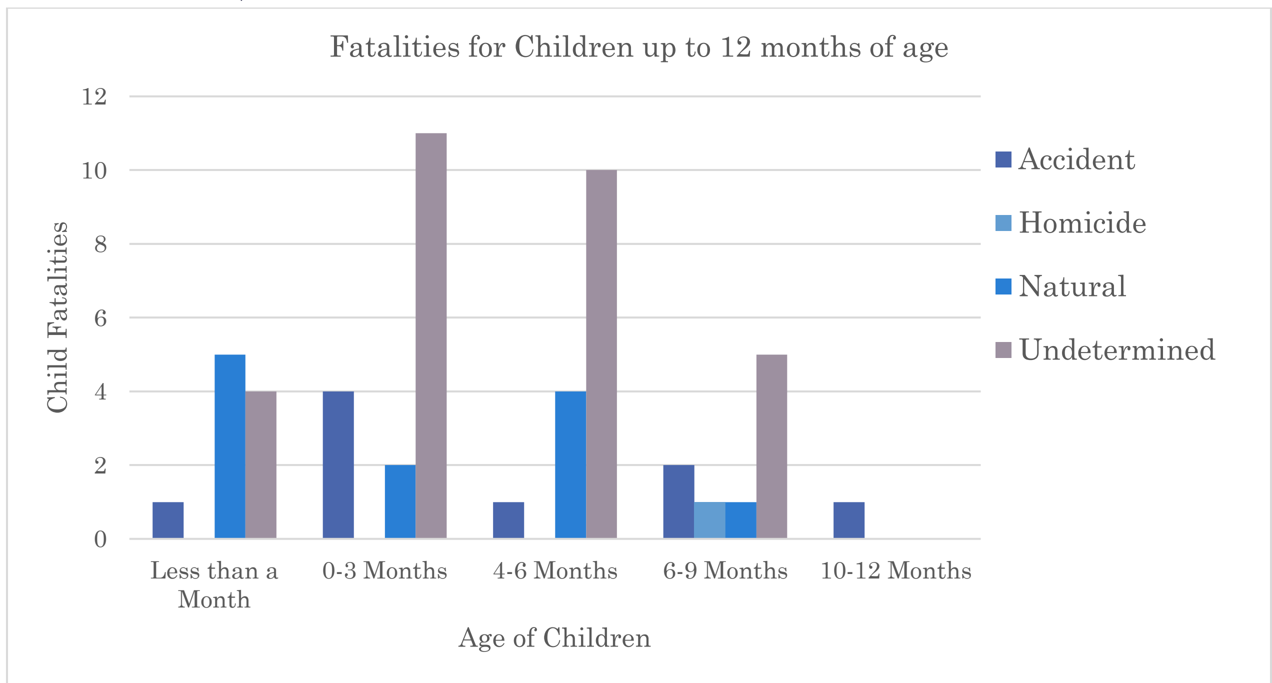
Figure 5.2 examines the age and manner of death for the 52 children who were between 0 and 12 months of age with prior involvement and closed cases at the time of death. This includes 32 cases where the child was born after the case was closed.

Figure 5.2. Fatalities by Age Group for Children Up to 12 Months of Age, Delineated by Manner of Death, *N* = 52.



Note. There were 52 children aged 0-12 months in 2016 who had closed cases at the time of death.

Open Cases

An open case indicates active Division involvement with a child or family. In 2016, there were 71 fatalities with open cases at the time of the child's death.

Of those 71 fatalities with open cases, 17 (24%) had substantiated findings of maltreatment in relation to their deaths. Three of the 17 cases (18%) were open due to the incident which resulted in the child's death. The other 14 (82%) cases had substantiated findings in their death, but had open cases with the Division for various unrelated reasons.

Table 5.3 breaks down these 17 fatalities by case type and whether the case was open due to the incident that caused the death or for other reasons.

Table 5.3. Number of Substantiated Fatalities with Open Cases at the Time of Death (with Case Type) for Children with Prior Involvement, $N = 17$.

Substantiated Fatalities with Open Cases at the Time of Death	Case Open Due to Incident that Led to the Death	Case Open for Other Reasons	Total Number (and Percentage) of Open Cases at the Time of Death
Investigation for Abuse or Neglect	2 (12%)	4 (23%)	6 (35%)
Family Preservation Services	0 (0%)	5 (29%)	5 (29%)
Family Support Services	0 (0%)	3 (18%)	3 (18%)
Foster Care	1 (6%)	1 (6%)	2 (12%)
Post Foster Care	0 (0%)	1 (6%)	1 (6%)
Total *N* (%)	**3 (18%)**	**14 (82%)**	**17 (100%)**

Table 5.4 provides a breakdown for *open cases with a substantiated finding* of maltreatment in the death and is broken down by the official manner of death.

Table 5.4. Number of Substantiated Fatalities with Open Cases at the Time of Death (with Manner of Death) for Children with Prior Involvement, *N* = 17.

Substantiated Fatalities with Open Cases at the Time of Death	Case Open Due to Incident that Led to the Death	Case Open for Other Reasons	Total *N* (%)
Accident	1 (33%)	4 (29%)	**5 (29%)**
Homicide	2 (67%)	2 (14%)	**4 (24%)**
Natural	0 (0%)	1 (7%)	**1 (6%)**
Suicide	0 (0%)	2 (14%)	**2 (12%)**
Undetermined	0 (0%)	5 (36%)	**5 (29%)**
Total *N* (%)	**3 (18%)**	**14 (82%)**	**17 (100%)**

Note. All children with cases open due to the incident that led to the death also had cases open prior to the incident that led to the death. The percentages in individual cells are calculated from the column totals while total percentages represent the percentage from the total N=17.

Implications for Practice

Deaths of children with Division contact may occur in multiple ways and, therefore, have different implications for understanding, learning, and improving practice. One of the most disconcerting manners of death for the Division is when a child suffers an abusive death at the hands of a caregiver in which the risk was pre-existing and interventions offered did not prevent harm from happening to the child. In these cases, maltreatment is the proximal cause of death. These types of incidents raise service improvement questions about risk assessment (e.g., was the risk detectable?), provision of services (e.g., were the services appropriate?), decision-making (e.g., was maintaining the child in their present situation a reasonable decision?), and management of aftercare needs (e.g., were services after reunification or post termination adequate?).

Other manners of death may be caused by complex circumstances in which parental negligence plays a partial, but not a proximal or even necessary role. For example, a child may die in a vehicular accident in which the child was not properly secured in a car seat, or a child may die from an illness complicated by delayed medical care. These types of cases

may alert case managers about possible future maltreatment if other children are present in the home.

In some situations, the Division may end its involvement with a family after it has ensured the safety of existing children in the home, but the parent(s) may later bear other children who are not known to the Division. For example, a drug addicted mother may have all of her children placed in DFCS custody and after reunification efforts have failed, her parental rights are terminated. As a result, the Division would close its case because she has no other children in her home and risk has been eliminated. The mother may later have additional children whom the Division is unaware of, and a report is made because she has given birth to a drug exposed infant; the infant has medical complications and dies due to those complications. The implications for practice under these types of scenarios would focus on strategies involving Georgia's maternal and child health system and community supports. For 2016, there were 52 children born after the Division's last involvement with the family; therefore, intervention efforts were improbable.

The Division continuously reviews its practices at many levels. Whenever there has been prior involvement with a family, there is an opportunity to review its response and potentially the responses from other agencies that may have been involved in the family's life. Division intervention in a family's life can be crucial and have lasting effects. Open and effective communication between all parties who have a responsibility to ensure a child's safety is critical to having successful outcomes for children.

SECTION 6: VULNERABLE POPULATIONS

Children under the Age of One

Of the 180 deaths reviewed in this report, 84 (47%) were children under one-year-old. Of those 84 children, 43 (51%) were born after the Division's last involvement with the family. The primary manner of death of the 84 children under age one (see Table 6.1) was Undetermined (42 children), and the second most common manner was Natural (29 children). Additionally, 51 (61%) of the 84 children in this age group had caregivers who were alleged to have been engaging in substance use at some time.

Unsafe sleep practices have been identified as a major factor contributing to death among children under age one. Being placed on a soft surface and/or sharing sleep surfaces with adults or siblings remain factors in sleep-related deaths. This is a recognized public health matter nationwide and underscores the need to educate parents and caregivers about infant safe-sleep practices used not only during night time sleeping, but also during any sleep-related event throughout the day.[6]

Table 6.1. Manners of Death for Children under the Age of One with Prior Involvement, *N* = 84.

Age	Accident	Homicide	Natural	Undetermined	Total *N* (%)
0-5 Months	7 (70%)	1 (33%)	26 (90%)	33 (86%)	**67 (80%)**
6-11 Months	3 (30%)	2 (67%)	3 (10%)	9 (14%)	**17 (20%)**
Total *N* (%)	**10 (12%)**	**3 (4%)**	**29 (34%)**	**42 (50%)**	**84 (100%)**

Note. Percentages in individual cells represent the percentage the age range constitutes of that manner of death. Total percentages represent the percent of the total *N*=84.

[6] The Centers for Disease Control and Prevention reported that the leading causes of infant deaths in 2014 were: birth defects, preterm birth (birth before 37 weeks gestation) and low birth weight (under 2500 grams), maternal complications of pregnancy, sudden infant death syndrome (SIDS), and injuries (e.g. suffocation).

Table 6.2 examines the causes of death in children under age one, divided into the first and second 6 months of life. The leading two causes of death for this age group were Sudden Unexpected Infant Death (SUID) (33 children) and congenital or pre-existing conditions (19 children).

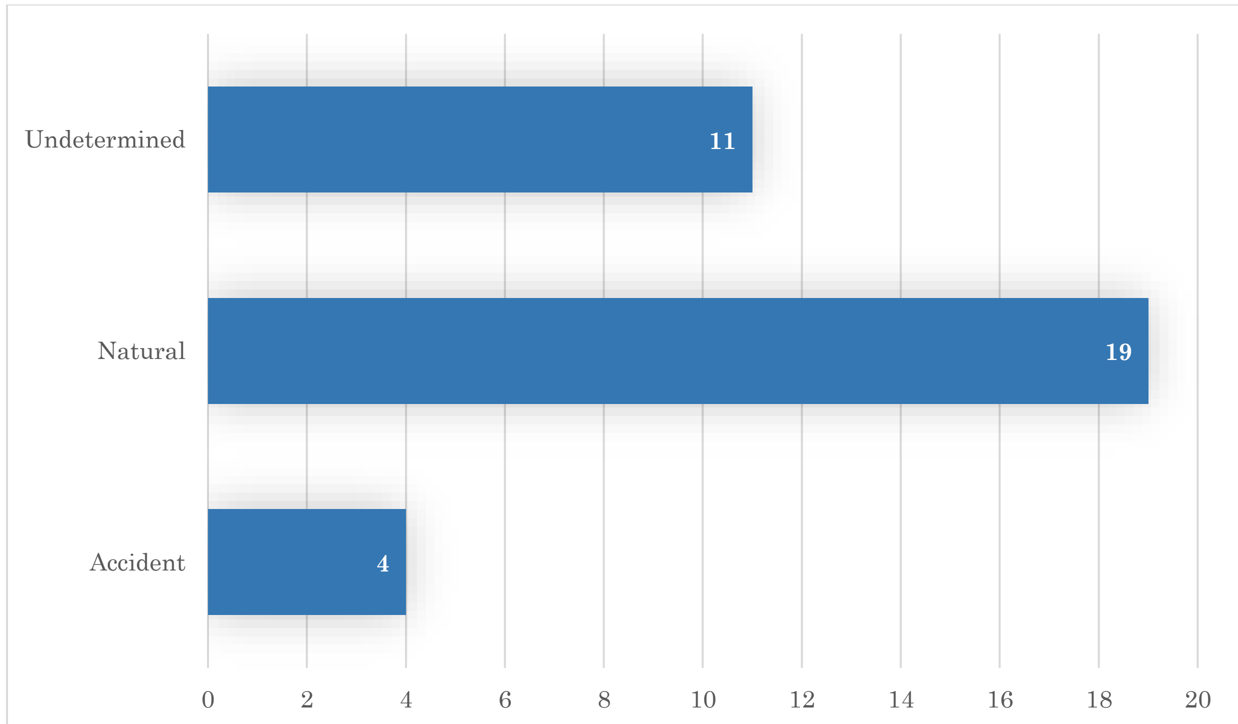
Table 6.2. Causes of Death for Children under the Age of One with Prior Involvement, *N* = 84.

Causation	Age 0-5 Months	Age 6-11 Months	Total *N* (%)
Asphyxia	6 (9%)	2 (12%)	**8 (10%)**
Blunt Force Head Injury	0 (0%)	1 (6%)	**1 (1%)**
Blunt Force Trauma	0 (0%)	1 (6%)	**1 (1%)**
Congenital/Pre-Existing Condition	16 (24%)	2 (12%)	**19 (23%)**
Contracted Illness/Disease	2 (3%)	0 (0%)	**2 (2%)**
Drowning	0 (0%)	1 (6%)	**1 (1%)**
Other	3 (4%)	0 (0%)	**2 (2%)**
SIDS	4 (6%)	1 (6%)	**5 (6%)**
SUID	27 (40%)	6 (34%)	**33 (40%)**
Traumatic Brain Injury	1 (2%)	1 (6%)	**2 (2%)**
Undetermined	8 (12%)	2 (12%)	**10 (12%)**
Total *N* (%)	**67 (80%)**	**17 (20%)**	**84 (100%)**

Premature Children

Premature (or preterm) birth occurs when a child is born before a full 37 weeks of pregnancy. Premature birth increases the risk of developmental delays and congenital defects. **Thirty-four (40%)** of the children in this report younger than 12 months old were also born prematurely. Of those 34 children, **19 (56%)** died of natural causes.

Figure 6.3. Manner of Death in Premature Children under 12 Months of Age, $N = 34$.



In this data set, premature children under 12-months-old appear particularly vulnerable to death from sleep-related causes. Their delayed development may put them at special risk from hazards related to unsafe sleep practices.

- **34** premature children in this report were fewer than 12 months old.
- **12** of the 34 premature children under 12 months died due to congenital/pre-existing conditions, the most frequent cause of death.
- **17** of the 34 premature children under 12 months died from sleep-related causes including asphyxia, SIDS, SUID, and undetermined causes.
- All **4** asphyxia deaths were ruled as accidental and were sleep-related.

Table 6.4. Causes of Death in Premature Children under 12 Months of Age, *N* = 34.

Causation	Non-Sleep-Related	Sleep-Related	Total *N* (%)
Asphyxia	0 (0%)	4 (24%)	**4 (12%)**
Blunt Force Head Injury	1 (6%)	0 (0%)	**1 (3%)**
Congenital/Pre-Existing Condition	12 (70%)	0 (0%)	**12 (35%)**
Other	2 (12%)	0 (0%)	**2 (6%)**
SIDS	0 (0%)	2 (12%)	**2 (6%)**
SUIDs	1 (6%)	8 (46%)	**9 (26%)**
Undetermined	1 (6%)	3 (18%)	**4 (12%)**
Total *N* (%)	**17 (50%)**	**17 (50%)**	**34 (100%)**

Note. Individual percentages represent the proportion of a given sleep-related status attributable to a cause of death. Total percentages represent the percentage of the 34 premature children under 12-months-old.

Prenatally Substance-Exposed Children

There were 28 children (16% of 180 children) who had a history of prenatal exposure to drugs. Of these children, 22 were under the 6 months old at the time of their deaths. While it is difficult to link deaths exclusively to prenatal exposure, the effects of prenatal exposure to substances may put infants at risk. Prenatal exposure to substances is associated with adverse health outcomes including low birth weight, extreme prematurity, congenital anomalies, and neurobehavioral issues (Behnke & Smith, 2013).

Even after an infant is born, substance use by an adult caregiver may place infants at risk. A parent or caregiver in an altered state places the child at risk, especially when the caregiver is unable to provide and recognize what is a safe environment for the child. Addiction recovery is best viewed as a long-term task, extending well beyond the time frame of involvement of a child welfare agency. Deaths associated with caregivers' abuse of methadone, alcohol, prescription medication, and illegal substances have been reported to the Division and continue to be a challenging characteristic of the child welfare population. When substance use is coupled with co-sleeping or a special needs child, the risk of harm or death is even higher.

There were **17** prenatally exposed children also born prematurely. Of those, many had complex medical issues; **9** died before they left the hospital.

Table 6.5. Prenatal Drug Exposure and Manner of Death, *N* = 28.

Exposure History	Accident	Natural	Undetermined	Total *N* (%)
Prenatal Drug Exposure	3 (2%)	17 (9%)	8 (5%)	28 (16%)

Children in DFCS Custody

10 foster children died in 2016:

- **8** deaths were determined to be from natural causes**, 5** were due to congenital or pre-existing conditions, **1** was due to contracting illness/disease, **1** was due to Sudden Infant Death Syndrome (SIDS) and **1** was undetermined.
- **1** child died due to a gunshot and the death was ruled a homicide (unidentified assailant).
- **1** child died due to drowning and the death was ruled an accident.

Table 6.6. Manners of Death for Children in DFCS custody at the Time of Death, *N* = 10.

Manner of Death	Accident	Homicide	Natural	Total *N* (%)
Total *N* (%)	1 (10%)	1 (10%)	8 (80%)	10 (100%)

Children/Families with Multiple Risk Factors

Often families who have prior involvement with the Division and have experienced a child death are affected by multiple risk factors, including, but not limited to, substance abuse, domestic violence, mental health issues, criminal history, and/or having a child with special needs. The greater the complexity of the issues within a family, the more challenging it can be for professionals to assess the ongoing safety of the children. Naturally, families are not always comfortable or willing to expose areas they may find embarrassing or difficult to address, making safety assessments even harder to thoroughly complete. Nevertheless, the Division recognizes the crucial need to consistently assess and address these multiple risk factors for such cases. The following table describes caregiver risk factors by manner of death.

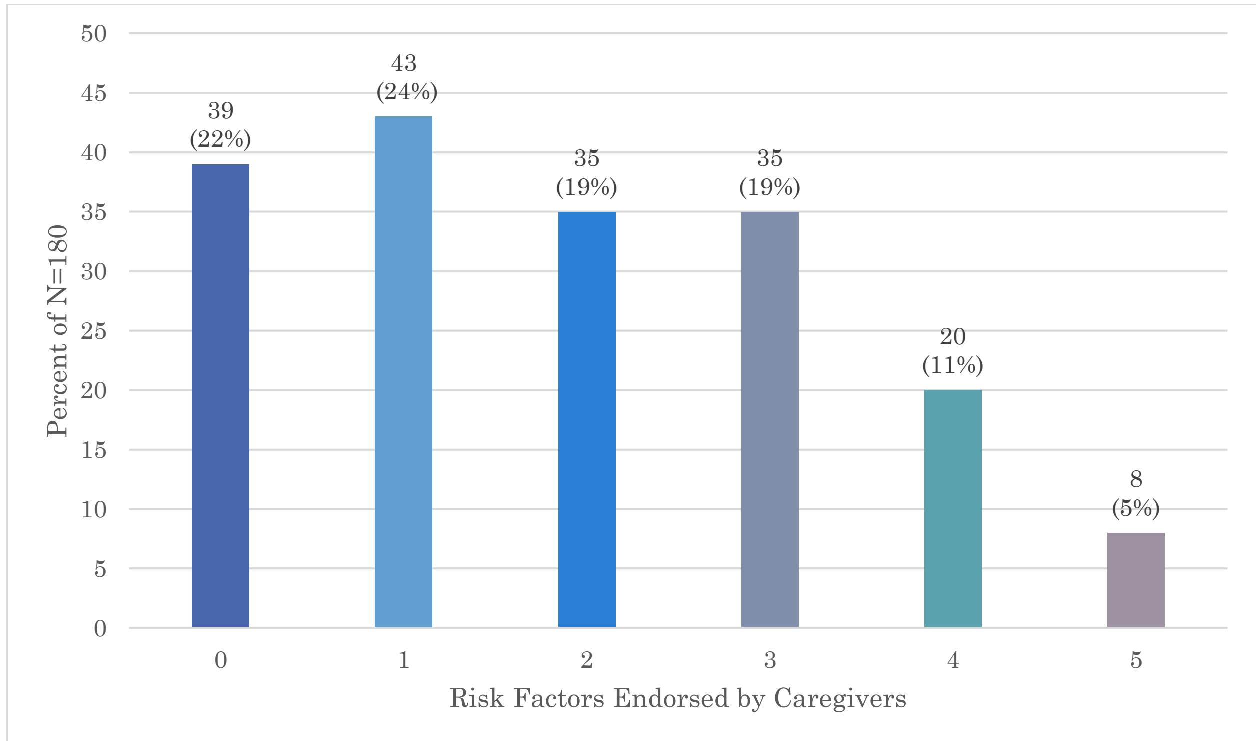
Table 6.7. Risk Factors of Caregivers and Manner of Death.

Caregiver Risk Factors	DFCS History as a Child *N* = 52	Alleged History of Substance Abuse *N* = 84	Alleged Criminal History *N* = 76	Alleged Mental Health History *N* = 57	Alleged History of Domestic Violence *N* = 69
Accident	16 (31%)	18 (21%)	21 (28%)	17 (30%)	17 (25%)
Homicide	3 (5%)	8 (10%)	10 (13%)	3 (5%)	11 (16%)
Natural	17 (33%)	26 (31%)	16 (21%)	19 (33%)	18 (26%)
Suicide	0 (0%)	4 (5%)	4 (5%)	4 (7%)	4 (6%)
Un-determined	16 (31%)	28 (33%)	25 (33%)	14 (25%)	19 (27%)
Total *N* (% of all cases)	**52 (29%)**	**84 (47%)**	**76 (42%)**	**57 (32%)**	**69 (38%)**

Note. Individual percentages represent manner of death in cases with a given risk factor. Caregivers may have met criteria for several risk factors. The total % for each risk factor represents the percentage out of all 180 cases in this report.

Figure 6.8 highlights the number of risk factors for child death endorsed by caregivers. These caregiver risk factors were DFCS history as a child, history of substance abuse, history of domestic violence, criminal history, and history of mental health issues.

Figure 6.8. Number of Risk Factors for Which Caregivers Met Criteria.



Tables 6.9 and 6.10 provide a breakdown of the 2016 deaths based on caregivers with histories substance abuse and/or domestic violence, and having a child with special needs, respectively. Note that **43** (**24%**) of the total deaths for children with prior Division involvement involved caregivers with a history of *both* substance abuse and domestic violence.

Table 6.9. Causes of Death in 2016 for Children with Prior Involvement and Caregivers with Alleged History of Substance Abuse and/or Domestic Violence, *N* = 110, which includes 43 caregivers who had both a history of substance abuse and domestic violence.

Causes of Death	Caregivers with History of Alleged Substance Abuse	Caregivers with History of Alleged Domestic Violence
Asphyxia	8 (10%)	6 (9%)
Blunt Force Head Injury	0 (0%)	0 (0%)
Blunt Force Trauma	2 (2%)	3 (4%)
Congenital/Pre-Existing Condition	17 (21%)	11 (16%)
Contracted Illness/Disease	3 (4%)	4 (6%)
Drowning	7 (8%)	6 (9%)
Gunshot	4 (5%)	7 (10%)
Hanging	1 (1%)	1 (1%)
Pedestrian Hit by Car	1 (1%)	2 (3%)
Motor Vehicle Accident	1 (1%)	2 (3%)
Other	5 (6%)	3 (4%)
Overdose	2 (2%)	0 (0%)
Probable Overlying	1 (1%)	0 (0%)
SIDS	4 (5%)	2 (3%)
SUIDs	15 (18%)	12 (18%)
Smoke Inhalation or House Fire	3 (3%)	1 (1%)
Traumatic Brain Injury	1 (1%)	3 (4%)
Undetermined	9 (11%)	6 (9%)
Total *N* (%)	**84 (76%)**	**69 (63%)**

Note. Some children are captured in both categories; 43 caregivers had both a history of substance abuse and domestic violence. Thus, the total reflects the category of exposure, not number of children.

Special Needs

Table 6.10. Manners of Death for Special Needs Children with Prior Division Involvement, *N* = 41.

Manner of Death	Accident	Homicide	Natural	Suicide	Un-determined	Total *N* (%)
Total Number	5 (3%)	4 (2%)	27 (15%)	3 (2%)	2 (1%)	41 (23%)

Teen Deaths

2016 identified **31** teenagers between the ages of 13 and 17 who died and also had prior involvement with the Division.

- **9** committed suicide**: 4** by hanging, **4** by self-inflicted gunshot wounds, and **1** by overdose.
- **9** died due to accidental causes: **3** died in motor vehicle-related incidents, **3** by blunt force trauma, **2** pedestrians struck by motor vehicle, and **1** by drowning.
- **7** died due to homicide: **5** deaths were due to gunshot wounds; **2** deaths were due to stabbing (Caregiver committed **1** homicide, others were committed by youths or unknown assailants).
- **6** died due to natural causes: **3** by contracting illness/disease, **2** by a congenital pre-existing condition, and **1** due to other cause.

SECTION 7: UNSAFE SLEEP ENVIRONMENT

Many of the sleep-related deaths involved incidents where there was a combination of co-sleeping and an overall unsafe sleep environment. Caregivers or others falling asleep with infants in chairs, couches, or adult beds were a factor in 40 of the 56 sleep-related deaths. It is recommended that infants always sleep alone, on their backs, and in a sleep setting such as a crib (Moon, 2016). 33 infant deaths were ruled as SUIDs (Sudden Unexpected Infant Deaths) and 10 were ruled undetermined. Review of these fatalities has uncovered other contributing factors not readily observed at the time of death, such as substance use and/or untreated mental health needs of caregivers, and the presence of soft bedding material being used in a crib or bassinet. Circumstances surrounding sleep-related deaths continue to be explored to identify underlying contributing factors. In this report, 55 of the 56 children with sleep-related deaths were under one-year-old at the time of their death. In 32 of the 56 sleep-related deaths, caregivers had a history of alleged substance abuse. The Division believes that most of these deaths, though unintentional, were preventable.

Figure 7.1. 2016 Sleep-Related Death Rates per 100,000 Children by Region.

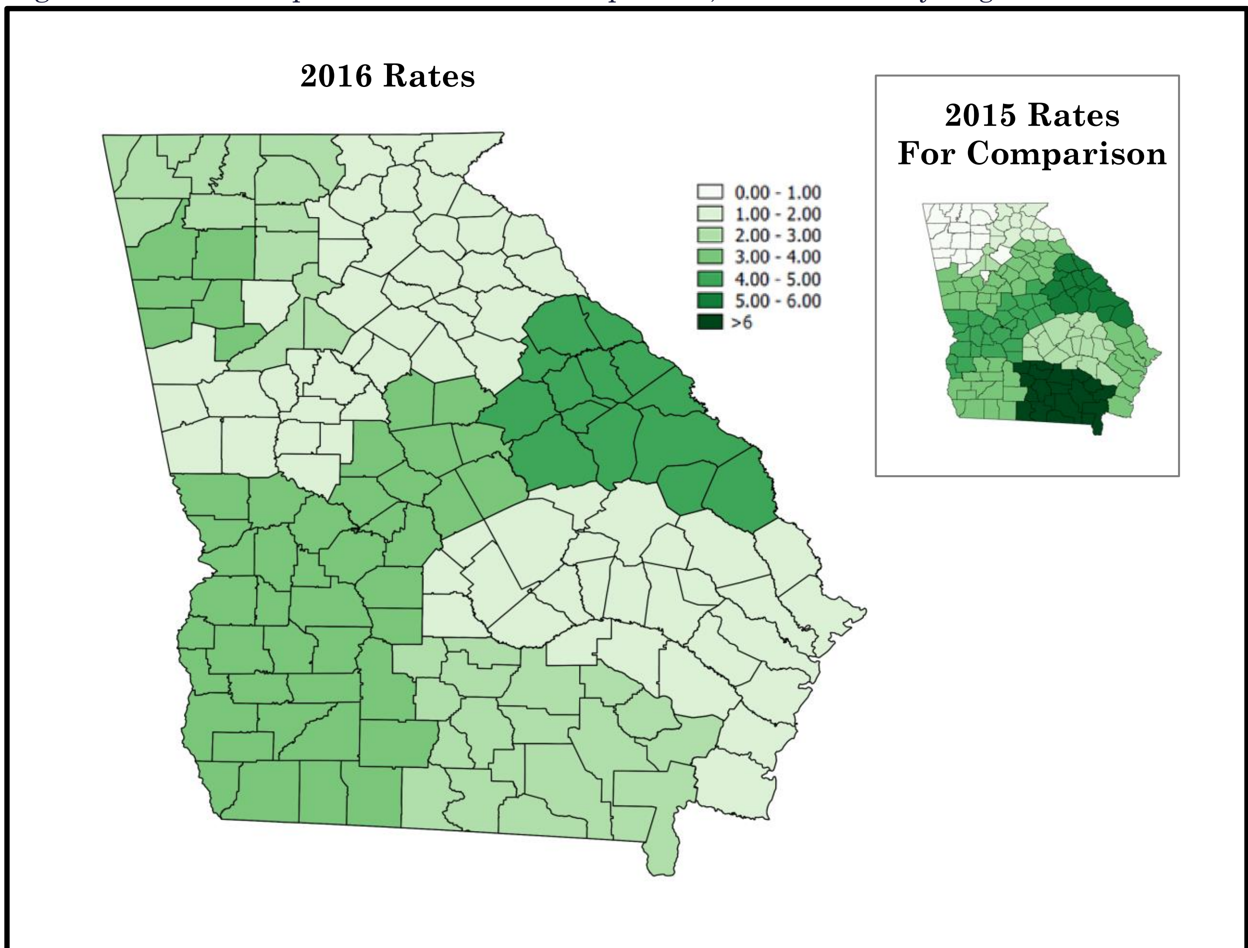


Table 7.2. Fatality Numbers/Percentages for Sleep-Related Deaths for All Division Regions, *N* = 56

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 56)
1	Catoosa, Chattooga, Cherokee, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	4	169,036	2.37	7%
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	3	168,188	1.78	5%
3	Bartow, Douglas, Floyd, Haralson, Paulding, Polk	5	145,481	3.44	9%
4	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson	4	207,261	1.93	7%
5	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale, Walton	2	164,024	1.22	4%

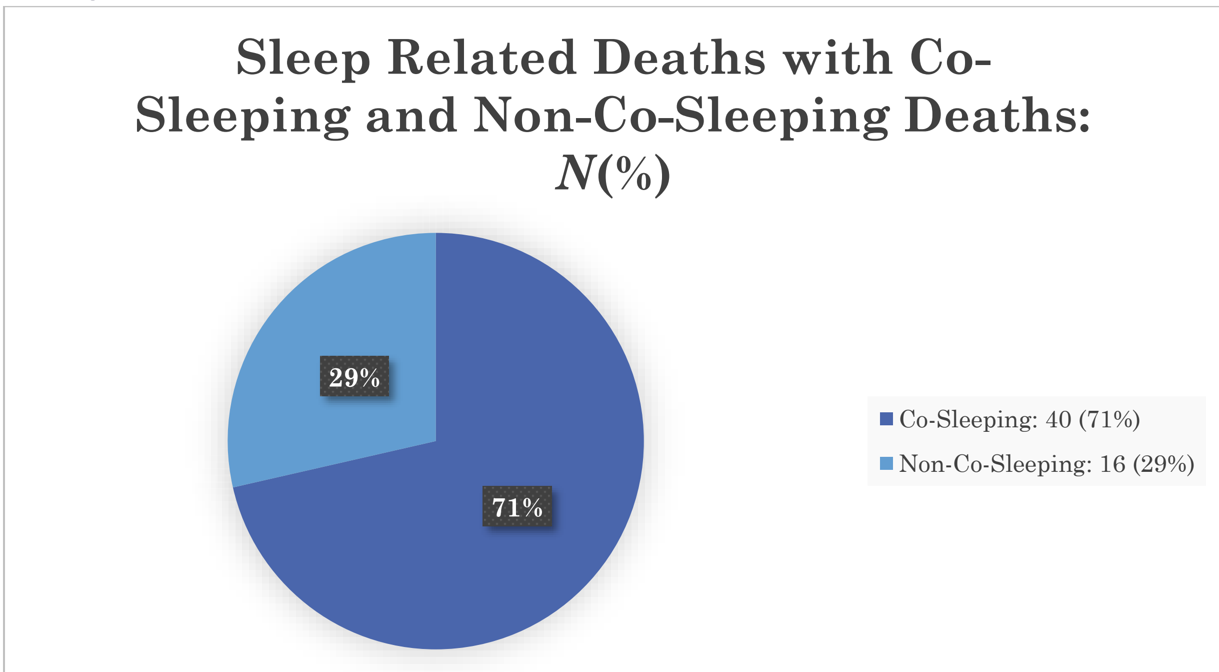
Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 56)
6	Baldwin, Bibb, Crawford, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	4	118,218	3.38	7%
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	5	116,928	4.28	9%
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	3	85,654	3.50	5%

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 56)
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	1	71,741	1.39	2%
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	3	85,676	3.50	5%
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	2	100,152	2.00	4%
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	2	161,854	1.24	4%

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 56)
13	Clayton, Cobb, Gwinnett	6	510,236	1.18	11%
14	DeKalb, Fulton	12	407,095	2.95	21%
Total	**Statewide**	**56**	**2,511,544**	**2.23**	**100%**

At the time of analysis, 56 deaths were sleep-related of which 40 involved co-sleeping. *Co-sleeping is a preventable risk factor.*

Figure 7.3. Breakdown of Sleep-Related Deaths by Co-Sleeping or Non-Co-Sleeping Arrangements, $N = 56$.



Section 9: Glossary

Child Abuse: (A) Any non-accidental physical injury or physical injury which is inconsistent with the explanation given for it suffered by a child as the result of the acts or omissions of a person responsible for the care of a child; (B) Emotional abuse; (C) Sexual abuse or sexual exploitation; (D) Prenatal abuse; or (E) The commission of an act of family violence as defined in Code Section 19-13-1 in the presence of a child. An act includes a single act, multiple acts, or a continuing course of conduct. As used in this subparagraph, the term "presence" means physically present or able to see or hear. (OCGA § 15-11-2).

Closed case: Division involvement with a child or family has been concluded.

Collateral contacts: Individuals that can provide reliable information about the family and are not meant to be "character references."

Family Preservation Services: This term is described by the Family Preservation and Support Services Act of 1993 (PL 103-66) as a continuum of family-focused services for at-risk children and families. Services include activities designed to assist families in crisis, often where a child is at risk of being placed in out-of-home care because of abuse and/or neglect. Support services include preventive activities, typically provided by community-based organizations designed to improve the nurturing of children and to strengthen and enhance the stability of families.

Family Support Services: Intake reports that are assigned to Family Support Services contain an allegation of child abuse or neglect and there is no preliminary indication of a present danger situation or an impending danger safety threat. Family Support Services are designed to ensure child safety and prevent future involvement in the child welfare system through the use of formal and informal services to strengthen and support families and enhance caregiver protective capacity to ensure the protection and care of children. (Georgia Child Welfare Policy Manual, 7.0).

Fictive Kin: A person who is known to a child as a relative, but is not, in fact, related by blood or marriage to such child and with whom such child has resided or had significant contact. (Georgia Child Welfare Policy Manual, 19.20).

Foster Care: The Foster Care program provides temporary out-of-home care for children who cannot legally remain safely in their home. Foster Care services are also provided for eligible Foster Care youth ages 18-21 through the Extended Youth Support Services program unless they opt out of participation.

Investigation: The investigative track is utilized when an intake report is received and safety threats are identified during the intake process. An investigation is a non-voluntary intervention with families. During an investigation, the Division assesses and determines child safety, maltreatment and caregiver protective capacities. (Georgia Child Welfare Policy Manual, 5.0).

Involvement: This includes, but is not limited to, all prior Child Protective Services involvement with the Division, whether reports were screened in or screened out. A thorough

review of DFCS history includes reviewing any current or prior cases involving Family Support Services, Investigations, Foster Care (Permanency) and Resource Development. A thorough review also includes review of information uploaded in external documents within Georgia SHINES, a web-based statewide automated child welfare information system. History is often a predictor of future behavior and the information in DFCS case history plays a significant role when making decisions regarding child welfare.

Maltreatment: A term including abuse and/or neglect.

Neglect: (A) The failure to provide proper parental care or control, subsistence, education as required by law, or other care or control necessary for a child's physical, mental, or emotional health or morals; (B) The failure to provide a child with adequate supervision necessary for such child's well-being; or (C) The abandonment of a child by his or her parent, guardian, or legal custodian. (OCGA § 15-11-2).

Open case: Active Child Protective Services involvement with a child or family.

Post Foster Care: When a child transitions from foster care (DFCS custody) to the custody of their parent(s) or another caregiver, and a case remains open in Georgia SHINES.

Report: Any information regarding identified or suspected maltreatment of a child, received by the Division, via the Child Protective Services, Centralized Intake Communication Center (CICC).

Screen Out: There are no allegations of maltreatment based on an analysis of the information gathered. (Georgia Child Welfare Policy Manual, 3.0).

Substantiated: The allegations of child abuse, as defined by Georgia statute, are supported by a preponderance of the evidence. A preponderance of evidence means that the greater the weight of the evidence makes it more probable than not that child abuse/neglect occurred. (Georgia Child Welfare Policy Manual, 5.3).

Unsubstantiated: There is no evidence of maltreatment or the evidence of maltreatment was not supported by a preponderance of the evidence as defined by Georgia statute and DFCS policy. (Georgia Child Welfare Policy Manual, 5.3).

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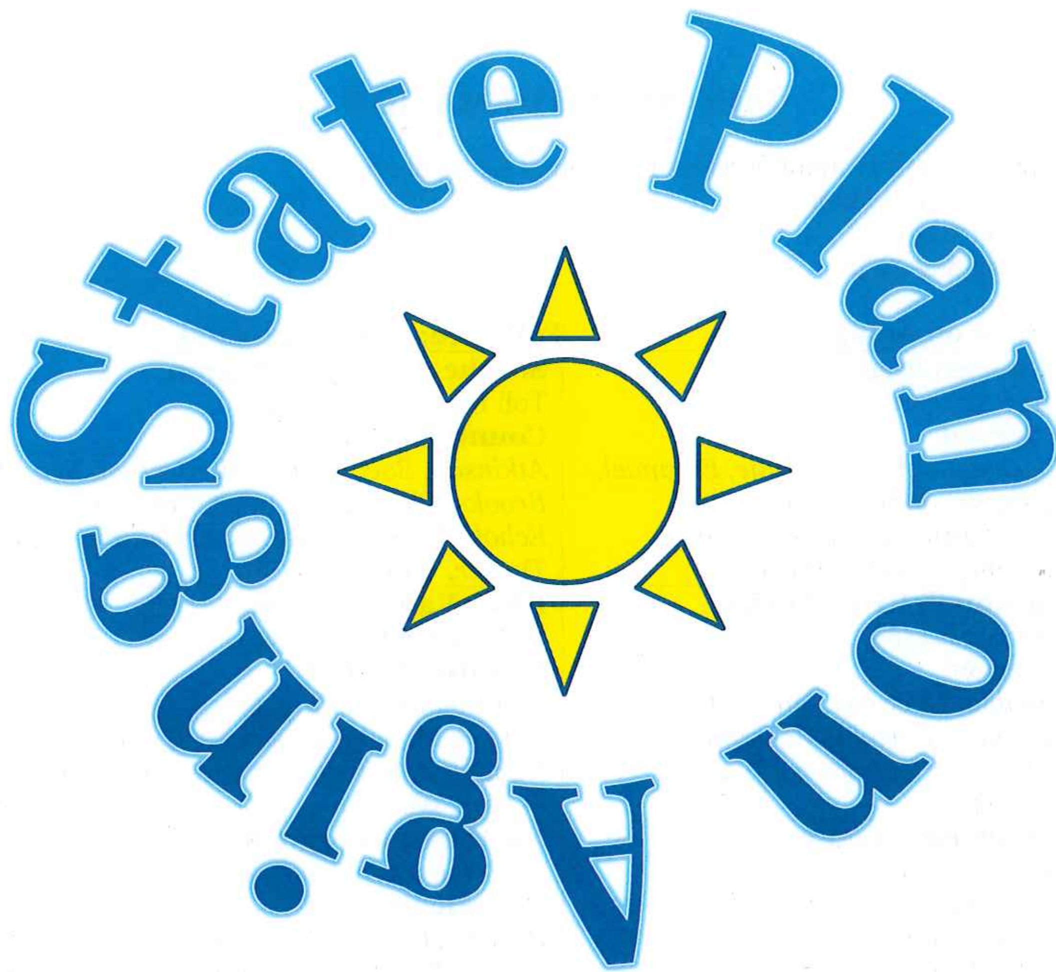

October 1, 2015 through September 30, 2019

Georgia Department of Human Services
Division of Aging Services

Nathan Deal
Governor of Georgia

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MISSION VISION AND VALUES

Mission Statement

The Georgia Department of Human Services (DHS) Division of Aging Services (DAS) supports the larger goals of DHS by assisting older individuals, at-risk adults, persons with disabilities, their families and caregivers to achieve safe, healthy, independent and self-reliant lives.

Vision

Living Longer, Living Safely, Living Well.

Values

A Strong Customer Focus
We are driven by customer – not organizational – need. We consider customer's input and preferences in all decision-making.

Accountability and Results
We are good stewards of the trust and resources placed with us. We base our decisions on data analysis and strive for quality improvement.

Teamwork
We do business through teamwork and collaboration. We practice shared decision-making and everyone's contribution is valued.

Open Communication
Our communication is open and responsive. We listen to our customers and partners and provide them accurate, timely information.

A Proactive Approach
We envision the future needs of our customers and the changing service network. We lead and advocate with innovation.

Dignity and Respect
We respect the rights and self-worth of all people.

Our Workforce
Our workforce, including volunteers, is our best asset. We maintain a learning environment with opportunities to increase professional growth, share knowledge and stimulate creative thinking.

Trust
Compassion and integrity drive what we do and who we are.

Diversity
We value a diverse workforce; it broadens our perspective and enables us to better serve our customers.

Empowerment
We support the right of our customers and workforce to make choices and assume responsibility for their decisions.

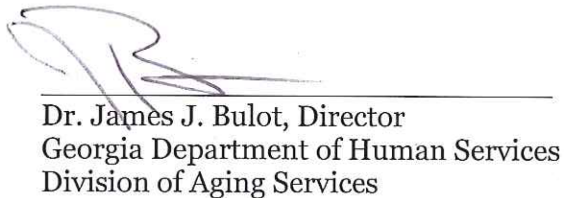
SIGNED VERIFICATION OF INTENT

The State Plan on Aging covers the period of October 1, 2015 through September 30, 2019. It includes all assurances and plans to be conducted by the Georgia Department of Human Services Division of Aging Services under the provisions of the Older Americans Act (OAA) (amended). The state agency named above has been authorized to develop and administer the State Plan on Aging in accordance with all requirements of the OAA, including the development of comprehensive and coordinated systems for the delivery of supportive services, such as multipurpose senior centers and nutrition services. DAS, under the guidance of DHS, serves as the State of Georgia's effective and visible advocate for older individuals, at-risk adults, and persons with disabilities. DAS also serves as an effective and visible advocate for the families and caregivers of those served.

The State Plan on Aging, developed in accordance with all Federal statutory and regulatory requirements and approved by the Governor is hereby submitted.

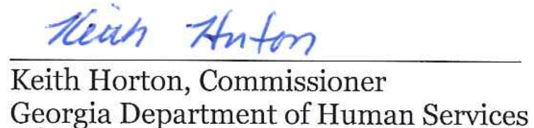
The State Plan's approval by the Governor constitutes authorization to proceed with activities under the State Plan upon approval by the Assistant Secretary on Aging.

5/22/15
(Date)



Dr. James J. Bulot, Director
Georgia Department of Human Services
Division of Aging Services

12 Jun 15
(Date)



Keith Horton, Commissioner
Georgia Department of Human Services

I hereby approve the State Plan on Aging and submit it to the Assistant Secretary for Aging.

22 June 2015
(Date)

Nathan Deal, Governor
State of Georgia

Georgia Department of Human Services
Division of Aging Services
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NARRATIVE

Executive Summary

The Georgia Department of Human Services Division of Aging Services' mission is to support the larger goals of DHS by assisting older individuals, at-risk adults, persons with disabilities, their families and caregivers to achieve safe, healthy, independent and self-reliant lives. In order to accomplish this mission, DAS works collaboratively with others within Georgia's Aging Services Network (Area Agencies on Aging (AAA), providers, older adults and advocates) and with key organizations serving individuals with disabilities. Moreover, DAS is committed to continually improving its person-centered, statewide comprehensive and coordinated system of programs and services. The programs and services are available to all eligible individuals. They provide seamless access to long-term supports and services needed for consumers to remain at home and in the community, safely, for as long as they desire.

The State Plan provides leadership and guidance in rebalancing the long-term care system and development of a comprehensive and coordinated infrastructure for home and community based services. The Plan documents the goals, objectives, and strategies outcomes planned and achieved, translating activities, data, and outcomes into proven best practices, and providing a blueprint that spells out the coordination and advocacy activities the state will undertake to meet the needs of older adults and persons with disabilities.

The Georgia State Plan on Aging reflects the focus areas outlined by the United States Department of Health and Human Services Administration for Community Living (ACL). The focus areas include OAA Core Programs, ACL Discretionary Grants, Participant-Directed/Person-Centered Planning, and Elder Justice. DAS will provide the leadership for accomplishing the goals in collaboration with the aging services network and other state agency partners. Specific objectives and strategies to achieve the goals along with metrics to measure performance in reaching the goals are specifically outlined in the Goals and Objectives section of this plan.

The goals set forth in this State Plan will continue to advance the service delivery system and allow for a higher quality of service and potentially increase the number of available services for Georgia's continually growing older adult population, disability population and their families and caregivers. DAS will continue to deploy innovative methodologies to efficiently and effectively expand capacity, foster collaborations, and drive cost efficiencies to deliver a comprehensive system of programs and services to assist Georgians in living longer, living safely and living well.

Introduction and Context

State Agency on Aging

The Georgia Department of Human Services Division of Aging Services, as the State Agency on Aging provides leadership to administer a statewide system of comprehensive and coordinated array of services for older adults and their families and caregivers. DAS administers federal and state funding to AAA, manages contract requirements with AAA and their governing bodies, and provides the policy framework for programmatic direction and operations, standards, and guidelines for service delivery systems, quality assurance and training. DAS continuously seeks to improve the effectiveness and efficiency of the services provided to older adults, people with disabilities and their families.

As Georgia's State Agency on Aging, DAS assures that preference will be given to the provision of services to older individuals with the greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals, individuals at risk for nursing home placement, older individuals living alone and older individuals living in rural areas. The Aging and Disability Resource Connection (ADRC) provides a "no wrong door" single entry point for adults who are aging and/or have a disability to access long-term care support services. The ADRC provides information, assistance, counseling, and referrals to community resources.

State Agencies on Aging administering funds under Titles III and VII of the OAA of 1965, as amended, are required to develop and submit to the Assistant Secretary on Aging a State plan for approval under Section 307 of the OAA. DAS has adopted a four-year State Plan on Aging for the period extending from October 1, 2015 through September 30, 2019.

The State Plan serves as roadmap to guide Georgia's twelve (12) AAA, designated under Section 305 of the OAA, in developing area plans. The AAAs will formulate their area plans using a uniform format developed by the State Agency in collaboration with the Area Agencies. The goal is to align area plans with this State Plan.

Area Agencies on Aging

In Georgia, DAS has designated twelve (12) Planning and Service Areas (PSAs) . All community-based services for older adults are coordinated through the AAAs. Ten of the Area Agencies are housed within Regional Commissions (RCs), which are the units of general-purpose local government. The remaining two agencies are freestanding, private non-profit organizations, both of which have 501(c) 3 status with the Internal Revenue Service.

The AAAs are responsible for:

- Assuring the availability of an adequate supply of high quality services through contractual arrangements with service providers, and for monitoring their performance;
- Local planning, program development and coordination, advocacy, monitoring;
- Developing the Area Plan on Aging and area plan administration, and resource development;
- Working with local business and community leaders, the private sector and local elected officials to develop a comprehensive coordinated service delivery system;
- Establishing and coordinating the activities of an advisory council, which will provide input on development, and implementation of the area plan; assist in conducting public hearings; review and comment on all community policies, programs and actions

affecting older persons in the area.

The State Plan encompasses a listing of Georgia's AAA. The map on the following page depicts the geographical boundaries of the AAAs within the State of Georgia.

Georgia Council on Aging

In 1977, the Georgia General Assembly created the Georgia Council on Aging (GCOA). The Governor, the Lieutenant Governor, the Speaker of the House and the Commissioner of the Department of Human Services appoint Council members. The Council has twenty members, including ten consumers at least 60 years of age and ten service providers. Members represent all older Georgians and ensure that minorities, low-income, rural, urban, public, and private organizations are included.

The Georgia Council on Aging's primary mission is to:

- Advocate with and on behalf of aging Georgians and their families to improve their quality of life;
- Educate, advise, inform and make recommendations concerning programs for the elderly in Georgia; and
- Serve in an advisory capacity on aging issues to the Governor, General Assembly, DHS and all other state agencies.

The Coalition of Advocates for Georgia's Elderly (CO-AGE) is led by the GCOA. The coalition is meant to be:

- a forum to identify and address concerns of older Georgians;
- a vehicle for bringing broad-based input on aging issues from across the state;
- a diverse group of organizations, individuals, consumers and providers interested in "aging specific" and intergenerational issues; and
- a unifying force communicating the importance of providing supportive communities and adequate services & programs for older Georgians.

Alzheimer's and Related Dementias Advisory Council

During the 2013 session of the Georgia General Assembly, legislators created the Georgia Alzheimer's and Related Dementias State Plan Task Force, a multidisciplinary group convened to improve dementia research, awareness, training, and care. Starting in June of that year, the six task force members and dozens of experts in diverse fields formed committees, conducted research, and made detailed recommendations.

The recommendations formed the core of the Georgia Alzheimer's and Related Dementias State Plan. The document described current demographics, prevalence statistics, and existing resources; analyzed the state's capacity to meet growing needs; and presented a roadmap to create a more dementia-capable Georgia.

In June 2014, Governor Nathan Deal signed the Georgia Alzheimer's and Related Dementias State Plan into action, and the Task Force became an Advisory Council.

Georgia's recommendations cover a range of topics, including research, services, policy, public safety, workforce development, and public education. And undergirding all of these areas is the

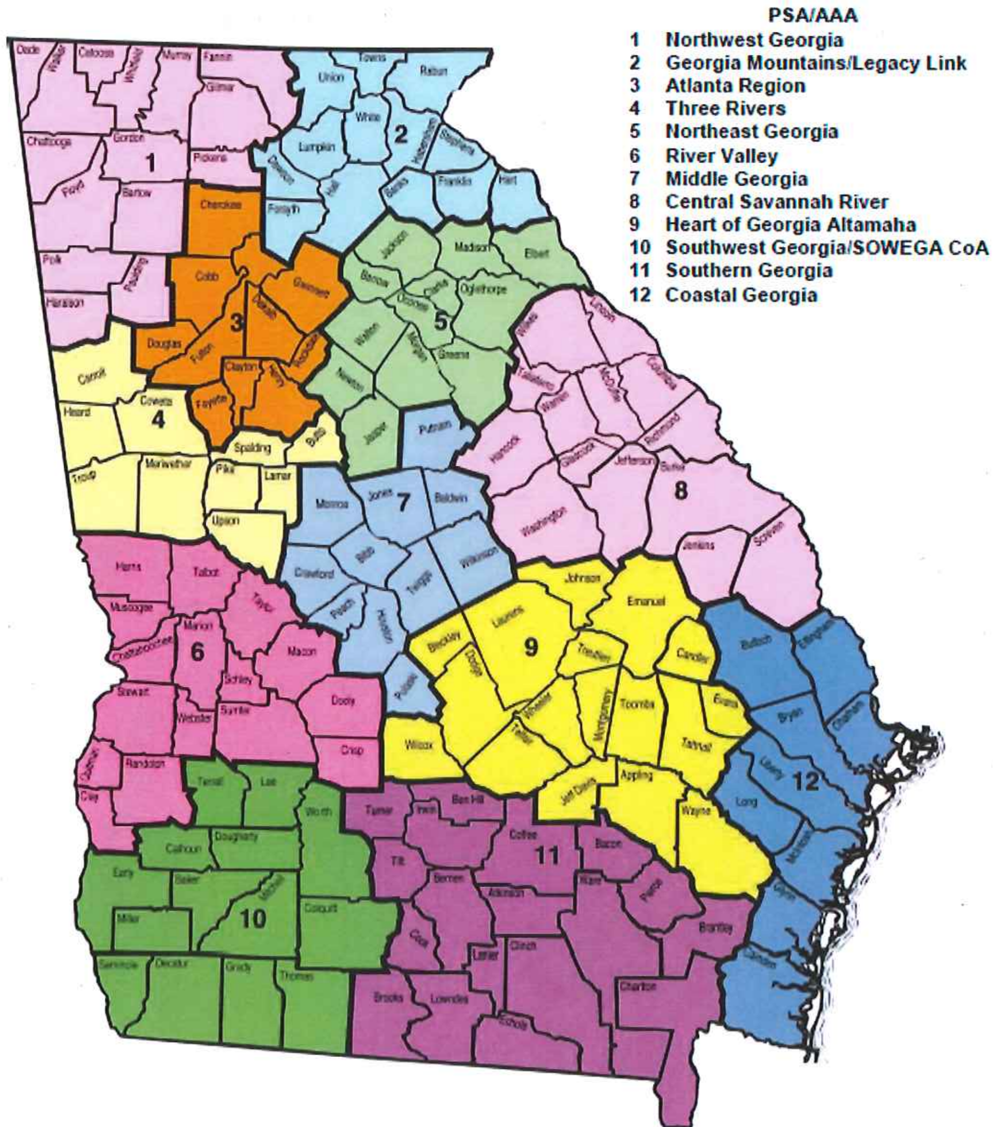
importance of partnerships – creating a deeply coordinated statewide team of agencies, nonprofits, businesses, and organizations.

The Georgia Alzheimer's and Related Dementias Advisory Council serves as a hub for cultivating new initiatives and improving communication about what Georgia is doing to address dementia needs.

The Georgia Alzheimer's and Related Dementias State Plan will undergo regular review to ensure that it reflects emerging priorities, shifts in resources, and evolving public- and private-sector roles. The Advisory Council will work with partner stakeholders, state agencies, and legislators to develop and file appropriate legislation and corresponding appropriations requests throughout the life of the Plan.

Planning and Service Areas Overview

DHS Division of Aging Services
Planning and Service Areas



Needs Assessment

In the fall of 2014, DAS collected public input through five statewide public hearings and an online survey. The primary objectives were to ascertain the perceived value of and barriers to DAS programs and services, obtain consumer suggestions for recommended improvements to the service delivery system and home and community based services, and ideas for new DAS initiatives. During the hearings, consumers praised DAS and the network for the positive differences that our supports and services provide. However, through the questions listed below, some opportunities for improvement were uncovered:

- which services were most needed by consumers to maximize their independence;
- which services were most needed by consumers to stay healthy or improve their health; and
- what could the State STOP, START or CHANGE to improve services.

Public hearing participants identified services most needed to maximize consumers' independence. The top three services, ranked in order of importance statewide were (1) transportation, (2) health care, and (3) housing. It is noteworthy that transportation was identified as the most needed service during the public hearings for the last State Plan development cycle in 2011. A recurring theme among many of the participants was a greater need for caregiver support programs.

In 2014, Public hearing participants also identified services most needed to stay healthy or improve their health. The top three services, ranked in order of importance statewide, were: (1) health care, (2) exercise nutrition, and (3) transportation.

The survey question **"What must we Start, Stop or Change"** was presented as an open-ended query during the public hearings; 333 respondents replied. Refer to Appendix C for a broadly categorized summary of results.

Goals and Objectives (Older Americans Act Core Programs)

State plans must include measurable objectives that address focus areas outlined by the United States Department of Health and Human Services Administration for Community Living. The focus areas include OAA Core Programs, ACL Discretionary Grants, Participant-Directed/Person-Centered Planning, and Elder Justice. A chart outlining goals developed by DAS for each focus area is below. DAS will directly accomplish some goals while the AAAs will accomplish others under DAS' oversight. Checkmarks in the tables below differentiate between AAA specific and DAS specific goals. Specific objectives and strategies to achieve the goals along with metrics to measure performance in reaching the goals are specifically outlined in this section of the plan.

Older Americans Act Core Program Goals

Goal	DAS	AAA	Goal	DAS	AAA
Focus on sustainability		☑	Advocate for person-centered long-term care facility resident access to less restrictive housing options	☑	
Focus on reaching underserved persons		☑	Increase the numbers of individuals served by GeorgiaCares from "targeted populations."		☑
Expand opportunities for transportation in underserved areas		☑	Increase the number of consumers reached that could benefit from assistance offered through the Medicare Improvements for Patients and Providers Act (MIPPA)		☑
Empower older adults to stay active and healthy	☑		Improve quality of services performed by the Community Care Services Program (CCSP)	☑	
Increase veterans enrollment and successful completion in Senior Community Services Employment Program (SCSEP)	☑		Ensure consumers receive services in their homes and communities	☑	
Increase enrollment of older adults with minimum English language proficiency in SCSEP	☑		Strengthen the Elderly Legal Assistance Program	☑	
Increase SCSEP participant placement in entrepreneurial ventures	☑		Exceed the expectations of our clients	☑	
Expand efforts to support individuals to remain in their desired residence as long as possible		☑	Improve the capacity of Georgia's aging and behavioral health networks to address the needs of older adults with behavioral health conditions by increasing knowledge, awareness, and referrals	☑	

ACL Discretionary Grants Goals

Goal	DAS	AAA	Goal	DAS	AAA
Support older adults and people with disabilities to transition from an institutional setting to a setting of their choosing using a person centered approach through the Money Follows the Person grant and other means	☑		Empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse	☑	

Participant Directed Person Centered Planning Goals

Goal	DAS	AAA	Goal	DAS	AAA
Utilize a person centered approach to service delivery designed to support older adults and individuals with disabilities living in the community	☑		Ensure maximum access and efficient delivery of Home and Community Based Services (HCBS) to older adults, persons with disabilities, and caregivers		☑
Develop and implement a person-centered approach to service mix		☑	Increase participation in and sustainability of evidence-based health and wellness programs		☑
Maximize the variety of approaches to support consumer control and choice		☑	Empower residents of facilities to fully participate in directing their care		☑
Increase the professional capacity of Georgia's Aging network to better meet the needs of family caregivers and at-risk adults		☑	Empower older people and people with disabilities, along with their support systems, to make informed decisions about community vs. institutional living based on their preferences, values, and strengths	☑	
Support grandparents and other relative caregivers to maximize family independence		☑			

Elder Justice Goals

Goal	DAS	AAA	Goal	DAS	AAA
Empower persons under guardianship through greater autonomy, independence, and self-determination	☑		Increase professional capacity to address abuse, neglect and exploitation of older adults and adults with disabilities	☑	
Decrease unnecessary removal of rights	☑		Increase collaboration among stakeholders to address abuse of older adults and adults with disabilities	☑	
Provide persons under guardianship with strong guardian-advocates	☑		Ensure the protection and rights of older and disabled individuals who are victims of abuse, neglect and exploitation	☑	
Protect residents of long-term care facilities from abuse, neglect and exploitation	☑		Increase understanding of "suspicious deaths" in older adults amongst medical examiners, coroners, medicolegal death investigators, and criminal justice professionals	☑	

Goal 1: Focus on sustainability to ensure programs and services remain available for those in need

Objective 1: Develop an aging network that is sustainable in all economic climates	
Strategies:	Expand fee-for-service program model (example: Evidence Based Programs, Case Management, Community Living Program, Senior Centers) by 2019
	Implement evidence-based hospital transition programs in all AAAs by 2019
	All AAAs have business plan with a regular review process by 2019
Performance Metrics:	100% of AAAs will receive business plan training by 2019
	100% of AAAs will implement business plans by 2019

	Develop a minimum of 3 new funds sources to support service provision by 2019
	Number of statewide hospital transition programs in operation will increase by 25% by 2019.
	Monitor dollar amount increase and percentage increase in funds (fee for service)

Goal 2: Create a statewide focus on reaching underserved persons

Objective 2.1: Develop an aging network that reaches underserved persons across the state	
Strategies:	Identify and prioritize potential underserved populations to be reached
	Develop partnerships that facilitate outreach for underserved populations such as veterans, those with limited English proficiency and those with other cultural barriers
	Develop service plan to address prioritized populations
	Focus network activity to address the needs of underserved populations (nutrition, social, etc.)
	Develop and implement training for community partners to aid in outreach and service provision to underserved populations
Performance Metrics:	Increase percentage of underserved individuals served by 10% after setting baseline in 2016
	Increase number of partner cooperatives by 10% after setting baseline in 2016
	Increase number of underserved populations for which service plans are developed
	Increase number of trainings
Objectives 2.2: Promote greater access to waiver services in underserved/rural parts of the state	
Strategies:	Develop effective ways to address potentially-eligible consumers' concerns related to cost-share and estate recovery
	Provide training for ADRC and case management staff to deliver consistent messages about cost share and estate recovery
	Partner with the DCH to explore opportunities for provider growth and/or partnerships in under-served/rural areas
	Develop a best-practice training geared towards providers serving under-served/rural parts of the state
Performance Metrics:	SFY 16: Identify the number and % of providers who visit the CCSP GIS Maps resource link after its launch in SFY 15
	SFY 17: Provide 2 best practice trainings geared towards the unique challenges and opportunities faced by providers delivering CCSP services in underserved/rural parts of the state
	SFY 18 to SFY19: Provide 1 refresher training session on cost-share and estate recovery for the ADRC

Goal 3: Expand the opportunities for transportation in underserved areas of Georgia

Objective 3: Increase community based transportation opportunities	
Strategies:	Develop county-based transportation cooperatives that work on local transportation options for older adults and persons living with disabilities
	Develop volunteer transportation programs in each AAA
	Build partnerships with transportation organizations (for-profit and nonprofit) to further develop transportation options for vulnerable populations
	Establish baseline data for number of cooperatives, number of volunteer programs and number of corporate partnerships by 2016.
Performance Metrics:	Measure number of cooperatives developed in each year of the plan after the 2016 baseline and increase number of cooperatives developed by 10% each year
	Measure number of volunteer programs developed after the 2016 baseline Increase number of volunteer programs by 10% each year.
	Measure number of corporate partnerships developed after the 2016 baseline. Increase number of corporate partnerships by 10% each year.

Goal 4: Empower older adults to stay active and healthy

Objective 4.1: Increase food security and access to healthy food options	
Strategies:	Increase the number served through congregate sites and home-delivered meals by increased efficiencies in all fund sources
	Connect older adults to local food systems (farmer's markets and community gardens)
	Strengthen partnerships with SNAP and senior centers
	Increase knowledge through nutrition education
	Develop a partner group to support and implement a State Senior Hunger Summit with the goal of illuminating the hunger issues in Georgia, where the need is greatest and potential strategies for stakeholders across the state. This would be a great opportunity to have the attendees complete a survey to aid in the next steps
Performance Metrics:	Increase food security for food insecure HDM clients and increase access to healthy foods for congregate clients
	Participation in Congregate and HDM programs will increase by 5% by 2019
	Increase number of community gardens with senior focus after 2016 baseline is established
	All senior centers will have a minimum of one SNAP sign-up day per quarter by 2019

	Form a partner group (CCSP, DPH, DFCS, G4A, Dollar General, Farmers Market Association, Grocers Association, The Food Policy Network, Food Bank Association, Wholesome Wave, Etc.). The partner group would be convened to plan and hold the summit and following the event; compile the survey results, develop at GA position statement, then begin work on a statewide plan with initial attention to identifying the policy barriers and identifying policy and planning strategies to fee a variety of food systems needs across the state.
	Convene State Senior Hunger Forum by 2019
Objective 4.2: Increase quality of life for community dwelling senior participants by providing opportunities for socialization, community involvement, health and wellness, civic engagement, and recreational activities	
Strategies:	Adapt a tool to capture QOL info
	Pilot the tool and establish baseline data
	Explore use of technology to increase socialization
	Explore the idea of an intergenerational wellness center system
Performance Metrics:	SFY16: Revise, Train and Implement the new survey on QOL
	SFY17-18: Use new survey with all senior center participants
	SFY 19-Evaluate effectiveness of tool
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to National Core Indicators – Aging and Disabilities (NCI –AD) consumer survey results question 48: "Are you able to do things you enjoy outside of your home when and with whom you want to?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results for question 50: "Do you have transportation when you want to do things outside of your home, like visit a friend, go for entertainment, or do something for fun?"
Objective 4.3: Senior Centers will become an integrated focal point in the community for healthy, active aging and access to services to help older adults remain in the community of their choosing	
Strategies:	Each senior center will adopt and implement a wellness goal
	Increase community partnerships that support senior centers
	Increase community events that occur at senior centers
	Increase outreach to the community about senior center activities
	Explore center as an economic hub holding education and application sessions around support programs (SNAP, GA Cares, SSI Application, Etc. Monthly for each)
	Number of activities involving multi-demographic populations
Performance Metrics:	Number of community partners, community events increased by 25% over 2016 baseline by 2019
	Increased participation due to expanded outreach to 20% over 2016 baseline by 2019

	Number of senior center participants that receive education sessions about economic support programs such as SNAP, Energy Assistance and other community resources that can assist with maintenance of community residence increased by 20% over 2016 baseline by 2019
	75% of senior centers will achieve their wellness goals by 2019
Objective 4.4: Implement a person-centered approach to dining options	
Strategies:	Evaluate the extent of choice of dining options
	Conduct training with all AAAs about menu options, vouchers, etc.
	Expand the role of site councils to improve dining choices
	Work with center management/wellness coordinators/RDs to work on a biannual plate-waste study
	Develop and implement outreach and culturally appropriate meal options for underserved populations
Performance Metrics:	100% of menus will provide meal options by 2019
	Increase number of community partners by 20% over 2016 baseline by 2019 (for centers using vouchers)
	Increase number of dining options (culturally competent meals, vegan and vegetarian options, etc.) by 25% over 2016 baseline by 2019
	Increase number of underserved individuals who have received outreach and or economic support education through the senior centers by 10% over 2016 baseline by 2019

Goal 5: Increase veteran enrollment and successful completion of SCSEP program (leading to unsubsidized employment)

Objective 5: Develop collaborative relationship with public and private agencies serving veterans' employment needs	
Strategies:	Engage veteran centers and develop collaborative relationships for SCSEP service
	Develop relationship with GA Department of Labor, office of veterans employment
Performance Metrics:	SFY 16 – Conduct training for all sub-grantees to raise awareness about veterans' employment barriers
	SFY 17 – SFY 18 - Ensure that no less than 20% of statewide SCSEP enrollees are veterans
	SFY 18 – SFY 19 – Maintain at least 85% of veterans enrolled in SCSEP training

Goal 6: Increase enrollment of older adults with minimum English language proficiency (i.e., refugees, recent immigrants, etc.)

Objective 6: Intentionally focus on minorities by establishing collaborative relationships with agencies serving minority communities in Georgia	
Strategies:	Reprint SCSEP information literature in multiple languages
	Employ local media to reach to hard-to-reach communities
	Establish relationships with civic organizations serving minorities statewide
	Develop training curriculum for SCSEP Coordinators about recruiting host agencies and potential employers that support this population

Performance Metrics:	SFY '16 - Ensure that no less than 2% of statewide SCSEP enrollees are from hard-to-reach communities
	SFY 17 – 18 – Ensure that no less than 4% of statewide SCSEP enrollees are from hard-to-reach communities
	SFY 18 – 19 – Ensure that no less than 6% of statewide SCSEP enrollees are from hard-to-reach communities

Goal 7: Increase participants' placement in entrepreneurial ventures in order to enhance participants' opportunities for entrepreneurship

Objectives 7: Enhance participants' knowledge of opportunities for self-employment and foster opportunities for participants to engage in startup businesses	
Strategies:	Target and recruit more host agencies that offer entrepreneurial opportunities to participants
	Engage state agencies that promote entrepreneurship in Georgia
	Solicit startup funding for participants
Performance Metrics:	SFY 16 - Conduct at least one workshop for all enrollees in each sub-grantee program
	SFY 17 – SFY 18 – Develop 3 new partnerships with potential funders for startup opportunities by 2019
	SFY 18 – SFY 19 – Provide opportunities for at least 5 participants to launch a business

Goal 8: Expand efforts to support individuals to remain in their desired residence as long as possible

Objectives 8: Expand and increase statewide access to home modification/home repair services	
Strategies:	Develop co-op with local organizations (Boy Scouts; home improvement stores; high schools; tech programs; and faith-based communities)
	Increase home modification/home repair services access statewide
Performance Metrics:	Home modification/home repair services are available in all 12 AAAs by 2019
	Increase number of consumers receiving home modification/home repair services by 40% by 2019 (Note: for SFY 2014, 2 AAAs provided this service to 143 people; this would take it to 200 statewide)
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results for question 2: "In general, do you like where you are living right now?"

Goal 9: Advocate for person-centered long-term care facility resident access to less restrictive housing options

Objectives 9: Provide advocacy for residents of long-term care facilities, particularly nursing home residents, to access less restrictive housing options	
Strategies:	MDS-Q information received monthly from Options Counselors will be distributed to local representatives of the SLTCO to follow up and assist nursing home residents who have expressed interest in learning more about less restrictive housing options

	When representatives of the SLTCO make presentations to resident councils at nursing homes, assisted living communities and personal care homes, the representative will include information about how to access less restrictive housing options through referral to facility Social Worker, or referral directly to Aging and Disability Resource Connection
	Representatives of the SLTCO will include information about how to access less restrictive housing options when providing consultations to facility staff, community education outreach activities and at other trainings
Performance Metrics:	SFY 16: Determine a baseline of information and assistance to residents and families, facility consultations, community education outreach events and training events for representatives of SLTCO related to how to access information about less restrictive housing options
	SFY 17 - 19: The Office of the SLTCO will increase by 5% per year the number of activities including information and assistance, consultations, community education outreach and training for representatives of the SLTCO, related to how to access less restrictive housing options

Goal 10: Increase the numbers of individuals served by GeorgiaCares from "targeted populations"

Objectives 10: Increase the number of client contacts	
Strategies:	Market the DAS toll-free number to increase calls routed to the local GeorgiaCares programs. Provide various methods of contact; one-on-one, mail, telephone, email, GeorgiaCares website (www.mygeorgiacares.org) for clients seeking Medicare assistance
	Expand reach to limited English proficient populations by recruiting bilingual volunteers and use the Language Line services to assist clients
	Maintain off-site counseling stations in every county to provide services locally to clients
Performance Metrics:	Increase the number of client contacts by 3% each year
	Maintain 2-day standard of promptness for returning client calls (GeorgiaCares Standards and Guidelines)

Goal 11: Increase the number of consumers reached that could benefit from assistance offered through the Medicare Improvements for Patients and Providers Act (MIPPA)

Objective 11: Extend outreach and assistance efforts for Medicare beneficiaries, including disease prevention and wellness promotion	
Strategies:	Develop collaboration between GeorgiaCares, ADRC and Health and Wellness staff to conduct outreach and educate Medicare beneficiaries
	Establish and foster community partnerships with organizations and agencies serving Medicare beneficiaries

	Increase marketing efforts for the GeorgiaCares program to improve brand awareness
	Continue partnership with Fort Valley State University mobile information technology center to reach individuals in rural counties
Performance Metrics:	Increase the number and percent increase of enrollments for MSP and LIS applications each year by 3% within the state during SFY 16-20
	Establish 1 offsite counseling station in each county within the state during SFY 16-20
	Establish one new partnership in each county within the state during SFY 16-20

Goal 12: Improve quality of services performed by CCSP providers

Objective 12: Increase the professional capacity of CCSP Providers and Care Coordination agencies	
Strategies:	Partner with AAAs and professional membership organizations to provide annual continuing education programs by service type for current providers
	Partner with DCH to ensure providers' compliance with the Centers for Medicare and Medicaid Services (CMS) Final Rule on Home and Community-Based Services (HCBS)
	Develop and implement a Mentoring Pilot Project for new providers
	Develop a Tool Kit of Best Practices and Resources to assist the AAA with quarterly network meetings. Provide training to Care Coordination agencies and CCSP Providers on best practices regarding adult learning, facilitation skills, etc. to enhance their training of direct service workers
Performance Metrics:	SFY 16: Launch 1 CCSP training for providers by service type (to be conducted on an annual basis)
	SFY 17: Launch the Mentoring Pilot Project to match 2 current providers with 2 new providers by service types
	SFY 17: Provide 2 additional trainings for providers by service type
	SFY 18: Provide 1 additional training for providers by service type
	SFY 18: Recruit and add 2 current and 2 new providers into the Mentoring Program
	SFY 19: Provide 1 additional training for providers by service type

Goal 13: Ensure consumers receive services in their own homes and communities

Objective 13: Increase greater access to 1915 (c) Medicaid waiver and non-Medicaid services across the state	
Strategies:	Expand service types and options to be available to consumers (i.e. assistive technology, home modifications, kinship care/paid family caregivers, consumer-directed option, fee-for-service care coordination)
	Incorporate person-centered planning and consumer choice into the delivery services

Performance Metrics:	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 10: "How did you first find out about the services available to you?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 12: "Do you have a case manager or care coordinator– someone whose job it is to help set up and coordinate services with you?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 16: "Can you choose or change what kind of services you get and determine how often and when you get them?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 17: "Can you choose or change who provides your services if you want to?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 21: "Do you always get enough assistance for self-care when you need it?"

Goal 14: Strengthen the Elderly Legal Assistance Program (ELAP)

Objective 14: Target the substantive core legal priority areas that Older Georgians will have access to, for an adequate supply of quality publicly funded legal services to address their eligibility for and receipt of benefits, housing, health insurance, health care, advance planning and protection from consumer fraud and abuse	
Strategies:	Develop a plan for outreach to potential clients
	Develop an educational/publicity plan or protocol to disseminate to targeted groups
	Host public forums or education sessions to provide group info
	Designate point person to receive calls or act as issue specialist
	Conduct targeted satisfaction survey on this issue to determine the impact on the lives of the clients served to determine if the performance measure set was achieved
Performance Metric:	The number of cases successfully handled as listed in the objective will increase by 3% over the 2015 baseline during the next fiscal year

Goal 15: Exceed the expectations of our clients

Objective 15: Strengthen continuous quality improvement system across programs and services	
Strategies:	Develop a dashboard system of transparent progress disclosure
	Develop online training modules for programs and processes
	Develop CQI training materials for community partners
	Enhance division process evaluation and improvement
	Evaluate and update quality measures (MAPS, Contract Management, Process Management, ODIS Updates, etc.)

Performance Metrics:	Implementation of dashboard system
	Number of online trainings developed and implemented
	Number of trainings viewed electronically

Goal 16: Improve the capacity of Georgia's aging and behavioral health networks to address the needs of older adults with behavioral health conditions by increasing knowledge, awareness, and referrals

Objective 16.1: Increase demonstrated knowledge of aging and behavioral health issues to address the needs of older adults with behavioral health conditions by increasing knowledge, awareness and referrals.	
Strategies:	Develop annual assessment tool in collaboration with Coalition partners
	Develop training module/materials for appropriate staff (revise each year to align with identified issues)
	Administer required training with pre/post assessment to statewide audience annually via WebEx (live & recorded)
	Training will include data collection related to behavioral health calls and information provided.
	Analyze data in quarterly ADRC reports adjusting training/guidance as needed
	Utilize ADRC behavioral health assessment test-annual
Performance Metric:	Percent change in pre/post-assessment results
Objective 16.2: Increase referrals from ADRC to behavioral health providers by 5% per year, establishing baseline in year 1.	
Strategies:	Coalition will review ADRC database for behavioral resources resources annually for additions/deletions
	ADRC Resource Specialists will receive training on behavioral health resources, identification/vetting of local resources
	All ADRC staff will receive annual training on behavioral health needs/resources
	ADRC marketing materials will include provision of behavioral health information/resources
	ADRC outreach by local programs will include behavioral health information
Performance Metric:	Increase in numbers of behavioral health referrals with additional training provided as needed

Goals and Objectives (ACL Discretionary Grants)

Goal 1: Support older adults and people with disabilities to transition from an institutional setting to a setting of their choosing using a person centered approach through the Money Follows the Person grant and other means

Objective 1: Maintain Nursing Home Transitions over the Plan duration	
Strategies:	Enhance partnerships with Centers for Independent Living for cross support in transition activities
	Identify additional community resources (outside of MFP Grant & Medicaid waivers) to support transition activities
	Increase non-MDSQ referrals through integration of DAS programs & other referral sources

	Find programmatic efficiencies within DAS/AAA frameworks to reduce administrative cost per transition
	Increase the use of transition services
	Increase public awareness of nursing home transitions Ensure quality of data collection and entry
Performance Metrics:	Number of Transitions
	Number of MFP Completions

Goal 2: Empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse

Objective 2: Increase the number of volunteers, beneficiaries educated, and media events statewide.	
Strategies:	Develop partnerships at the AAA level to advertise volunteer opportunities, host offsite counseling stations, and provide educational presentations.
	Provide SMP Foundations, Group Education, and Counselor training for volunteers at each AAA. The role of the volunteer will determine the type of training.
	Utilize various media outlets to expand the mission of the Senior Medicare Patrol statewide. Media outlets include billboards, newspapers, TV and radio PSAs, and social media.
	Provide targeted training and education to isolated and hard-to-reach populations.
	Partner with Forensic Science Investigative Unit for dissemination of SMP materials to Adult Crime Tactics Training participants as well as email subscribers and other conferences, trainings, etc.
	Partner with LTCO to train volunteers about Medicare fraud, waste, and abuse.
Performance Metrics:	Number of volunteers per AAA
	Number of group education events conducted each year
	Number of internal DAS partners
	Number of community partners

Goals and Objectives (Participant – Directed/Person Centered Planning)

Goal 1: Utilize a person-centered approach to service delivery designed to support older adults and individuals with disabilities living in the community

Objective 1: Develop and implement consumer driven mechanisms of support to support community based long term living	
Strategies:	Implement the community living program in all 12 AAAs
	Continue development of and technical support for Village Models
	Develop and implement Senior Center without Walls models in 4 AAAs
Performance Metrics:	Enroll 240 clients in CLP by 2019.

	Establish 5 villages that are capable of being self-sustaining by 2019.
	Establish 4 centers without walls by 2019
	Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results for question 16: "Can you choose or change what kind of services you get and determine how often and when you get them?"
	Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results for question 17: "Can you choose or change who provides your services if you want to?"

Goal 2: Develop and Implement a person-centered approach to service mix

Objective 2: Develop and implement a new non-programmatic regional wait list for HCBS services based	
Strategies:	Analyze and assess current wait lists and how they are used
	Develop new method to merge specific service wait lists into one centralized needs-based wait list
	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for a CLP or support options model to meet the individual's needs
	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individuals greatest need
Performance Metrics:	SFY 16: Conduct analysis of all AAA wait lists
	SFY 17: Develop method to merge wait list
	SFY18-19: Merge and maintain wait lists

Goal 3: Maximize the variety of approaches to support consumer control and choice

Objective 3: Develop and implement the purchase and use of assistive technology as an option in place of service.	
Strategies:	Develop a tool to match individuals to assistive technology
	Implement an assistive technology program
	Establish a baseline of number of HCBS consumers referred for AT
	Establish a baseline of number of HCBS consumers currently using AT
Performance Metrics:	SFY 16: Develop assistive technology matching tool using assessments currently used (DON-R)
	All AAAs have AT program implemented and functioning by 2019
	Increase number of consumers referred for AT by 25% by 2019
	Increase number of consumers using AT by 25% by 2019

Goal 4: Increase professional capacity of Georgia's aging network to better meet the needs of family caregivers and at-risk adults

Objectives 4: Form collaborative teams and partnerships, conduct workshops, and utilize technology to increase professional capacity	
Strategies:	Establish a Work Team composed of DAS, Alzheimer's Association, and Georgia Alzheimer's and Related Dementias Advisory Council (GARD) Service Delivery members to develop a protocol for referral to a physician for probable dementia
	Conduct annual workshops to share best practices for recruiting, certifying, and retaining Powerful Tools for Caregivers class leaders and Master Trainers
	Facilitate conference calls and webinars between Health and Wellness coordinators and caregiver specialists to increase cross referrals between programs.
	Co-sponsor an annual financial exploitation summit with other organizations
	Participate in DAS-sponsored Financial Exploitation Work Team
	Incorporate Alzheimer's Association dementia capable training across the network
	Develop process for conducting ongoing cost-benefit analyses of caregiver services offered (cost-per-service vs. number of caregivers served vs. outcomes)
Performance Metrics:	**Protocol for Probable Dementia** SFY 16: Convene Work Team. Determine parameters of the protocol, including but not limited to self-referrals, confidentiality. Make recommendations to DAS
	SFY 17: DAS finalizes protocol, and modifies appropriate policies and standards; disseminates information to ADRC and case management staff
	Powerful Tools for Caregivers SFY 16: Identify baseline of class leaders and Master Trainers for each AAA
	SFY 17: Conduct workshops on best practices to AAA network
	SFY 18: Provide site visits and mentors to AAAs identified as needing technical assistance
	SFY 19: Compare baseline data to current numbers of class leaders and Master Trainers for each AAA to ensure goal of 20% more class leaders, and 24 more Master Trainers, is met
	Caregiver Programs Establish a baseline of caregiver intention to place during 2016. During FY17,18 and 19 decrease intention to place by 10%
	Statewide Referral Website SFY 16: Identify which AAAs are using the livewellagewell.info website. Contact those AAAs not using the website to provide technical assistance
	SFY 17: Monitor website quarterly to ensure that 100% of AAAs are adding classes for family caregivers and class leader trainings

Goal 5: Support Grandparents and other Relative Caregivers to maximize family independence

Objectives 5: I Increase access to and use of formal resources and prevention of disruption of family care systems	
Strategies:	Meet at least twice per year with state's Kinship Care Coordinators
	Meet at least twice per year with Grandparents Raising Grand Children Work Team
	Pursue designation of September as "Kinship Care Month" in Georgia
	Develop mechanism to document families providing kinship care vs. foster care system
Performance Metrics:	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019
	Increase number of caregivers and children served by Kinship Care services by 10% by 2019
	Increase number of referrals on behalf of kinship families by 10% by 2019

Goal 6: Ensure maximum access and efficient delivery of Home and Community Based Services to older adults, persons with disabilities, and caregivers

Objectives 6: Provide the right service(s) to the right person at the right time for the right duration	
Strategies:	Develop and approve Risk Assessment Tool
	Develop operational definitions for OAA target criteria
	Train all network staff involved in access to services on Risk Assessment Tool and operational definitions for OAA target criteria
	Enhance conflict-free assessment and utilization review process
	Determine baseline average per capita cost for HCBS services compared to monthly cost of nursing home
	Determine baseline of persons who have decline in Level of Risk or number of Risk domains based on Utilization Review
	Identify baseline % of current consumers receiving OAA services that meet target criteria
Performance Metrics:	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019
	Number of persons served who have decline in Level of Risk or Number of Risk domains based on UR will increase by 25% by 2019
	100% of persons referred for HCBS from wait list will meet target criteria by 2019
	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year
	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.

Goal 7: Increase participation in and the sustainability of evidence-based health and wellness programs offered across the state

Objectives 7: Increase participation in and the sustainability of evidence-based health and wellness programs offered across the state	
Strategies:	Communicate available evidence-based programs to ADRC staff on a regular basis
	Continue to maintain a statewide referral website to list all available evidence-based services (workshops, trainings, etc.)
	Present available evidence-based programs to health care professionals via association meetings, conference calls, conferences, etc.
	Incorporate evidence-based health and wellness programs in annual Healthy Communities Summit pre-intensive sessions
	Provide continuous technical assistance to AAAs engaged in evidence-based program implementation
	Develop and implement DAS-wide falls prevention protocols (assessments, referrals, etc.)
	Provide guidance for establishing fee-for-service mechanisms for organizations offering evidence-based programs
	Convene workgroup to develop/select appropriate falls assessment and develop statewide protocol for falls discovery, documentation and referral
	Partner with local, state and national organizations to increase referrals and promote continuous quality improvement for evidence-based programs in Georgia
	Maintain established health care professional partnerships and expand on them regionally; provide regular communication opportunities (teleconference and face-to-face – group and one-on-one) to provide assistance to AAAs
Performance Metrics:	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019
	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019
	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs
	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019
	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019
	Increase statewide marketing of evidence-based health and wellness programs

Goal8: Empower residents of facilities to fully participate in directing their care

Objectives 8.1: Develop and implement a plan to increase resident and family self-advocacy	
Strategies:	Determine what resources for self-advocacy are currently available
	Determine any gaps
	Develop resources to fill the gaps
	Analyze resident councils and family councils in each LTCO region
	Increase the number of resident councils and family councils
	Increase local LTCO representative participation in resident and family councils
Performance Metrics:	SFY 16:Convene workgroup to determine resources and gaps
	SFY 17:Create materials to be distributed and a plan for deployment,
	SFY 18: Require an increase of 10% participation in resident and family councils specifically to deploy the plan for resident and family self-advocacy
	SFY 19: Evaluate success of plan
Objectives 8.2: Increase awareness of community options including MFP	
Strategies:	Provide local LTCO representatives with materials to distribute to residents and families, including brochures and other materials about the ADRC, MFP and HCBS
	Provide regular outreach to nursing home staff about community options and MFP
	Include in local LTCO representatives' training conferences information about how to use the materials to provide information to residents about other options
Performance Metrics:	SFY 16,17, 18 and 19: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information

Goal 9: Goal: Empower older people and people with disabilities, along with their support systems to make informed decisions about community vs. institutional living based on their preferences, values, and strengths

Objectives 9.1: Expand awareness of and access to the ADRC - the No Wrong Door, Single Entry Point for all long-term supports and services	
Strategies:	Establish marketing strategies to serve individuals who pay privately
	Provide collaboration events for community partners (hospitals, home-health agencies, faith-based communities and institutions, and medical offices) to reach individuals who may be at medical or financial risk for institutional placement
	Market the ADRC toll-free number in Spanish
	Promote utilization of COMPASS system by ADRC staff to initiate Medicaid applications when necessary
	Expand strategies to build collaboration with aging and disability partners, including the Centers for Independent Living
Performance Metrics:	Number of incoming ADRC contacts, including increasing number of incoming ADRC contact for caregiver and kinship care

	Increase types of referral sources
	Number of individuals diverted from institutional placement
	Number of Medicaid applications generated by ADRC staff
	Number of private-pay individuals served
	Number of aging and disability cross-referrals
	Number of individuals with disabilities served
Objectives 9.2: Increase community options counseling to individuals who are most at risk for institutional placement	
Strategies:	Promote and provide options counseling certification to all AAAs for ADRC staff
	Expand Access Point staff that are certified in options counseling
	Provide training and quality assurance on correct documentation and data entry for options counseling. Train hospital and nursing home discharge planners on accessing community services
	Ensure that all ADRC staff are trained in using Risk Assessment to identify targeted group
Performance Metrics:	Number of individuals who receive community options counseling increases by 25% from 2016 baseline
	Each of the 12 AAAs have identified and have expanded Access Point staff and at least one is certified in Community Options Counseling
	Each of the 12 AAAs have at least three Community Options Counselors

Goals and Objectives (Elder Justice)

Goal 1: Empower persons under guardianship of the department through greater autonomy, independence, and self-determination

Objective 1.1: Promote increased autonomy and independence for persons under guardianship of the department	
Strategy:	Provide at least one training per year to Public Guardianship Office (PGO) staff on how to help a person under guardianship plan for termination of the guardianship and how to refer a case for restoration of rights or modification
Performance Metric:	Increased number of persons under guardianship to whom assistance with petitioning for restoration of rights or modification for a more limited guardianship is offered
Objective 1.2.: Boost self-determination in decisions made on behalf of persons under guardianship	
Strategy:	Enhance PGO staff's practice of determining the preference or wishes of a person under guardianship and incorporating that input into surrogate decision-making by providing PGO staff at least one training annually on surrogate decision-making, including the substituted judgment model, and strategies on seeking input from the person under guardianship

Performance Metrics:	An increase of at least 50% of staff trained in seeking, documenting, and using the input of the person under guardianship in surrogate decision-making
	More references in case management notes to the person under guardianship's preferences and wishes

Goal 2: Decrease unnecessary removal of rights

Objective 2: Promote the use of lesser restrictive alternatives to guardianship of the department	
Strategy:	Increase awareness in stakeholder community on alternatives to guardianship by partnering with allies in the court system, the medical community, and the mental health provider community to train stakeholders in each of the three larger communities about the use of less restrictive alternatives to guardianship
	Increase the number of multi-disciplinary/multi-agency groups in which PGO staff participates, to coach and advocate for avoiding guardianship through less restrictive alternatives
	Refer cases that are more appropriate for less restrictive alternatives back to court
Performance Metrics:	Established partnerships with ally-stakeholders
	Decreased number of appointments for persons under guardianship for whom no alternatives have been attempted
	Increased number of persons under guardianship whose cases are referred back to the court for restoration of rights or modification for a more limited guardianship

Goal 3: Provide persons under guardianship with strong guardian-advocates

Objective 3.1: Implement a program that develops the professional competencies of PGO staff	
Strategies:	Develop a monthly in-service training taught by professionals of disciplines relevant to guardianship case management so that PGO staff is educated in substantive issues
	Since staff are spread throughout the state, develop a virtual space for PGO staff to staff cases, discuss resources, and vet ideas or strategies
Performance Metrics:	Increased number of benefit appeals
	Increased attendance of and participation in care plan meetings
	Sharing of successful strategies in the staff's virtual meeting space
	Consistent participation in monthly in-service trainings

Goal 4: Protect residents of long-term care facilities from abuse, neglect and exploitation

Objectives 4: Local LTCO representatives will be active partners with Georgia Bureau of Investigation, Healthcare Facility Regulation (HFR), APS and other agencies in developing and implementing activities to address A/N/E for residents of facilities	
Strategies:	Develop materials for local LTCO representatives to share with resident and family councils and staff in-service specifically related to A/N/E
	Develop materials to use for community educations related to A/N/E
Performance Metrics:	SFY 16: Increase by 10% the participation of local LTCO representatives in relocations activated by HFR

	SFY 17: Increase by 10% the number of resident council and staff in-service presentations related to prevention and intervention in A/N/E
	SFY 18: Increase by 25% the number of local LTCO representatives who have completed ACT training
	SFY 19: Increase by 10% the number of local LTCO representative A/N/E presentations to the community

Goal 5: Increase professional capacity to address abuse, neglect and exploitation of older adults and adults with disabilities

Objective 5.1: Increase the number of At-Risk Adult Crime Tactics (ACT) Certified Specialists by 20% by 2019	
Strategies:	Conduct at least 10 ACT classes per year
	Develop a pilot train-the-trainer model to increase the number of ACT trainers without decreasing quality
	Pursue partnerships to market ACT training and provide larger training venues
	Train all APS staff within 1 year of their employment
Performance Metrics:	SFY 16: Identify partners to improve marketing of ACT and increase additional outreach opportunities. Develop train-the-trainer pilot
	SFY 17: Implement and evaluate the train-the-trainer ACT pilot. Develop and maintain partnerships
	SFY 18-19: Depending on pilot results, develop plan to roll out statewide train-the-trainer program. Continue activities from SFY 16. Develop and maintain partnerships
	SFY 16-19: Maintain at least a 90% positive response rate to 6-month survey of ACT specialists measuring application of knowledge. Maintain at least a 20% increase in knowledge of ACT Specialists through pre-test and post-test questions
Objective 5.2:Certify at least 1 law enforcement officer in every county in Georgia by 2019	
Strategies:	Conduct at least 10 ACT classes per year
	Develop a pilot train-the-trainer model to increase the number of ACT trainers without decreasing quality
	Schedule ACT classes in areas with a higher need for training
	Develop and deploy targeted training for prosecutors
Performance Metrics:	SFY 16: Determine the number of counties with no law enforcement officers trained. Develop outreach plan to schedule future ACT classes. Develop train-the-trainer pilot
	SFY 17: Implement and evaluate the train-the-trainer ACT pilot
	SFY 18-19: Depending on pilot results, develop plan to roll out statewide train-the-trainer program. Continue activities from SFY 16. Develop and maintain partnerships
	SFY 16-19: Maintain at least a 90% positive response rate to 6-month survey of ACT specialists measuring application of knowledge. Maintain at least a 20% increase in knowledge of ACT Specialists through pre-test and post-test questions

Objective 5.3: Increase the number of professionals trained through outreach events other than ACT by 20% by 2019	
Strategies:	Partner with all programs within DAS to provide training to program staff on recognizing and reporting abuse
	Provide technical assistance and templates for the AAA to provide training at the local level
	Provide a quarterly webinar on recognizing and reporting abuse available to all professionals
	Actively pursue training opportunities through statewide conferences reaching professionals
	Pursue partnerships with professional organizations to market and provide training opportunities for their members
Performance Metrics:	SFY 16: Develop schedule of webinar training and resources for AAAs. Develop outreach plan for training all program staff
	SFY 17: Deploy outreach plan developed on SFY 17. Develop partnerships with professional organizations
	SFY 18: Provide training resulting from SFY 17 partnership development
	SFY 19: Continue activities from SFY 16-18
	SFY 16-19: Actively pursue training opportunities through statewide conferences

Goal 6: Increase collaboration among stakeholders to address abuse of older adults and adults with disabilities

Objective 6.1: Participate in multi-disciplinary teams addressing abuse of older adults and adults with disabilities	
Strategies:	Continue involvement in the Georgia Bureau of Investigation's At-Risk Adult Working Group (local, state and federal partners) identifying gaps in response to at-risk adult abuse and developing strategies to fill gaps
	Continue involvement in the U.S. Attorney's Office Skilled Nursing Facility Task Force to develop strategies to address abuse in facilities
	Facilitate a Financial Exploitation Working Group to identify barriers to addressing financial exploitation and developing strategies to overcome barriers
	Provide technical assistance to other states through the National Adult Protective Services Association on partnership development
	Provide technical assistance to the Elder Rights Teams provided through the AAA to ensure coordinated efforts between local and state initiatives
	Provide technical assistance to local criminal justice agencies in developing local task forces
Performance Metric:	SFY 16-19: Continue involvement in multi-disciplinary groups and document activities and process changes
Objective 6.2: Develop a process for collecting data on law enforcement cases of abuse against older adults and adults with disabilities	
Strategies:	Engage law enforcement partners to determine most effective way of tracking data
	If a mandating is an option, identify steps needed to make change

	If a mandated option is not available, work with state law enforcement to develop a voluntary option
	Work with law enforcement partners to educate local law enforcement on using the option identified
Performance Metrics:	SFY 16: Meet with law enforcement partners to determine most effective way of tracking data. Provide recommendations for implementation
	SFY 17: Based on findings from SFY 16, implement recommendations
	SFY 18-19: Work with law enforcement partners to educate local law enforcement on the option provided

Goal 7: Ensure the protection and rights of older and disabled individuals who are victims of abuse, neglect and exploitation

Objective 7.1: Determine effectiveness of Georgia Abuse, Neglect and Exploitation (GANE) app in identifying at risk individuals and use of protective interventions	
Strategies:	Collect and analyze data on usage of Temporary Emergency Respite Funds (TERF); law enforcement interactions with APS Central Intake back door and referrals to Alzheimer's via GANE
	Identify and implement strategies to improve the effectiveness and efficiency of the app
	Make enhancements to the app and/or processes connecting users to the protective interventions
	Survey individuals to determine effectiveness of process to access TERF through app
	SFY 16: Analyze referral data resulting from access through GANE to the Alzheimer's Association
Performance Metrics:	Increase TERF interactions by 5% by 2019
	Increase ANE reporting by law enforcement by 5% by 2019
	Increase referrals to Alzheimer's Association by 5%
Objective 7.2: Increase number of APS clients moved to community based services by 5% by 2019	
Strategies:	Establish baseline number of APS clients who moved into HCBS, CCSP, Service Options Using Resources in a Community Environment (SOURCE), Independent Care Waiver Program (ICWP), and non-Medicaid services SFY13-15
	Identify services needed by APS clients (investigation/ongoing)
	Coordinate with ADRC to screen and identify options for APS clients in the aging network
	Track number of clients admitted to service and on the waitlist
	Monitor clients' status to determine if services are provided
	Report total clients referred by APS to HCBS and received services
	Continue process and evaluate at end of SFY19 to determine number increase (from baseline)
	Analyze and evaluate data to determine possible root causes for

	APS clients not moving to HCBS and convene workgroup to develop strategies to improve access to HCBS/CCSP for APS clients
	Deploy improvement strategies and monitor APS client statuses
	Review the performance of the provider awarded the contract for TERF on an annual basis
Performance Metrics:	Establish baseline number of APS clients who moved into HCBS or CCSP SFY13-15
	Determine % increase (from baseline) APS clients receiving and/or on waitlist for HCBS/CCSP services
Objective: 7.3 Reduce the incidence of elder abuse, neglect and exploitation across HCBS Programs	
Strategies:	Continue to educate providers about elder abuse, neglect and exploitation
	Develop a system to ensure adequate monitoring of all service types
	Provide information to all HCBS consumers on how to self-report ANE
	Utilize data obtained from critical incident reports and the complaint log to develop training to address these findings
	Continue to build partnerships within the Department of Community Health and other State agencies in order to increase provider compliance with policy and improve training
Performance Metrics:	SFY 16: Conduct on-site provider monitoring of Personal Support Services providers by visiting every 5th PSS service provider
	SFY 16: Partner with Forensic Unit to provide 2 trainings on abuse, neglect and exploitation
	SFY 17: Increase the % of on-site provider monitoring by 25% over SFY 15 % of on-site provider monitoring conducted in SFY 15
	SFY 17-19: Increase the % of Personal Support Services (PSS) providers who receive on-site monitoring by 25% over SFY 15 % of on-site provider monitoring conducted in SFY 15

Goal 8: Increase understanding of "suspicious deaths" in older adults amongst medical examiners, coroners, medicolegal death investigators, and criminal justice professionals

Objective 8: Develop a process for identifying "suspicious" deaths in adults 65 and older	
Strategies:	Facilitate a half-day summit with medical examiners and coroners to identify how they view deaths of adults 65 and older
	Develop checklist for death investigators to use on-scene
	Develop a basic ANE training course for Medical Examiners/Coroners/Medicolegal Death Investigators
	Develop checklist for death investigators to use on-scene

Performance Metrics:	SYF 16: Meet with MEs/Coroners/Medicolegal Death Investigators to identify how they view deaths of adults 65 and older and provide recommendations
	SYF 17: Based on findings from SY16, implement recommendations of meetings and provide initial results of FCMEO research project
	SYF 18-19: Work with forensic specialist and death investigator on Elder Death Investigation Text

Quality Management

DAS uses the Baldrige Criteria for Performance Excellence to systematically improve quality throughout the organization. An annual self-assessment and quarterly reviews of performance metrics allow DAS to ensure that key outcomes for both customers and the Aging Network are achieved and sustained. The Baldrige Criteria encompassan overview of the organization's leadership, strategy, customers, measurement analysis and knowledge management, workforce, operations, and results. In 2009 DAS was the recipient of the Georgia Oglethorpe Progress Award, which promotes improvement and performance optimization. The Georgia Oglethorpe Award is the state version of the Malcolm Baldrige Award for Performance Excellence.

The Division uses comparative data to examine organizational performance and improvement opportunities. DAS' quality assurance activities include quarterly review of performance measures of operational and service effectiveness and efficiency, quarterly and annual compliance reviews of contractors, annual customer, and workforce satisfaction surveys. DAS conducts quarterly customer satisfaction surveys. The Regional Coordinators at DAS complete these surveys to help to ensure the information in the surveys are appropriately separated from the agency providing the services. Each local program manager uses the survey results to improve customer service.

DAS has procured Harmony for Aging, the most widely used solution in the United States for home and community-based Medicaid Waiver management and federal NAPIS and National Ombudsman Reporting System compliance. Today more than 35 state-level agencies utilize Harmony. Harmony for Aging will help DAS automate processes so that it can provide the best service for consumers.

Attachments

Attachment A – State Plan Assurances and Required Activities

Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES
Sec. 305(a) - (c),
ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service 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.

(a)(2)(B) The State agency shall 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.

(a)(2)(E) The State agency shall 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;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall 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 and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies 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.

States must assure 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(a), AREA PLANS

(2) Each area agency on aging shall 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 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 who are victims of 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.

(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 subclause (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

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas 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 (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall 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--
(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; and

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

(9) Each area agency on aging shall provide assurances that 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 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall 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.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will 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.

(13)(C) Each area agency on aging shall provide assurances that the area agency will 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 non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will 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 non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, 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) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out 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; and
(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.

Sec. 307, STATE PLANS

(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.

(7)(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.

(9) The plan shall provide assurances that 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 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance 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)(A) The plan shall provide 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 (A) 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.

(11)(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;

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

(11)(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;

(11)(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, 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--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) 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
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(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 childcare, youth daycare, 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 funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) 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.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(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 (as numbered in statute)

(1) The State plan shall provide 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) The State plan shall provide 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) The State plan shall provide 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) The State plan shall provide 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) The State plan shall provide 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) The State plan shall provide 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.

REQUIRED ACTIVITIES
Sec. 307(a) STATE PLANS

(1)(A)The State Agency requires 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) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, 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) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(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). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:
(A) affords an opportunity for a public 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) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a 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 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.

(8)(A) No supportive services, nutrition services, or in-home services are 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.

Dr. James J. Bulot, Director
Georgia Department of Human Services
Division of Aging Services

5/22/15
Date

Attachment B – Information Requirements

Section 305(a)(2)(E)

Describe the mechanism(s) for assuring 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;

Response: DAS utilizes its Intrastate Funding Formula (IFF) to ensure preference in providing services to older individuals with greatest economic need and older individuals with greatest social need. In the IFF, emphasis is placed on low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. See DAS' IFF in Attachment 'D.'

Section 306(a)(17)

Describe the mechanism for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Response: Within the Area Plan standard assurances, each AAA must state how it will coordinate its emergency preparedness activities. All AAAs have an individual assigned with primary responsibility for emergency management planning and require that person to develop a long-range emergency preparedness plan. They are also typically required to work with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery. See DAS' Emergency Planning and Management policy in Attachment "G."

Section 307(a)(2)

(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 or service.*

Response: Title III B includes Maintenance of Effort and/or Minimum Percentages for LTCO, Legal, In-Home and Access. DAS has allocated $6,412,852.00 in SFY 2016 (June 30, 2015 through July 1, 2016) to carry out Title III B. Eighty-five percent of which are federal funds, five percent are state funds and the remaining fifteen percent come through a minimum required match. The minimum proportion of the funds received by each area agency on aging carry out part B is 5%. There is no minimum percentage mandate to area agencies for individual services within Title III B.

Section (307(a)(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 distribution of funds); *(Note: the "statement and demonstration" are the numerical statement of the intrastate funding formula, and a demonstration of the allocation of funds to each planning and service area)*

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

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

Response: For each fiscal year of this State Plan, DAS will not expend less than the amount expended for services for older individuals residing in rural areas than expended in 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).

Response: During the beginning of each state fiscal year, DAS issues a budget allocation. At this time, DAS does not project allocations. However, with each allocation, older individuals residing in rural parts of each service area receive funding. A key attribute of DAS' IFF is the allocation of funds for individuals 60 and older residing in rural areas. There is fifteen percent weighted variable for individuals who are 60 and older residing in rural areas.

(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: DAS utilizes several tools to help determine the location of the older individuals residing in rural areas in Georgia. Some include mapping, census data and analysis through DAS' data management system. AAAs then target these individuals and utilize a person centered approach to service delivery designed to support older adults and individuals with disabilities to live longer, safely and well.

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: DAS' IFF provides a greater weighted variable (15%) for individuals who are age 60 and older and reside in rural areas, in addition to a lesser 10% weighted variable for individuals who are 60 and older. Sixty and older rural for the previous fiscal year numbered 457,199, while population ages 60 and older (non-rural) was 1,528,041. Georgians ages 60 and older both in rural and non-rural areas are having their needs met by providing them access to community resources and/or assisting them in identifying and securing resources or services in order to enhance wellness and remain in the community for as long and as safely as possible.

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: DAS' IFF breaks this into two separate variables, with differing weights. Total statewide 65+ low income minority population considered for the preceding fiscal year was 50,148, and the variable has the assigned weight of 10%. Older individuals with limited English proficiency numbered 34,079, and the variable has a weight of 4%. In an effort to meet the needs of low-income minority older individuals, and individuals with limited English proficiency, DAS and the Area Agencies shall provide them access to community resources and/or assist them in identifying and securing resources or services in order to enhance wellness and remain in the community for as long and as safely as possible.

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 *(title III),* if applicable, and specify the ways in which the State agency intends to implement the activities .

Response: Two-tenths of one percent of Georgian's aging population are reported as American Indian or Alaska Native, numbering an estimated 2,093 individuals. DAS will purse numerous activities to assure older Georgians who are American Indian or Alaska Native will have access to Title III funded services. DAS will provide them access to community resources and/or assist them in identifying and securing resources or services in order to enhance wellness and remain in the community for as long and as safely as possible. Additionally, they will also have the opportunity to review the DAS State Plan and other documents made available for public comment.

Section 307(a)(29)
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: See DAS' Emergency Planning and Management in Attachment "G."

Section 307(a)(30)
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: DAS' Division Director is responsible for reviewing and approving all Emergency Preparedness policy and procedures. He or his designee are also responsible for implementing said policies and procedures.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note:*

Paragraphs (1) of through (6) of this section are listed below)

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;

Response: DAS, in carrying out any chapter of this subtitle ((Section 705(a)(7)) for which it receives funding under this subtitle, will establish programs in accordance with the requirements of the 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;

Response: DAS 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 ((Section 705(a)(7));

(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;

Response: DAS, in consultation with AAA, 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;

Response: DAS will not supplant, any funds that are expended under any Federal or State law

(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);

Response: DAS 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;

Response: With respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3, DAS will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:

- public education to identify and prevent elder abuse;
- receipt of reports of elder abuse;
- 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
- 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

Response: DAS will not permit involuntary or coerced participation in adult protective services activities by alleged victims, abusers, or their households.

(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.

Response: All information gathered in the course of receiving reports of abuse, neglect and exploitation, and making referrals shall remain confidential except:
- if all parties to such complaint consent in writing to the release of such information;
- 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
- upon court order.

Attachment C – Public Hearing Data

Public hearing participants identified services most needed to maximize consumers' independence. The top three services, ranked in order of importance statewide, are: (1) transportation, (2) health care, and (3) housing.

Services Most Needed By Consumers to Maximize Their Independence

537 Survey Respondents Maximize Independence	Respondents	% of responses	% of all respondents
Transportation	369	18.2%	68.7%
Health Care	314	15.5%	58.4%
Housing	270	13.3%	50.2%
Financial Assistance	222	11%	41.3%
Exercise/Nutrition	221	11%	41.1%
Support for Caregivers	202	9.9%	37.6%
Prescription Assistance	165	8.2%	30.7%
Legal	104	5.15%	19.4%
Abuse Prevention	66	3.2%	12.7%
Employment	55	2.7%	10.2%
Volunteer Opportunities	33	1.6%	6.1%
	2021		

Public hearing participants identified services most needed to stay healthy or improve their health. The top three services, ranked in order of importance statewide, are: (1) health care, (2) exercise nutrition, and (3) transportation.

Services Most Needed by Consumers to Stay Healthy or Improve Health

537 Survey Respondents			
Stay Healthy	**Respondents**	**% of Responses**	**% of all respondents**
Health Care	354	18.6%	66%
Exercise/Nutrition	319	16.7%	59.4%
Transportation	295	15.5%	54.9%
Prescription Assistance	219	11.5%	41%
Housing	181	9.5%	33.7%
Financial Assistance	160	8.4%	30%
Support for Caregivers	156	8.2%	29%
Abuse Prevention	75	3.9%	14%
Legal	62	3.3%	11.5%
Employment	42	2.2%	7.8%
Volunteer Opportunities	41	2.2%	7.6%
Total Respondents	1904		

Services Most Needed By Consumers to Maximize Their Independence by Age Group

Age Group (Years)	Primary Need Identified	Percent by Age Group	Secondary Need Identified	Percent by Age Group
18-59	Transportation	19.46%	Health Care	16.08%
60-64	Transportation	19.17%	Housing	15.81%
65-84	Transportation	17.76%	Health Care and Exercise/Nutrition	14.41%
85 and over	Transportation	17.04%	Health Care	14.28%
No Response	Support for Caregiver	15.31%	Exercise/Nutrition	13.48%

Services Most Needed by Consumers to Stay Healthy or Improve Health by Age Group

Age Group (Years)	Primary Need Identified	Percent by Age Group	Secondary Need Identified	Percent by Age Group
18-59	Health Care	21.98%	Exercise/Nutrition	19.87%
60-64	Health Care	20.49%	Exercise/Nutrition and Transportation	16.80%
65-84	Health Care	18.26%	Transportation	15.65%
85 and over	Exercise/Nutrition	20.05%	Health Care	18.91%
No Response	Exercise/Nutrition and Transportation	19.44	Health Care	17.59%

The survey question **What must we Start, Stop or Change** was presented as an open-ended query, where 333 respondents replied. Broadly categorized, the results are as follows:

Broad Category Response	Number of Responses	Representative Statement
Funding	61	To maximize independence, Ga needs to provide more funding for adult daycare and daycare for Alzheimer's and dementia
Maintain or Increase Services	60	Improving all services will help individuals remain independent. Stop screening by income alone. We all enjoy good programs and entertainment.
Transportation	50	We need to have a better transportation schedule for people going to the center and the doctor.
Affordable Health Care and Medicaid/Medicare needs	25	Older adults need more affordable health care, help with more prescriptions, and more affordable and dependable transportation for appointments. Persons with disabilities need affordable housing.
Caregiver Supports	9	Georgia must start offering more supportive services that help keep seniors at home.
Home and vehicle modifications	6	Georgia needs to help fix problems with seniors'

		homes, such as home repair and roofing. Seniors cannot physically repair their homes, let alone the financial aspect of it all. Provide more accessible vehicles for seniors.
Improve DFCS Systems	12	Georgia needs to improve its DFCS system so that elders can easily apply for and continue the public benefits to which they are entitled. Elders often need legal assistance to access their benefits.

Attachment D – Intrastate Funding Formula

The Older Americans Act requires the SUA, in consultation with AAA, to develop a formula for allocation of funds within the State that takes into account the geographic distribution of older individuals within the State and the distribution among PSAs of low-income minority older individuals with the greatest economic and social need.

The Intrastate Funding Formula (IFF) is used by State Units on Aging to distribute funds to AAA for Titles III and VII of the Older Americans Act. The Older Americans Act, as amended, requires in Title III Section 305(a)(2)(C), 42 U.S.C. that the SUA:

> "States shall,
> (C) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account--
> (i) the geographical distribution of older individuals in the State; and
> (ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals."

DAS revises the Intrastate Funding Formula decennially (every ten years) based upon demographics and population changes from the most current Census data. The last revision to the DAS IFF was on 2014. Yearly, estimates released by the Census Bureau for factors in the DAS formula are applied to subsequent allocations to account for any funding impact to AAAs related to population changes.

DAS utilizes the following factors to distribute OAA funds by Planning and Service Area (PSA). The current formula provides a specific weight for each of the following populations: persons age 60 years of age and older, persons age 75 years of age or older, low-income minority population age 65 and older, low-income 65 and older population, estimated rural population 60 years of age and older, limited English speaking population 65 years of age and older, disabled adults 65 years of age and older, and living alone 65 years of age and older.

Definitions for each population are indicated below:

60+ population
The number of persons in the age group 60 and above.

75+ population
Number of persons in the age group 75 and above.

Low-income minority 65+ population
The numbers of persons in the age group 65 and above who are minorities (non-white) and are below the poverty level, as established by the Office of Management and Budget in Directive 14 as the standard to be used by federal agencies for statistical purposes. This factor represents "special attention to low income minority older individuals" as required by the OAA.

Low-income 65+ population
Numbers of persons in the age group 65 and above who are at or below the poverty level as established by the Office of Management and Budget in Directive 14 as the standard to be used by federal agencies for statistical purposes. This factor represents economic need as defined by the OAA.

Estimated rural 60+ population
An estimate of the numbers of persons in the age group 60 and above who reside in a rural area as defined by the Census Bureau. This factor represents the social need factor of "geographic isolation" as defined by the OAA.

Limited English speaking 65+ population
Numbers of persons in the age group 65 and above who speak a language other than English and speak English "not well" or "not at all." This factor represents the social-need factor of language barriers as defined by the OAA.

Disabled 65+ population
Numbers of persons in the age group 65 and above who have a "mobility or self-care limitation" as defined by the Census Bureau. This factor represents the social need-factor of "physical and mental disability" as defined by the OAA.

Living Alone 65+
Number of persons in the age group 65 and above who live alone

Factors and Weights:

Population 60+	**10%**
Population 75+	**30%**
Low Income Minority 65+	**10%**
Low Income 65+	**13%**
Rural 60+	**15%**
Disabled 65+	**10%**
Limited English Speaking 65+	**4%**
Living Alone 65+	**8%**

The above factors have been incorporated into a mathematical formula for administration as reflected below. In addition to these factors and weights, the Division of Aging Services incorporates a 6 percent funding base for parts B, C1, C2, and E of Title III of the OAA, not to exceed $200,000 annually.

Intrastate Funding Formula

Y=((.10(X)(%60))+((.30(X)(%75))+((.10(X)(%LIM))+((.13(X)(%LI))+ ((.15(X)(%RUR))+((.10(X)(%DIS))+((.04(X)(%LES))+((.08(X)(%LA))

Factors:

Y	The service allocation for a Planning and Service Area (PSA)
(X)	The total services allocation amount for the state.
%60	The PSA percentage of the State total population ages 60 and above.

%75	The PSA percentage of the State total population ages 75 and above
%LIM	The PSA percentage of the State total population ages 65 and above who are low income and are minorities
% LI	The PSA percentage of the State total population age 65 and above who are low income
% RUR	The PSA percentage of the State total population age 60 and above who live in rural areas
%DIS	The PSA percentage of the State total population who are age 65 and above and are disabled
%LES	The PSA percentage of the State total population age 65 and above and have limited English speaking ability
%LA	The PSA percentage of the State total population who are 65 and above and living alone

Attachment E – Demographic Data

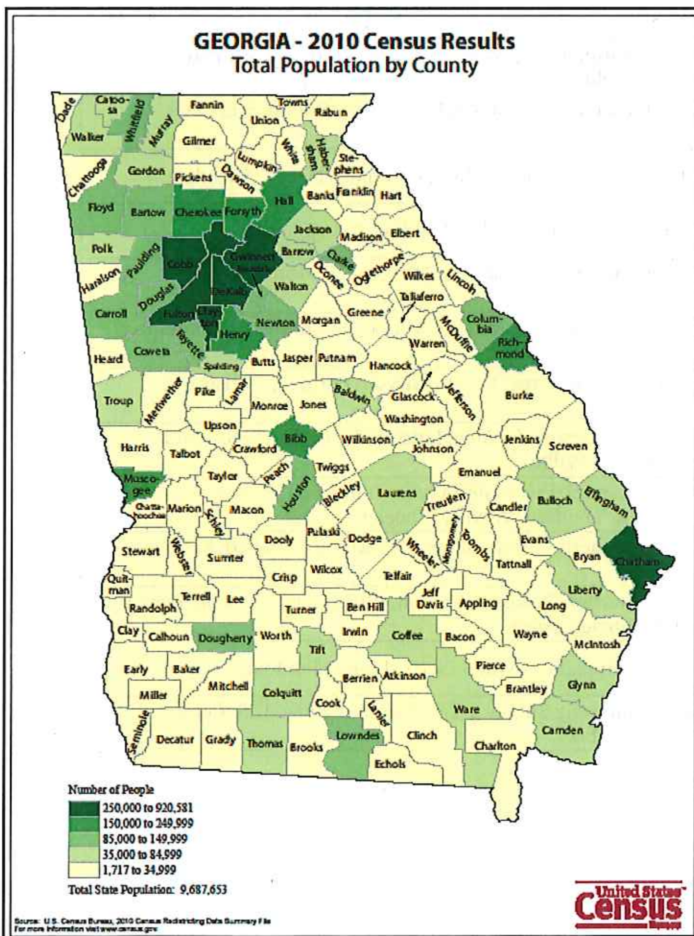
Aging Trends in Georgia

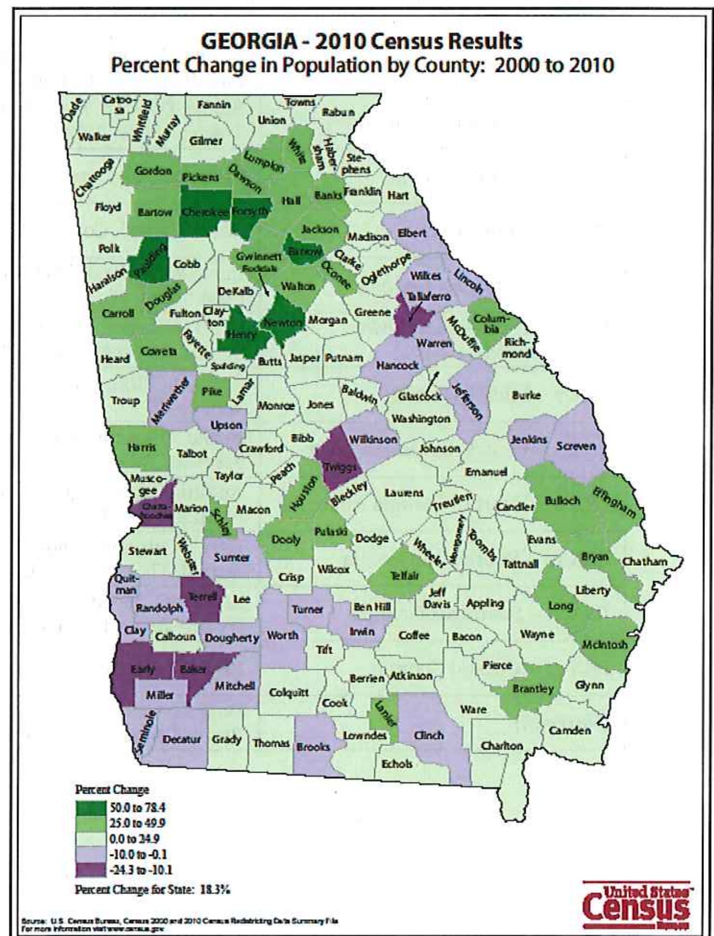
- Georgia's population ages 60 and above increased from a reported 1,071,080 in the 2000 Census to an estimated 1,599,098 per the 2009-2013 American Community Survey, a 49.3 percent increase.

- Georgia's population, ages 65 and above, is expected to increase 142.95% and 65.5% as a percent of the total population, between 2000 and 2030.

- During the 20th century, the number of Georgians age 60 and above increased ten-fold, compared to a four-fold growth in the population overall.

- Georgia continues to be a young state compared to the nation. Although the median age continues to rise, was lower than all but five states in 2010. This is due to several factors. Georgia has a higher minority population than the national average. These groups have higher birth rates and lower median age than the non-Hispanic white population. In addition, Georgia's high level of migration from other states is concentrated in younger population age cohorts. This is demonstrated by the fact that Georgia has a higher percentage of its population in the 25 to 44 age group than the national average (32.4 percent versus 30.2 percent). Only two states, Alaska and Colorado, have a higher percentage of their population in this group.





Georgia Population Data Summary
2009 - 2013 Estimates

PSA	60+ Population	60+ as % of Total Populat ion	65+ Living Alone	65+ Living Alone as % of 65+ Population	65+ In Poverty	65+ In Povert y as % of 65+ Popu-lation	65+ Limited English	65+ Lim Eng as % of 65+ Population
1-Northwest Georgia	158,883	20%	27,284	25%	12,173	11%	1,176	1.1%
2-Georgia Mountains	123,045	25%	19,439	22%	7,889	9%	2,670	3.1%
3-Atlanta Region	578,171	15%	94,555	25%	36,123	10%	25,305	6.7%
4-Three Rivers	88,945	19%	15,537	25%	6,116	10%	640	1.0%
5-Northeast Georgia	97,441	20%	15,772	23%	6,547	10%	1,337	2.0%
6-River Valley/Lower Chattahoochee	67,365	21%	15,049	32%	6,424	14%	826	1.7%
7-Middle Georgia	89,926	21%	15,587	25%	7,073	11%	724	1.2%
8-Central Savannah	86,010	22%	16,194	27%	7,375	12%	1,300	2.2%
9-Heart of GA Altamaha	60,311	20%	12.858	30%	6,765	16%	326	0.8%
10-Southwest Georgia	69,303	21%	13,006	27%	7,016	14%	439	0.9%
11-Southern Georgia	74,099	19%	14,460	28%	7,395	14%	488	0.9%
12-Coastal Georgia	108,937	16%	20,272	27%	7,553	10%	1,406	1.9%
State of Georgia Totals	1,602,434	20%	280,013	26%	118,449	11%	36,637	3.4%

PSA 1 – Northwest Georgia	Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield
PSA 2 – Georgia Mountains	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White
PSA 3 – Atlanta Region	Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale
PSA 4 – Three Rivers	Butts, Carroll, Coweta, Heart, Lamar, Meriwether, Pike, Spalding, Troup, Upson
PSA 5 – Northeast Georgia	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton
PSA 6 – River Valley/Lower Chattahoochee	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster
PSA 7 – Middle Georgia	Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson
PSA 8 – Central Savannah River	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes
PSA 9 – Heart of Georgia Altamaha	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox
PSA 10 – Southwest Georgia	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth
PSA 11 – Southeast Georgia	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware
PSA 12 – Coastal Georgia	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh
Sources:	Data from 2009 - 2013 American Community Survey 5-Year Summary File, U.S. Census Bureau, American Community Survey Office

Georgia Population Data Summary Continued
2009 - 2013 Estimates

PSA	75+ Population	75+ as % of Total Population	65+ Disabled	65+ Disabled as % of 65+ Population	65+ Minority In Poverty	65+ Minority In Poverty as % of 65+ Population	60+ Rural	60+ Rural as % of 65+ Population
1-Northwest Georgia	44,933	5.8%	45,558	41%	1,295	1.2%	74,935	47%
2-Georgia Mountains	34,524	7.1%	31,123	36%	792	0.9%	61,909	50%
3-Atlanta Region	147,913	3.6%	127,149	34%	20,495	5.5%	21,219	4%
4-Three Rivers	24,594	5.4%	24,547	40%	2,578	4.2%	43,415	49%
5-Northeast Georgia	26,568	5.3%	25,230	37%	2,163	3.2%	46,040	47%
6-River Valley/Lower Chattahoochee	20,471	5.8%	20,396	43%	3,824	8.1%	25,634	38%
7-Middle Georgia	26,009	5.5%	23,763	38%	4,118	6.6%	32,629	36%
8-Central Savannah	24,680	6.8%	24,266	41%	4,360	7.3%	30,164	35%
9-Heart of GA Altamaha	17,976	5.9%	17,914	42%	2,523	5.9%	38,773	64%
10-Southwest Georgia	20,913	6.3%	20,109	41%	4,144	8.5%	32,973	48%
11-Southern Georgia	21,136	5.5%	23,255	45%	2,863	5.5%	38,807	52%
12-Coastal Georgia	30,200	4.1%	27,143	36%	3,678	4.9%	26,219	24%
State of Georgia Totals	439,918	5.6%	410,453	38%	52,833	4.8%	472,718	30%

PSA	Counties
PSA 1 – Northwest Georgia	Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield
PSA 2 – Georgia Mountains	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White
PSA 3 – Atlanta Region	Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale
PSA 4 – Three Rivers	Butts, Carroll, Coweta, Heart, Lamar, Meriwether, Pike, Spalding, Troup, Upson
PSA 5 – Northeast Georgia	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton
PSA 6 – River Valley/Lower Chattahoochee	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster
PSA 7 – Middle Georgia	Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson
PSA 8 – Central Savannah River	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes
PSA 9 – Heart of Georgia Altamaha	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox
PSA 10 – Southwest Georgia	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth
PSA 11 – Southeast Georgia	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware
PSA 12 – Coastal Georgia	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh

Sources:	60+ Rural based upon 2010 Census, Summary File 1, U.S. Census Bureau All remaining data from 2009 - 2013 American Community Survey 5-Year Summary File, U.S. Census Bureau, American Community Survey Office

Population by Age Group: February 2013, Population Estimates

Geography	All Ages	50+	55+	60+	65+	70+	75+	80+	85+
United States	100.0%	33.7%	26.6%	19.9%	14.1%	9.5%	6.2%	3.7%	1.9%
Georgia	100.0%	30.5%	23.6%	17.2%	11.9%	7.7%	4.6%	2.6%	1.2%

Source: U.S. Census Bureau, 2013 American Community Survey
Table S0101: Age and Sex; 2013 American Community Survey 1-Year Estimates

Population by Age Group: February 2013, Population Estimates

Geography	Total Population	60 to 64 years	65 to 74 years	75 to 84 years	85 years and over	60 years and over	65 years and over	Percent 60+	Percent 65+
United States	316,128,839	18,335,473	25,290,307	13,277,411	6,006,448	62,909,639	44,574,166	19.9%	14.1%
Georgia	9,992,167	529,585	729,428	349,726	119,906	1,718,653	1,189,068	17.2%	11.9%

Source: U.S. Census Bureau, 2013 American Community Survey
Table S0101: Age and Sex; 2013 American Community Survey 1-Year Estimates

Percent of Persons 60+ By Race and Hispanic Origin – 2013 Estimates

Geography	Total 60+	Persons Not Hispanic or Latino						Hispanic/Latino (may be of any race)
		Black/African American	American Indian/Alaskan Native (Alone)	Native Hawaiian/Pacific Islander (Alone)	Asian (Alone)	Two or more Races	White (Alone – Non-Hispanic)	
United States	100.0%	12.6%	0.8%	0.2%	5.1%	3.0%	62.4%	17.1%
Georgia	100.0%	31.0%	0.2%	0.0%	3.6%	2.1%	54.6%	9.1%

Source: U.S. Census Bureau, 2013 American Community Survey
Table S0102: Population 60 Years and Over in the Unites States; 2013 American Community Survey 1-Year Estimates

Types of Disability for the Population 65 Years and Over with Disabilities – 2013 Estimates

Note: A person may have more than one disability

Geography	Population 65 years and over	Persons with any difficulty	Persons with Hearing difficulty	Persons with Vision difficulty	Persons with Cognitive difficulty	Persons with Ambulatory difficulty	Persons with Self-Care difficulty	Persons with Independent Living difficulty
		Number	Number	Number	Number	Number	Number	Number
United States	43,353,631	15,775,788	6,572,050	2,966,615	3,993,337	10,090,255	3,688,100	6,692,064

Georgia	1,161,918	441,225	171,891	91,887	121,099	294,390	106,881	190,157

Source: U.S. Census Bureau, 2013 American Community Survey
Table S1810: Disability Characteristics; 2013 American Community Survey 1-Year Estimates

Types of Disability for the Population 65 Years and Over with Disabilities – 2013 Estimates

Note: A person may have more than one disability

Geography	Population 65 years and over	Persons with any difficulty	Persons with Hearing difficulty	Persons with Vision difficulty	Persons with Cognitive difficulty	Persons with Ambulatory difficulty	Persons with Self-Care difficulty	Persons with Independent Living difficulty
		Percent	Percent	Percent	Percent	Percent	Percent	Percent
United States	100.0%	36.4%	15.2%	6.8%	9.2%	23.3%	8.5%	15.4%
Georgia	100.0%	38.0%	14.8%	7.9%	10.4%	25.3%	9.2%	16.4%

Source: U.S. Census Bureau, 2013 American Community Survey
Table S0102: Population 60 Years and Over in the Unites States; 2013 American Community Survey 1-Year Estimates

Projections of the Population by Age 1990 to 2030

Ages 65 and Up	1990	2000	2010	2020	2030
Georgia	654,270	785,275	980,824	1,409,923	1,907,837
Increase by each 10 year period		131,005	195,549	429,099	463,506
Percent increase by each 10 year period		20.02%	24.90%	43.75%	32.09%
Increase with 2000 as base			195,549	624,648	1,122,562
Percent increase 2000 to 2030					142.95%

Source: U.S. Census Bureau, 2005 Interim State Population Projections
Table 5: Population under 18 and ages 65 and older, 2000, 2010 and 2030; and Table B1: Summary Tables of Projections - The total population by selected age groups.
https://www.census.gov/population/projections/data/state/projectionsagesex.html

Projections of the Population, by Age, 1990 to 2030 (in thousands)

Georgia	1990	2000	2010	2020	2030
ages 0 – 4		595,150	730,521	816,822	922,860
ages 5 – 17		1,574,084	1,771,865	2,020,441	2,223,764
ages 18 – 24		837,732	975,875	1,050,505	1,171,301
ages 25 – 64		4,394,212	5,129,995	5,546,062	5,792,076
ages 65 and up		785,275	980,824	1,409,923	1,907,837
Total population		8,186,453	9,589,080	10,843,753	12,017,838
65+ as a percent of total		9.59%	10.23%	13.00%	15.88%
Percent increase of %65+ 2000 to 2030					65.50%

Source: U.S. Census Bureau, 2005 Interim State Population Projections
Table B1: Summary Tables of Projections – The total population by selected age groups.
https://www.census.gov/population/projections/data/state/projectionsagesex.htmltes

Attachment F – Special Initiatives

Georgia Alzheimer's Disease and Related Dementias State Plan

Almost 30 years ago, at the request of the then-Atlanta Chapter of the of Alzheimer's Disease and Related Disorders Association, the Governor's Office and the Department of Human Resources delegated responsibility to the Office of Aging to conduct an Alzheimer's Disease Study Committee. Little was known about Alzheimer's at this time and much of the effort was devoted to understanding the nature of Alzheimer's. Early strides were made in identifying funding for respite services and expanding the Community Care Services Program, and the Office on Aging was directed to take an active role in educating the public.

In many ways, the initial study document was ahead of its time, and many of the recommendations floundered due to a lack of data (and the ability to collect and analyze data). Additionally, the public lacked a clear understanding of the extent to which Alzheimer's disease and related dementias would impact the state and nation.

The Alzheimer's Disease and Related Dementias State Plan builds upon previous work done by DAS in developing dementia-capable systems, coupled with knowledge gleaned through the Georgia Chapter of the Alzheimer's Association, the National Alzheimer's Plan and The Healthy Brain Initiative as well as professional expertise, personal experience, and public input from across the state.
This plan provides:

1. Numerous recommendations to State Agencies, Offices and Departments as a starting point for transitioning Georgia into becoming a dementia-capable state. Some recommendations will be acted upon immediately and others will take time, legislation or commitments from State leadership to ensure resources are available. These should be revisited regularly to ensure that we are meeting expected outcomes.

2. A guide for Public Health to begin to develop capacity to address Alzheimer's disease and related dementias as a public health crisis. It also provides recommendations for engaging public and private sector stakeholders to improve the State's response to community needs associated with Alzheimer's disease and related dementias.

This plan was developed to ensure that people with dementia, their families, and caregivers have ready access to reliable information, support and services and that they are delivered as effectively and efficiently as possible. Dementia is a devastating disease that causes changes in one's memory, behavior, and ability to think clearly. Statistically, dementia will eventually impact every region, every county and family in the state of Georgia. Alzheimer's is the sixth-leading cause of death in America. In Georgia in 1985, there were an estimated 40,000 people living with dementia. In the past six years alone, the number of Georgians reporting symptoms of dementia increased by 22 percent to 130,000 – this is a 427% increase from the 1985 estimates. The Georgia Alzheimer's and Related Dementias State Plan, signed by Governor Deal in 2014, puts forth a series of recommendations, which, if implemented, moves Georgia toward becoming a much more dementia-capable state.

The full document is posted at this link: **http://aging.dhs.georgia.gov/dementia-resources**.

Attachment G – Emergency Planning and Management Policy

CHAPTER 3000 AAA ADMINISTRATION

SECTION 3017 – Emergency Planning and Management

POLICY STATEMENT:

Area Agencies on Aging (AAA) are responsible for identifying themselves to and consulting with local (county and regional) emergency management agencies; public utilities; law enforcement authorities; other community service providers; state, county and municipal governments; and any other entities or organizations which have an interest or role in meeting the needs of the elderly in planning for, during and after natural, civil defense or other man-made disasters.

REQUIREMENTS:

AAAs are expected to:

- Designate a staff person to have primary responsibility for emergency management planning and coordination;
- Participate in state, regional, county and/or municipal planning activities with other human service agencies and entities and organizations charged with the responsibility of meeting the needs of disaster victims;
- Assist in identifying "at risk" elderly in the planning and service area, including but not limited to current consumers of contracted services;
- Require by contract provision that service providers develop plans for emergency management that fit the scope of their individual operations;
- Assure by annual review that service providers' policies, procedures and capabilities are adequate to meet the needs of the elderly in their areas prior to, during and after emergencies;
- Provide periodic training to providers regarding emergency management resources and activities;
- Upon request, provide information to the Division of Aging Services (DAS) regarding the impact of emergencies on the elderly population in the planning and service area;
- Provide authorized services to the elderly victims of disasters;
- Collect data necessary to submit reimbursement requests for services provided during the emergencies, which may be covered by other sources of funding available outside the aging program contract for disaster assistance;
- Participate in initial meetings of FEMA and GEMA on-site teams to assist in establishing recovery operations when appropriate.

SCOPE OF EMERGENCY PLANS and ACTIVITIES:

AAA plans will address four categories of activity: preparation, immediate response and stabilization, recovery and evaluation.

Preparation:

AAA emergency plans will address at a minimum:

- the types of natural disasters prevalent in the planning and service area (those that reasonably can be anticipated);
- the AAA's capabilities and limitations in addressing such incidents;
- ongoing maintenance and updating of resource databases;
- AAA emergency policies and procedures, including:
    - staff duties and responsibilities, including specific chain of command and alternates, if agency leadership is unavailable;
    - alert procedures for working and non-working hours;
    - procedures for providing for alternate communications channels and equipment;
    - locations of operations centers and alternates when primary offices are affected;
    - assuring availability of office supplies for alternate locations, staff identification badges, and the like.
    - roles of various relief organizations operating in and primarily responsible for relief authority in the area;
    - strategies for maintaining contact with staff, local organizations, and the Division if essential public services, such as communications and transportation, are limited or unavailable;
    - current disaster response systems and the Area Agency's linkages to, for example, county law enforcement and public safety agencies, emergency management agencies;
    - community education to alert first responders/other entities to special needs of the elderly and the Area Agency resources;
    - identification and mapping, if feasible, of heavy concentrations of elderly, including those residing in institutions, and households in which seniors reside alone, including apartments, and mobile homes;
    - demographic profiles of elderly in the area for targeting of specialized recovery assistance.

Response:

The initial reaction to ensure safety, hygiene/sanitation, and security, either in advance of an impending emergency or immediately following, will include:

- initiation of planned communications strategies and determination of impact of disaster on staff;
- assignment of duties;
- contact with key providers;
- initiation of disaster-specific record-keeping, including but not limited to records of :
    - staff time, including overtime;
    - supplies used;
    - documentation of contacts with seniors;
    - type and amount of services provided;

    - personal expenses;
    - specific telephone logs.

- preliminary assessment of scope of impact, including, but not limited to:
    - geographic scope and numbers of affected elderly/other target populations and their short and long term needs;
    - kinds of services needed, including impact on transportation resources;
    - identification of service gaps
    - provision of information to DAS.

- employment, training and deployment of field and outreach workers.

- follow-up contacts with all seniors/others initially assisted to determine additional needs which have developed, appropriateness of additional available resources, and need to advocate for additional resources.

Recovery:

Recovery involves sustained care over a longer period of time, for the purpose of assisting people in re-establishing as normal a life as possible. Recovery includes:

- shifting from emergency response to providing answers to more complex, long-range and long term problems, including arranging for psychological/mental health services for disaster victims;
- providing access to increased resources that have become available;
- participation in long range planning and coordination with other agencies;
- maintaining contact and providing services, including meeting non-immediate needs identified during the response phase.

Evaluation:

Evaluation involves analysis of the effectiveness of an emergency plan once deployed and provision of input and feedback to staff, volunteers and other community organization, following response and recovery phases. Evaluation results will drive improvements in emergency planning.

<u>EMERGENCY MANAGEMENT SERVICES:</u>

AAAs and their subcontract service providers are authorized to provide the following services to manage the emergency needs of the elderly:

- expansion of information and assistance services on a 24-hour basis, including escort assistance;
- special outreach activities to encourage elderly disaster victims to apply for benefits at federal emergency disaster assistance centers (DACs) as soon as they are established;
- special transportation for elderly disaster victims to DACs, doctors, clinics, shopping and such essential travel in the event that vehicles are not readily available. Since FEMA funds may be available to fund this service, the Area Agency will consult with the on-site federal coordinating officer prior to expending Older Americans Act or state funds on this service;

- assistance by case managers acting as disaster assistance advocates to older persons in the DACs in the benefits application process, including follow up to assure older victims receive approved grants and services and are protected from unscrupulous contractors for housing and other repairs;
- handyman and chore services, including clean-up, in the event that FEMA cannot provide these services in sufficient volume through volunteer efforts;
- licensed appraiser services to assist elderly disaster victims in arriving at realistic estimates of losses incurred;
- legal services, only when scope of the primary elderly legal assistance program must be expanded to address insurance and disaster grant assistance settlements;
- assistance to move elderly disaster victims from temporary housing back to their own places of residence;
- other Older Americans Act services, including meals, when assessments indicate that disaster related needs are unresolved by federal, state, or voluntary disaster assistance programs.

REIMBURSEMENT PROCEDURES FOR EMERGENCY SERVICES:

Reimbursement for the services specified above are authorized by the Older Americans Act, §310, as amended. AAAs shall forward requests for reimbursement to DAS within 30 business days of the date that disaster recovery operations are completed.

AAAs will prepare the reimbursement requests as follows:

- Sort the expenses for which reimbursement is requested into categories by service, as listed in the preceding section.
- Provide a narrative for each category, which documents the number of units provided and the number of elderly served. This will be the cover page for each set of reimbursement documentation materials.
- Enclose the billing documentation, such as paid bills and invoices, with the narrative for each category of service provided.
- Attach a description of the cause and scope of the disaster.
- Attach the certificate of non-duplication of services provided by the FEMA office, if it is available.

DAS will review all reimbursement requests, seek any additional information or clarification needed, and forward to the Administration on Community Living for payment.

Attachment H – Acronyms/Abbreviations

AAA	Area Agencies on Aging
ACL	Administration for Community Living
ACT	Adult Crime Tactics
ADRC	Aging and Disability Resource Connection
AIMS	Aging Information Management System
ANE	Abuse/Neglect/Exploitation
APS	Adult Protective Services
CCSP	Community Care Services Program
CILS	Centers for Independent Living
CLP	Community Living Program
CMS	Centers for Medicare and Medicaid Services
CO-AGE	Coalition of Advocates for Georgia's Elderly
CQI	Continuous Quality Improvement
DAS	Georgia Division of Aging Services
DCH	Department of Community Health
DD	Developmental Disabilities
DFCS/DFACS	Georgia Department of Family and Children Services
DHS	Department of Human Services
DON-R	Determination of Need - Revised
DPH	Georgia Department of Public Health
ELAP	Elderly Legal Assistance Program
FSIU	Forensic Special Investigations Unit
G4A	Georgia Association of Area Agencies on Aging
GCOA	Georgia Council on Aging
HCBS	Home and Community Based Services
HDM	Home Delivered Meals
HFR	Georgia Healthcare Facility Regulation
IFF	Intra-State Funding Formula
LIS	Low-Income Subsidy
LTCO	Long Term Care Ombudsman
LTCOP	Long Term Care Ombudsman Program
MAPs	Measurement and Analysis Plan (performance indicators)
MDS	Minimum Data Set
MFP	Money Follows the Person
MIPPA	Medicare Improvements for Patients and Providers Act
MSP	Medicare Savings Program
NAPIS	National Aging Program Information System
NCI –AD	National Core Indicators – Aging and Disabilities
NH	Nursing Home
NHT	Nursing Home Transitions
OAA	Older Americans Act

PGO	Public Guardianship Office
PSA	Planning and Service Area; Personal Support Aide
QOL	Quality of Life
RC	Regional Commission
RD	Regional Director
PSS	Personal Support Services
SCSEP	Senior Community Service Employment Program
SMP	Senior Medicare Patrol (See SHIP)
SNAP	Supplemental Nutrition Assistance Program
SFY	State Fiscal Year (July 1 through June 30)
SLTCO	State Long Term Care Ombudsman
SUA	State Unit on Aging

2018

Just the Facts

ANNUAL REPORT

Department of Human Services | Division of Aging Services

Aging services

The Department of Human Services (DHS) Division of Aging Services (DAS) is the federally designated unit on aging for the State of Georgia. DAS is committed to assisting older individuals, at-risk adults, persons with disabilities, their families and caregivers so that they may achieve safe, healthy and independent lives.

In fiscal year 2018, DAS continued to provide services in each of its program areas. A few of our results and accomplishments included:

- Helping 33,875 consumers achieve greater independence through Home and Community Based Services (HCBS). This was an increase of 9.9 percent over SFY17, when 30,832 consumers were served.
- Serving 2,497,845 home-delivered meals and 1,491,942 congregate (senior center) meals to older Georgians
- Addressing 50,159 reports of abuse, neglect and exploitation to Adult Protective Services (APS)
- Serving 952 individuals as Guardian of Last Resort
- Transitioning 175 individuals from nursing facilities back to the community using state Nursing Home Transition funds. This was an increase of 6 percent compared with SFY17, when there were 165 transitions. Additionally, we transitioned 264 individuals through the Money Follows the Person (MFP) Program.
- Saving older Georgians $9,083,926 through the Elderly Legal Service Program
- Saving Medicare beneficiaries $14,908,302 in out-of-pocket expenses through the GeorgiaCares program
- Providing 107,287 clients and family members with information regarding available resources and services through the Aging and Disability Resource Connection (ADRC) and
- Training 354 law enforcement officers, medical staff, prosecutors and other mandated reports on elder abuse, neglect and financial exploitation issues through the Forensic Special Initiatives Unit (FSIU).
- The percentage of clients retaining employment for six months or longer through the Senior Community Services Employment Program (SCSEP) is 45%.

Dementia Initiatives

DHS / DAS continues to advance the Georgia Alzheimer's and Related Dementias (GARD) State Plan through collaborations with stakeholders on initiatives in areas such as workforce development, service delivery and public safety. DHS / DAS partners with Emory University on Georgia Memory Net (GMN), which establishes Memory Assessment Clinics around the state to provide for early and accurate dementia diagnoses as well as linkages to community support. In SFY18, five Memory Assessment Clinics were established; a patient workflow was developed; Emory trained and educated clinicians, practitioners and community partners from across the state through a variety of forums; and the first annual GMN Summit was held at Lake Lanier.

Senior Hunger

In SFY18, DAS continued to make great strides in addressing senior hunger in Georgia. DAS hosted a second annual Senior Hunger Summit, and a Senior Hunger State Plan Coordinator was hired. Also, a multi-disciplinary committee was developed, which includes partners from Dollar General, the Georgia Farmers Market Association, the Georgia Grocers Association, the Food Policy Network, the Georgia Food Bank Association, Wholesome Wave and other state and local government agencies to plan ongoing senior hunger summits and identify policy and planning strategies to fill a variety of food systems needs across the state and What a Waste pilot sites were expanded.

Assistive Technology

Nine Area Agencies on Aging (AAAs) have established 11 Assistive Technology Labs to cover the entire state. All 12 AAAs have Assistive Technology toolkits for public demonstrations.

Georgia's Older Adults Cabinet

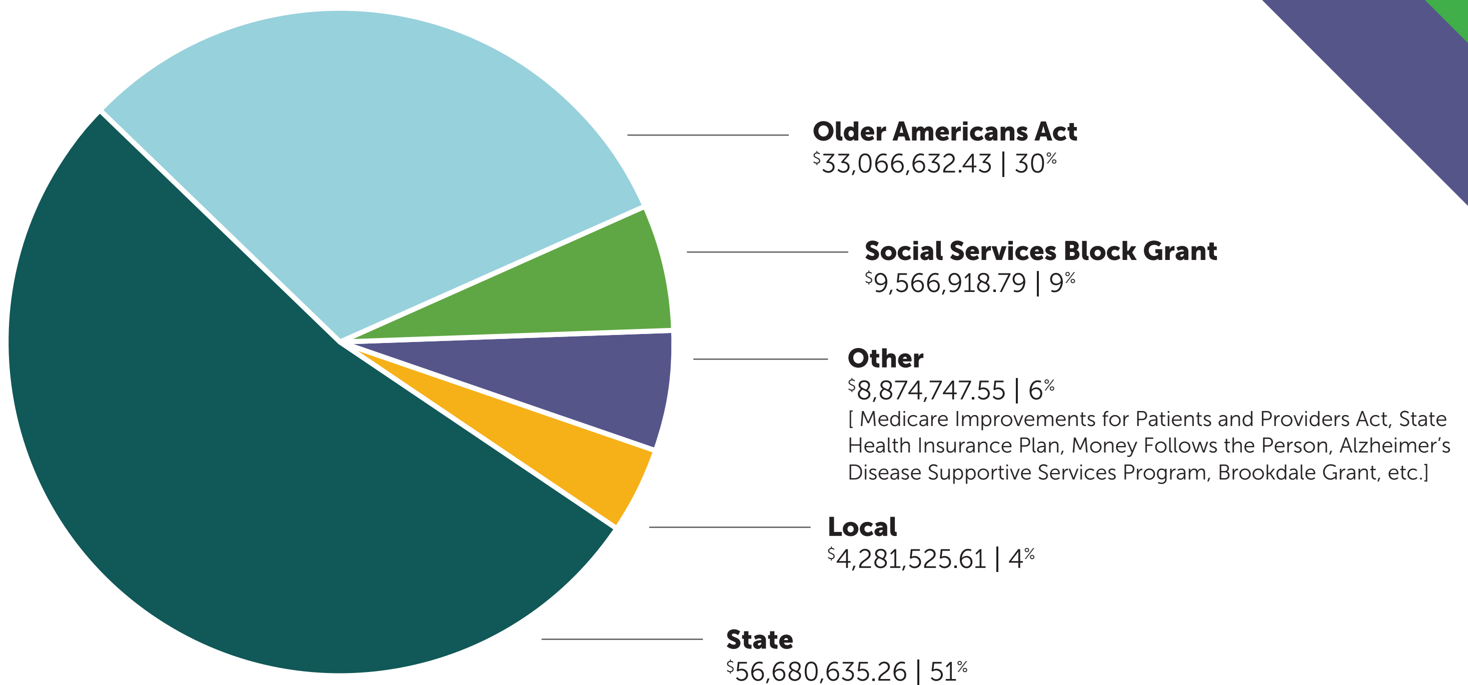
First Lady Sandra Deal and then-Commissioner Robyn A. Crittenden serve as co-chairs of the Older Adults Cabinet. This group of leaders works to enhance the state's capacity to serve older adults. The Older Adults Cabinet works to identify ways for Georgia to improve the well-being of its older residents by bringing together state agency heads whose work supports older Georgians, as well as stakeholders in the business, philanthropic and education communities. In SFY18, the Older Adults Cabinet identified three priorities: combating abuse, neglect and exploitation of older adults and individuals with disabilities; improving access to resources; and developing the workforce.

Gerlda B. Hines
Department of Human Services
Interim Commissioner

Abby Cox
Division of Aging Services
Director

Funding

Division Budget Expenditures
State Fiscal Year 2018

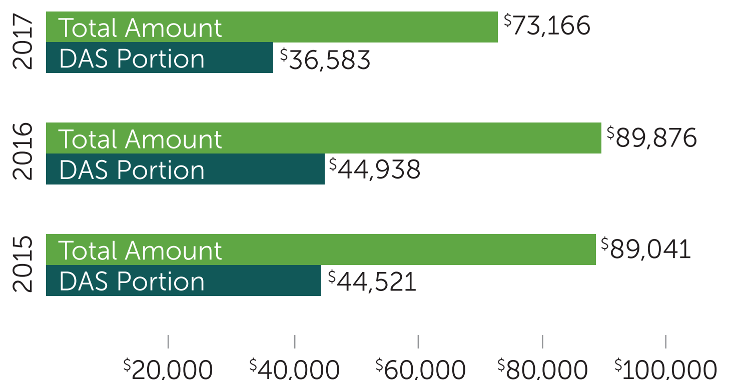


Georgia Fund for Children & Elderly

The Georgia Department of Human Services Division of Aging Services co-administers the fund with the Department of Public Health's Maternal and Child Health Program Division.

The Division of Aging Services receives 50% of the fund's donations each year, and those monies are distributed to Area Agencies on Aging for home-delivered meals and senior transportation. The remaining 50% is allotted to the Department of Public Health to provide grants for programs that serve children and youth with special needs.

Donations received between calendar years / income tax years 2015 and 2017 are shown below.



Programs & Services

Non-Medicaid Home & Community Services
Non-Medicaid Home and Community Based Services (HCBS) include individual and group services to support and assist older Georgians in staying in their homes and communities. These services promote health, self-sufficiency and independence.

Caregiver Programs and Services
Georgia's aging network provides an array of services designed to support family caregivers. Services to caregivers include adult day care; respite care; case management and counseling; information and assistance; support groups; material aid; homemaker and personal care; as well as education and training for caregivers.

Aging and Disability Resource Connection
The Georgia Aging and Disability Resource Connection (ADRC) is a partnership between DHS/DAS and multiple organizations, such as state agencies and other public or private organizations. Together, they offer a No Wrong Door system for resources and services for all populations and all payers.

Elderly Legal Assistance Program
The Georgia Elderly Legal Assistance Program (ELAP) serves people age 60 and older by providing legal representation, information and education in civil legal matters throughout the State of Georgia.

Money Follows the Person
The Money Follows the Person (MFP) Program transitions eligible individuals from long-term care facilities back into community settings.

GeorgiaCares Program

GeorgiaCares, Georgia's State Health Insurance Assistance Program (SHIP), is a volunteer-based program that provides free, unbiased and accurate information about health and drug plans to Medicare beneficiaries and their caregivers.

Adult Protective Services

The Division of Aging Services administers the Adult Protective Services (APS) program, which investigates reports alleging abuse, neglect or exploitation of persons with disabilities age 18 and older and prevents recurrence through the provision of protective services interventions.

The Public Guardianship Office

The Department of Human Services is the appointed guardian of last resort when there is no willing or suitable person to act as the guardian for an adult whom the probate court has determined lacks enough capacity to make or communicate significant responsible decisions concerning health or safety. The Public Guardianship Office (PGO) of the Division of Aging Services is assigned oversight and delivery of guardianship case management services on behalf of the Department of Human Services.

Forensic Special Initiatives Unit

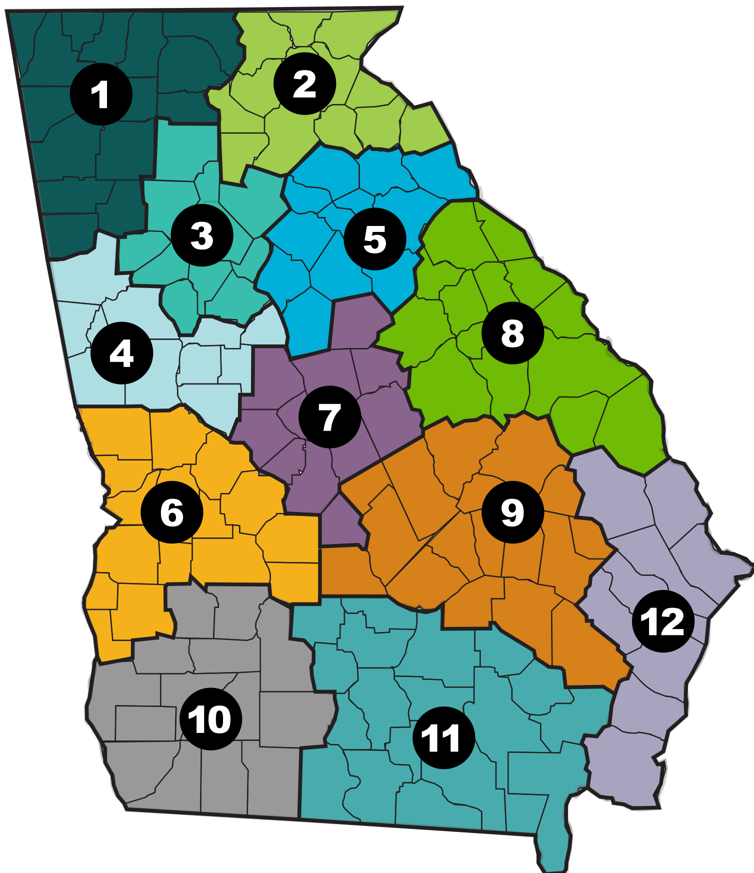
The Forensic Special Initiatives Unit (FSIU) increases awareness of elder abuse to statewide mandated reporters by identifying and addressing system gaps and developing process improvements to protect Georgia's at-risk adults from abuse, neglect and exploitation. Services provided by FSIU include training, outreach, technical assistance, and case consultation and review.

The Senior Community Service Employment Program

The Senior Community Service Employment Program (SCSEP) provides useful part-time community service assignments and training for unemployed, low-income older Georgians and helps them obtain unsubsidized paid employment. While participants develop job-related skills and earn minimum wage, the community directly benefits from the work they perform.

Area Agencies on Aging

Georgia Area Agencies on Aging
Area Agencies on Aging (AAA) are part of a nationwide network of state and local programs designed to help older people plan and care for their lifelong needs. AAAs are created under the Older American's Act. The State of Georgia is divided into 12 Planning and Service Areas named below, with their corresponding counties highlighted. The AAAs are the primary service provider arm of DAS.



Demographic Snapshot

1. Northwest Georgia
   9.94% | Percentage of Georgia's 65+ population
2. Georgia Mountains
   8.27% | Percentage of Georgia's 65+ population
3. Atlanta Region
   36.46% | Percentage of Georgia's 65+ population
4. Southern Crescent
   5.54% | Percentage of Georgia's 65+ population
5. Northeast Georgia
   6.28% | Percentage of Georgia's 65+ population
6. River Valley
   4.03% | Percentage of Georgia's 65+ population
7. Middle Georgia
   5.49% | Percentage of Georgia's 65+ population
8. Central Savannah River Area
   5.18% | Percentage of Georgia's 65+ population
9. Heart of Georgia
   3.52% | Percentage of Georgia's 65+ population
10. Southwest Georgia
    4.11% | Percentage of Georgia's 65+ population
11. Southern Georgia
    4.36% | Percentage of Georgia's 65+ population
12. Coastal Georgia
    6.81% | Percentage of Georgia's 65+ population

SFY 2018 Clients Served by Planning and Service Areas

Region	Aging and Disability Resource Connection	GeorgiaCares	Home and Community Based Services	Money Follows the Person	Nursing Home Transitions	Adult Protective Services
Atlanta Region	36,996	N/A	9,982	50	19	6,177
Central Savannah River Region	8,781	N/A	2,349	17	11	1,152
Coastal Georgia Region	5,030	291	2,334	9	10	1,203
Georgia Mountains Region	7,110	1,837	2,837	8	4	1,329
Heart of Georgia Region	3,539	243	1,333	19	11	664
Middle Georgia Region	7,624	1,214	1,755	16	12	1,102
Northeast Georgia Region	6,385	1,174	2,533	13	13	1,194
Northwest Georgia Region	6,744	968	3,136	20	11	1,970
River Valley Georgia Region	4,254	1,054	1,455	17	8	779
Southern Georgia Region	8,570	1,712	1,709	18	14	951
Southwest Georgia Region	6,340	2,005	2,141	8	11	750
Three Rivers Region	5,914	1,454	2,346	19	9	1,069
State DAS/CILS*	0	82	0	50	44	0
Georgia Legal Services Program*		2,224				

*Centers for Independent Living, Concerted Services and Georgia Legal Services Program are specific to GeorgiaCares, Money Follows the Person and Nursing Home Transitions.

State Fiscal Year 2017
Just the Facts

Georgia Department of Human Services
Division of Aging Services

Nathan Deal
Governor

Robyn A. Crittenden
Commissioner

Georgia Department of Human Services
Aging Services | Child Support Services | Family & Children Services

RE: State Fiscal Year 2017 Just the Facts

To Whom it May Concern:

The Department of Human Services (DHS) Division of Aging Services (DAS), is the federally designated unit on aging. DAS is committed to assisting older individuals, at-risk adults, persons with disabilities, their families and caregivers so that they may achieve safe, healthy and independent lives. In doing so, DAS supports the Department's vision of stronger families for a stronger Georgia.

In fiscal year 2017, DAS continued to provide services in each of its major program areas including Home and Community Based Services, Caregiver Support, Aging and Disability Resource Connection, Adult Protective Services and the Public Guardianship Office. In addition, DAS expanded programming with respect to combatting Alzheimer's and Related Dementias and Senior Hunger.

DAS is very proud of its history of providing services to Georgia's most vulnerable adults. DAS will continue to build on its successes and increase its efforts.

Thank you for your support.

Sincerely,

Robyn A. Crittenden
Commissioner

Abby Cox, Director
DHS Division of Aging Services

2 Peachtree St. N.W., Atlanta, GA 30303 | dhs.ga.gov

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Executive Summary

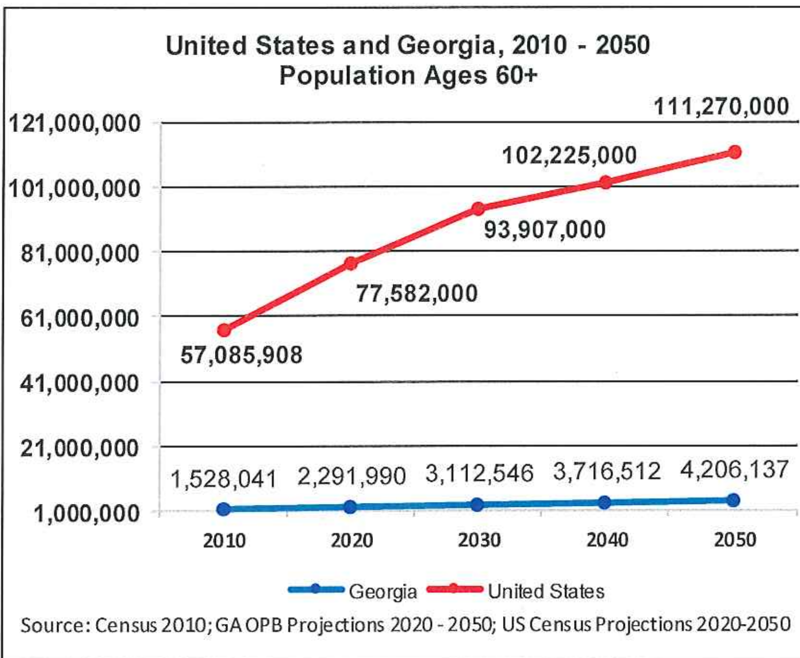
The mission of the Division of Aging Services (DAS) is to support the larger goals of the Department of Human Services (DHS) by assisting older individuals, at-risk adults, persons with disabilities, their families and caregivers to achieve safe, healthy, independent and self-reliant lives. To accomplish this mission, DHS/DAS works collaboratively with others within Georgia's Aging Service Network (Area Agencies on Aging – or AAAs – providers, older adults and advocates) and with key organizations serving individuals with disabilities. This network provides seamless access to long-term support and services consumers need to remain safely at home and in the community for as long as they desire.

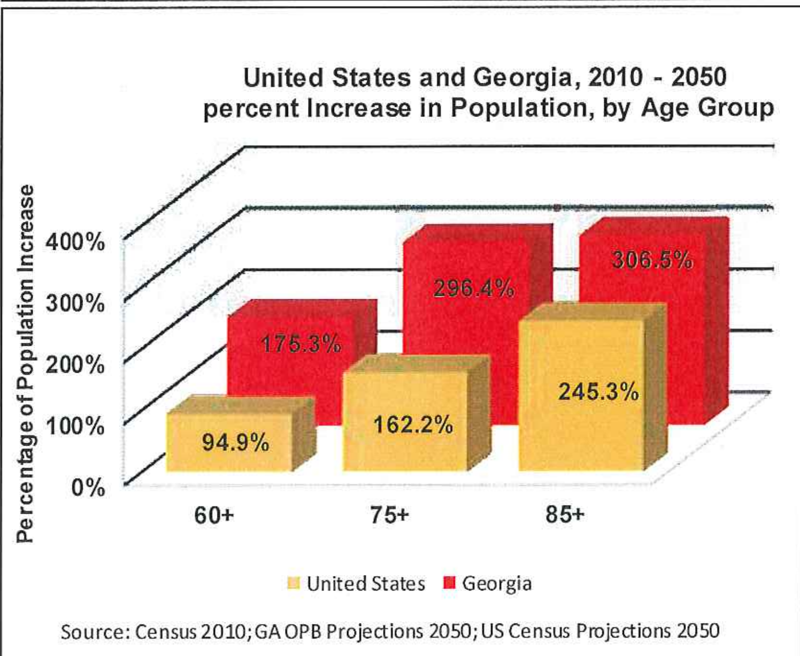
Just the Facts reflects outcomes of services outlined by the U.S. Department of Health and Human Services Administration for Community Living (ACL), including Older Americans Act core programs, ACL Discretionary Grants, Participant-Directed/Person-Centered Planning and Elder Justice-related activity. The results shown in this document demonstrate how DHS/DAS works strategically to increase the number of available services for Georgia's consistently growing population of older adults and people with disabilities, their families and caregivers. DHS/DAS will continue to develop innovations to efficiently and effectively expand capacity, foster collaboration and reduce costs to deliver a comprehensive system of programs and services that help Georgians live longer, live safely and live well.

Aging Trends in Georgia

GA DHS Division of Aging Services and the Aging Network

The Georgia Department of Human Services, Division of Aging Services' (DHS/DAS) mission is to assist older individuals, at-risk adults, persons with disabilities, their families and caregivers to achieve safe, healthy, independent and self-reliant lives. Through continuous service improvements and innovation, DHS/DAS provides programs and services that assist Georgians in living longer, living safely and living well.

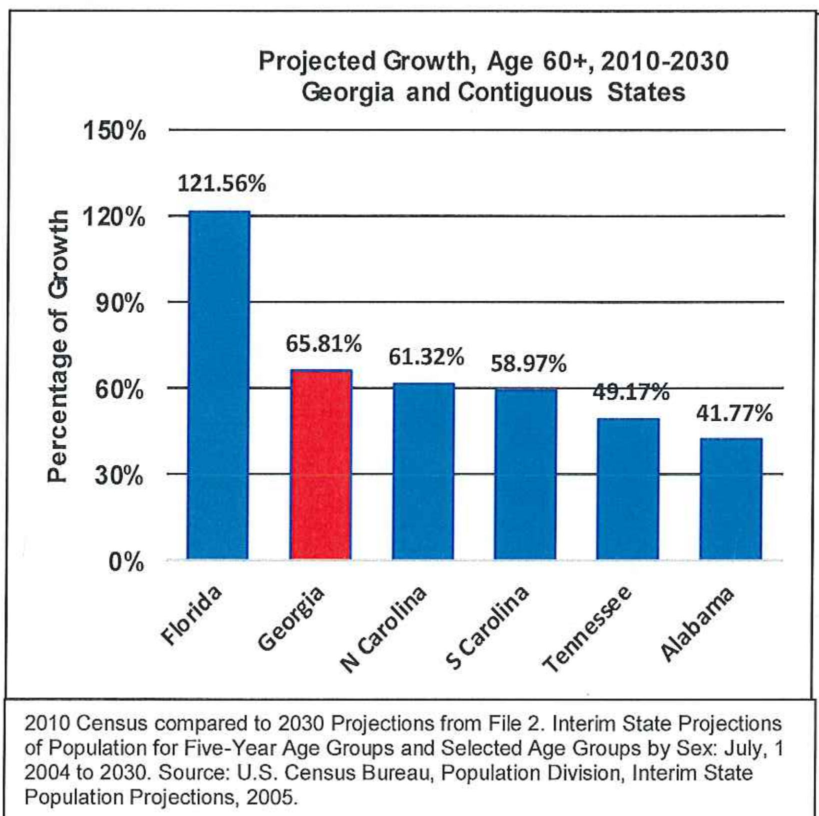




- Georgia has the 11th fastest growing 60+ population and the 10th fastest growing 85+ population in the United States between 2010 and 2030. (Source: Census 2010; GA OPB Projections 2050 special request)
- Georgia's 60+ population is expected to increase 65.8 percent between 2010 and 2030, from 1 in 6 persons in 2010 to 1 in 5 persons in 2030. (Source: Census 2010; GA OPB Projections 2050 special request)
- Georgia's 85+ population is expected to increase 306.5 percent from 2010 to 2050. Those age 85 and above are by far the fastest-growing group, projected to total 462,723 in 2050. (Source: Census 2010; GA OPB Projections 2050 special request)
- During the 20th century, the number of Georgians age 60+ increased ninefold, compared to a fourfold growth in the population overall. (Source: Census 2010; GA OPB Projections 2050 special request)

- Among Georgians age 60 and older, there were 80 men for every 100 women. For Georgians age 85 and above, there were 46 men for every 100 women.[1] (2010-2014)
- Of Georgia's population ages 60 and older, an estimated 385,845 lived alone.[2] (2010-2014)
- An estimated 339,355, or 20.35 percent, of Georgia's total civilian population age 60 and older were veterans.[3] (2010-2014)
- More Georgians ages 60 and older completed high school and earned post-secondary degrees:[4] (2010-2014)
  - High school graduates 536,305
  - Associate degree 84,455
  - Bachelor's degree 226,460
  - Master's degree 111,810
  - Professional degree 33,875
  - Doctoral degree 24,870

- An estimated 26.88 percent of Georgians 60 and older were in the workforce.[5]
- The at or below poverty level for Georgia's 60 and older population was 11.39 percent.[6]
- Georgia has the second-highest percentage increase in 60+ population compared with its bordering states.[7] (Reference chart on this page)

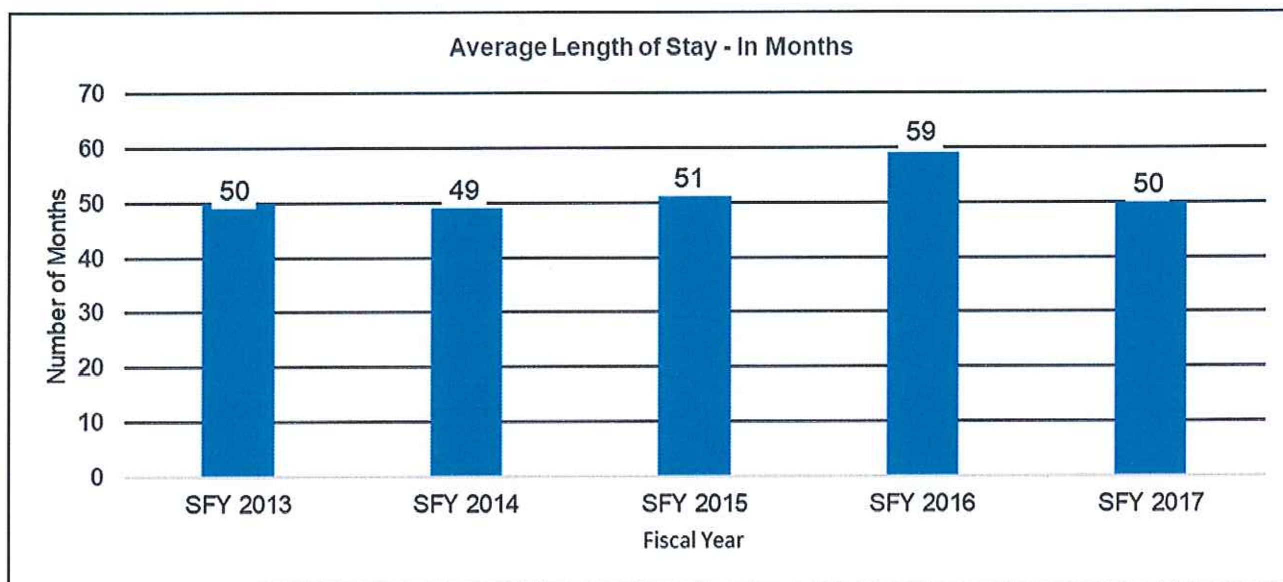


2010 Census compared to 2030 Projections from File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July, 1 2004 to 2030. Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

[1] AGID Table S210DIS01, GA 2010 - 2014.
[2] AGID Table S21004, GA 2010 - 2014.
[3] AGID Table S21025, GA 2010 - 2014.
[4] AGID Table S21021B, GA 2010-2014.
[5] AGID Table S21023, GA 2010 - 2014.
[6] AGID Table S21043B, GA 2010 - 2014.
[7] 2010 Census compared to 2030 Projections from File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July, 1 2004 to 2030. Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

Non-Medicaid Home and Community Based Services (HCBS)

Non-Medicaid Home and Community Based Services (HCBS) provides individual and group services to support and assist older Georgians in staying in their homes and communities. These services promote health, self-sufficiency and independence. During State Fiscal Year (SFY) 2017, 30,832 clients received HCBS services, and 16,559 clients received more than one service. Length of stay (LOS), the metric used to define return on investment, indicates how long our clients remain in their homes and in the community while receiving services.



Note: The average Length of Stay in SFY 2017 is lower than SFY 2016 due to data clean up that occurred transitioning between data systems.

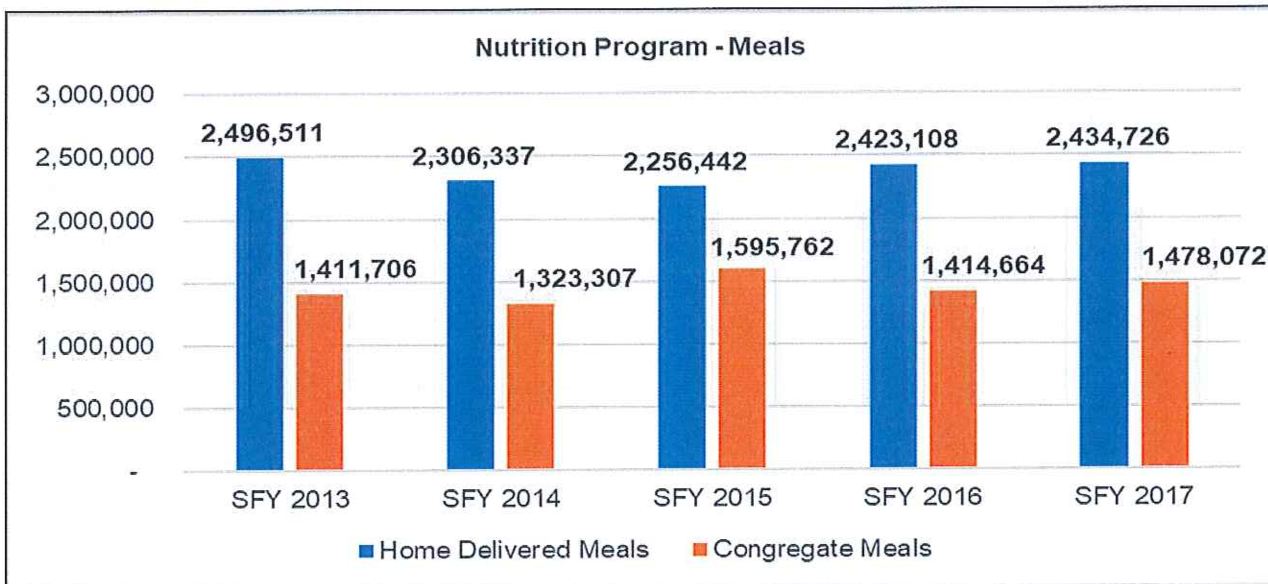
Nutrition and Wellness Programs: Living Longer, Living Well

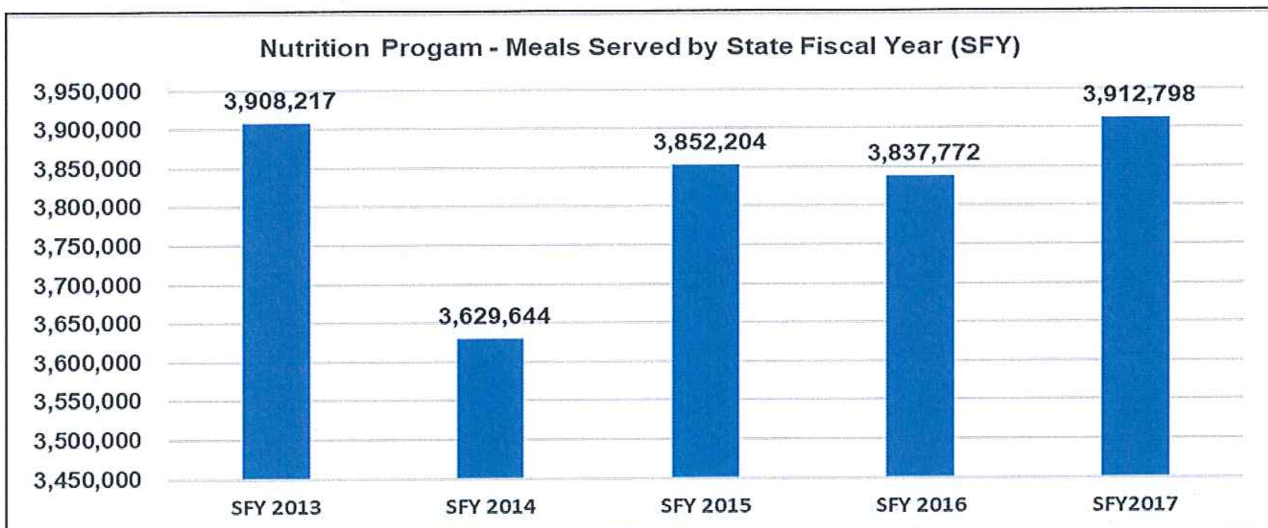
Nutrition and Wellness Programs aim at increasing the ability of older adults to perform everyday activities and remain in their homes. Activities are focused on evidence-based health promotion and disease prevention. Services are designed to improve nutrition and health status, increase functional abilities, promote safety at home, avoid or delay problems caused by chronic diseases, and enhance quality of life.

Nutrition counseling provides individualized guidance to individuals (or caregivers of individuals) who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses or medication use. Counseling, which is provided one-on-one by a registered dietitian, addresses options and methods for improving nutrition status. Nutrition education promotes better health by providing accurate and culturally sensitive information and instruction on nutrition, physical fitness, or health (as it relates to nutrition). The instruction takes place individually or in a group setting with participants, caregivers or both, and is overseen by a dietitian or individual of comparable expertise.

Qualified individuals who are unable to attend senior centers for these group meals benefit from home-delivered meals, which are provided to persons in their place of residence. The Home-Delivered Meals program is administered by State Units on Aging and/or AAAs and, like congregate meals, meets all requirements of the Older Americans Act as well as state and local laws.

Recent innovations enable the aging network to offer more person-centered, customized solutions. For example, funds may be used to purchase assistive technology that allows individuals to cook for themselves and eat independently at home.





More than 3,000 people benefitted from the following services offered by Nutrition and Wellness Programs:

- Exercise and physical fitness
- Medications management
- Nutrition counseling
- Health-related and health screening
- Georgia HealthMatters (evidence-based) programs, which include the Chronic Disease Self-Management Program, Diabetes Self-Management Program, Tomando Control de su Salud, Matter of Balance, Tai Chi for Health and the Otago Exercise Program
- Disease self management programs
- Falls prevention program
- Physical activities, including chair exercise, dancing, aerobics, walking, weight exercises, water aerobics, yoga, etc.
- Lifestyle Management, including recreation, safety, therapeutic activities and tobacco cessation
- Program Awareness/Prevention, including community events, distribution of materials, medications management, immunizations and group screening activities
- Nutrition Education, including nutrition and health sessions, menu planning and food preparation, explanation of dietary guidelines, eating and feeding information, and food safety

The Georgia Senior Hunger Initiative

During SFY 2017, DHS/DAS began the Senior Hunger Initiative. The first Senior Hunger Summit, held September 27-29, 2016, brought together elected officials, representatives of for-profit and nonprofit agencies, state agencies, college and university officials, older adults, caregivers and advocates. The event served to educate attendees about the issue of senior hunger and facilitate the building of community partnerships. Additionally, 12 listening sessions were conducted across the aging network planning and service areas and the Georgia AAAs. The sessions culminated in five common themes: Today's Seniors; Impact of Senior Hunger on Health; Food Access; Food Waste and Reclamations; and Meeting the Needs of the Community.

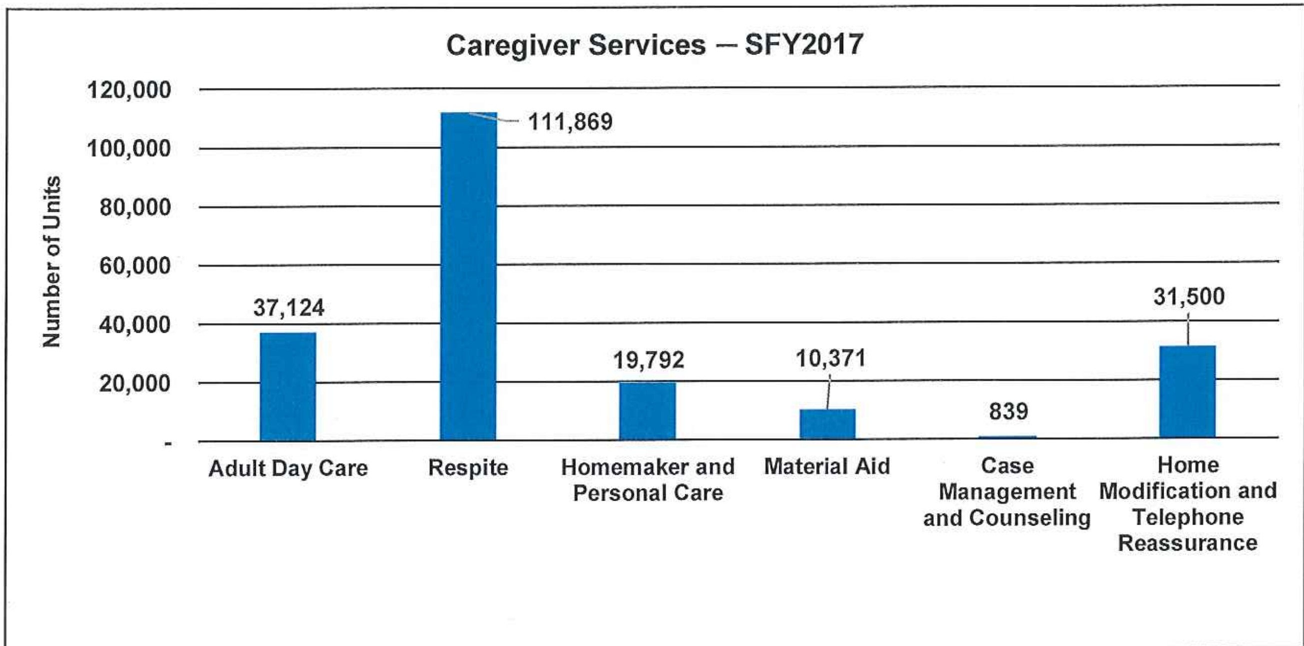
During this same period, DHS/DAS began a partnership with the National Foundation to End Senior Hunger (NFESH). What A Waste, an initiative designed to identify and decrease waste in congregate meals programs, was rolled out in nine sites across the state, representing three Area Agencies on Aging.

Future Activities for SFY 18

What A Waste will be expanded during SFY 2018 to 27 additional sites covering almost every region of the state.

Following the success of Senior Hunger Summit 2016, planning began for the Second Annual Georgia Senior Hunger Summit. It was held September 27-28, 2017, at Marriott Century Center Atlanta. More than 200 people attended, representing a wide variety of organizations—the food industry, AARP, for-profit and nonprofit meal providers, advocacy groups, aging network staff, nonprofit service providers, legislators and state government staff, faith-based organizations and more. The summit built on the information provided during the first event and previewed the Senior Hunger State Plan.

Caregiver Programs and Services

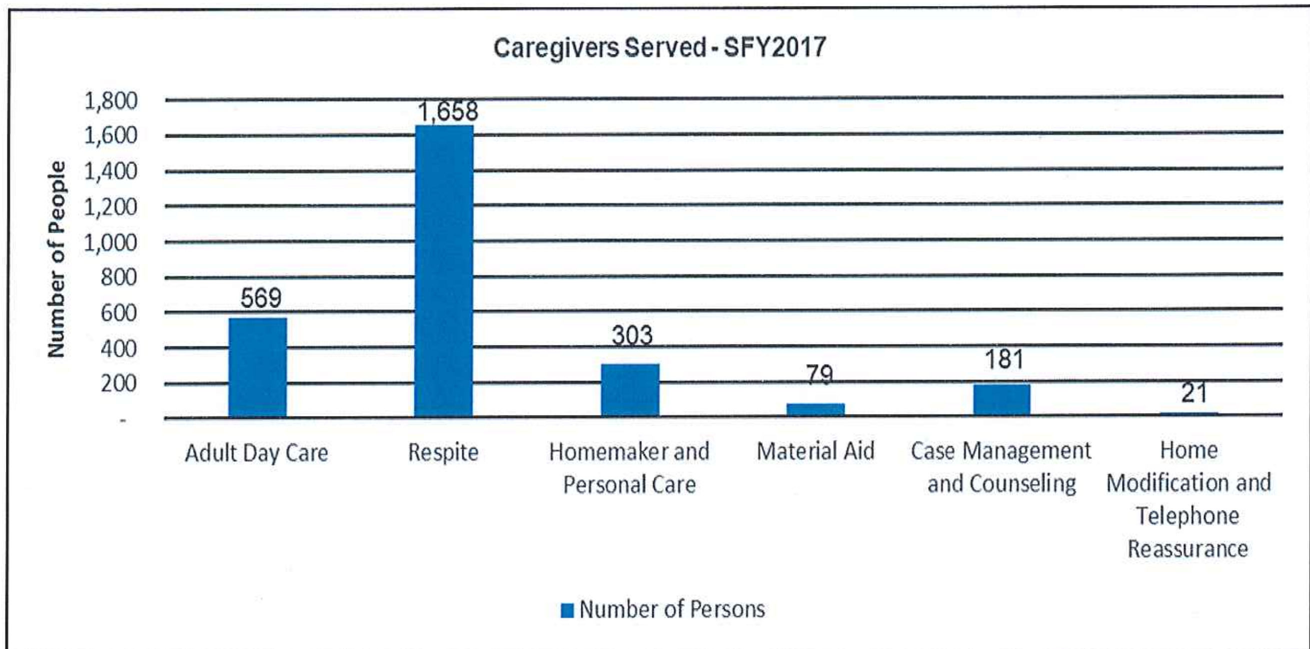


Definition of Units: Adult Day Care = 1 hour of service; Respite = 1 hour of service; Homemaker and Personal Care = 1 hour of service; Material Aid = 1 contact for service payment; Case Management and Counseling = 1 hour or 1 session of service; Home Modification and Telephone Reassurance = 1 job completed or 1 client contact

Overview

DHS/DAS provides program oversight, policy development, network funding and training at regional and local levels of the statewide aging network. Georgia's aging network provides an array of services designed to support family caregivers. During SFY 2017, services to caregivers included adult day care; respite care; case management and counseling; information and assistance; support groups; material aid; homemaker and personal care; as well as education and training for caregivers.

DHS/DAS contracts with 12 AAAs throughout the state to provide caregiver services. Various organizations partner with DHS/DAS and the AAAs in this endeavor, including: the Rosalynn Carter Institute for Caregiving; the Alzheimer's Association, Georgia Chapter; the Benjamin Rose Institute on Aging (BRI); Tools for Life at the Georgia Institute of Technology; the Brookdale Foundation Group, and Emory University's Alzheimer's Disease Research Center. In addition, many local service providers throughout Georgia are contracted through the AAAs to provide services to family caregivers and care receivers.



Caregiver Services

During SFY 2017, DHS/DAS continued to oversee and support area caregiver programs throughout Georgia. Highlights of these programs included:

- Further expansion of the Benjamin Rose Institute Care Consultation evidence-based, telephonic information and coaching service to assist caregivers in understanding options, managing care, and making decisions more effectively

- Continued support of caregiver support groups in all areas of the state

- Continued focus on caregiver group services, including: community and public education (via distribution of hard copy materials, presentations, television/radio, and web-based methods), material aid (help with purchasing transportation, food or groceries), caregiver events (field trips, sports and recreation, recognition and celebration), and caregiver training sessions (health promotion and disease prevention, professional development and leadership)

Kinship Care

AAAs are allowed to spend up to 10 percent of their National Family Caregiver Support Program Title III-E federal dollars towards dedicated kinship care programs. In Georgia, DHS/DAS contracts with six AAAs to provide kinship care services: Atlanta Regional Commission, Central Savannah River Area, Legacy Link, Northeast Georgia, Northwest Georgia, and Three Rivers. Kinship care activities such as support groups, financial support services, and health and wellness services are provided in other areas of the state via community partners.

Georgia Alzheimer's and Related Dementias State Plan

In SFY 2017, the Georgia Alzheimer's and Related Dementias (GARD) State Plan entered its fourth year of implementation. The Advisory Council and collaborating organizations made advancements in the plan's priority areas. Recommendations fall under the following categories:

- Health care, research and data collection
- Workforce development
- Service delivery
- Public safety
- Outreach and partnerships
- Policy

Selected highlights are below:

Georgia Alzheimer's and Related Dementias State Registry

The Georgia Department of Public Health (DPH) produced the Alzheimer's Disease and Related Dementias among Medicare Beneficiaries report for 2016. Here are some excerpts from that report.

- Nearly 17 percent (61,550) of Georgians ages 75 and older reported experiencing perceived cognitive impairment (PCI) that was happening more often or getting worse over the preceding 12 months. This was significantly higher than the prevalence among 45- to 54-year-olds and 65- to 74-year-olds (12 percent each).

- Approximately 13 percent (385,550) of Georgians ages 45 and older reported they had experienced PCI that was happening more often or was getting worse during the preceding 12 months.

- Fourteen percent (177,500) of men and 13 percent (208,000) of women reported experiencing PCI over the preceding 12 months.

- Approximately 92,000 (6.4 percent) of Medicare beneficiaries in Georgia were living with Alzheimer's disease and related dementias (ADRD) in 2013.

- Analysis shows that approximately 80 percent of Georgians who perceived themselves as having some form of cognitive impairment have not discussed their condition with their health care provider and therefore have not received treatment.

Alzheimer's Association Partnering with DPH and DHS/DAS on Training Programs

The Department of Public Health, DHS/DAS, and the Alzheimer's Association—Georgia Chapter are working to incorporate cognitive information into existing training programs and train-the-trainer programs such as diabetes, heart, stroke, falls prevention, etc. The three organizations will work collaboratively to ensure this occurs. An Alzheimer's and related dementias module will be incorporated into each department's existing modules.

Future Activities for SFY18

DHS/DAS will host the Georgia Dementia Summit in November 2017. This summit will convene multidisciplinary stakeholders in healthcare, research, social services, and policy as well as those living with dementia and their care partners. The work of the Georgia Alzheimer's Disease & Related Dementias (GARD) State Plan will be highlighted at the summit as we invite continued collaboration on shared goals and vision for a more dementia capable Georgia. The aim of this summit is to bring different sectors together to work toward a collective action plan and encourage commitment to a shared vision.

The General Assembly appropriated funding in SFY18 for the Georgia Alzheimer's Project (GAP). DHS/DAS will contract with Emory to provide a statewide system of diagnosis and care. Emory will sub-contract to establish five Memory Assessment Centers (MACs) in year one modeled after Emory Brain Health Center protocols. The project goals include:

1. Improve primary care clinicians' screening and care of Georgians with memory loss via sustainable Annual Wellness Visit model
2. Establish MACs around the state to improve Georgians' access to early and accurate diagnosis of Alzheimer's Disease and related disorders, and to improve long-term care and outcomes for patients and caregivers (5 MACs in year 1)
3. Establish an oversight structure to coordinate ongoing evaluation of project performance and continued education and training to improve the care that all Georgians receive for dementing illnesses.

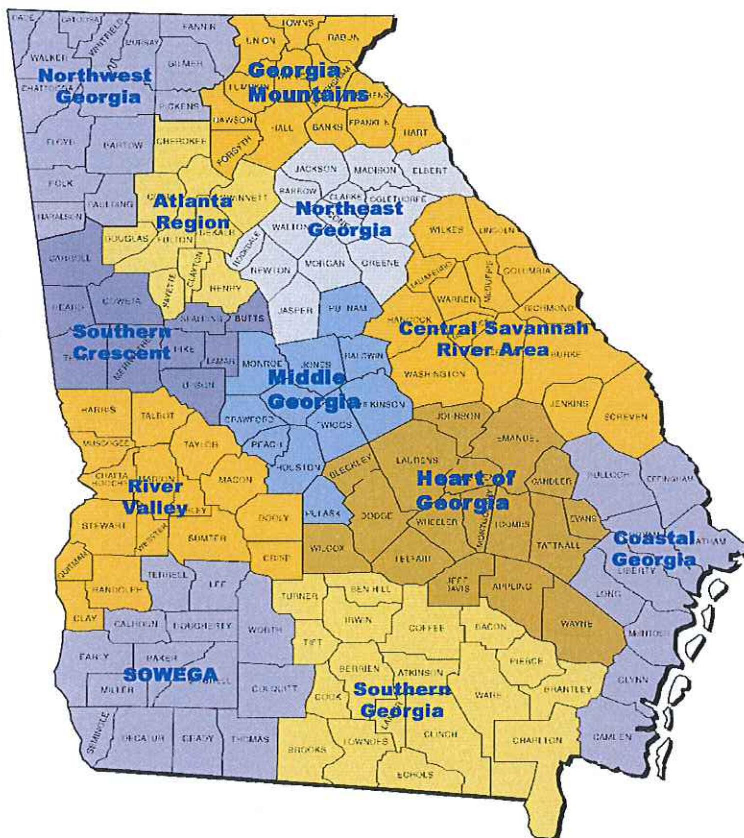
Aging and Disability Resource Connection (ADRC)

The Georgia Aging and Disability Resource Connection (ADRC) is a partnership between DHS/DAS and multiple organizations, including state agencies and other public or private organizations. The ADRC has expanded to a No Wrong Door system for resources and services for all populations and all payers. Counselors screen most callers to identify preferences and needs, using a database of more than 26,000 resources. Resources may be free, reduced-cost or private pay, depending on need and finances.

ADRC Partners

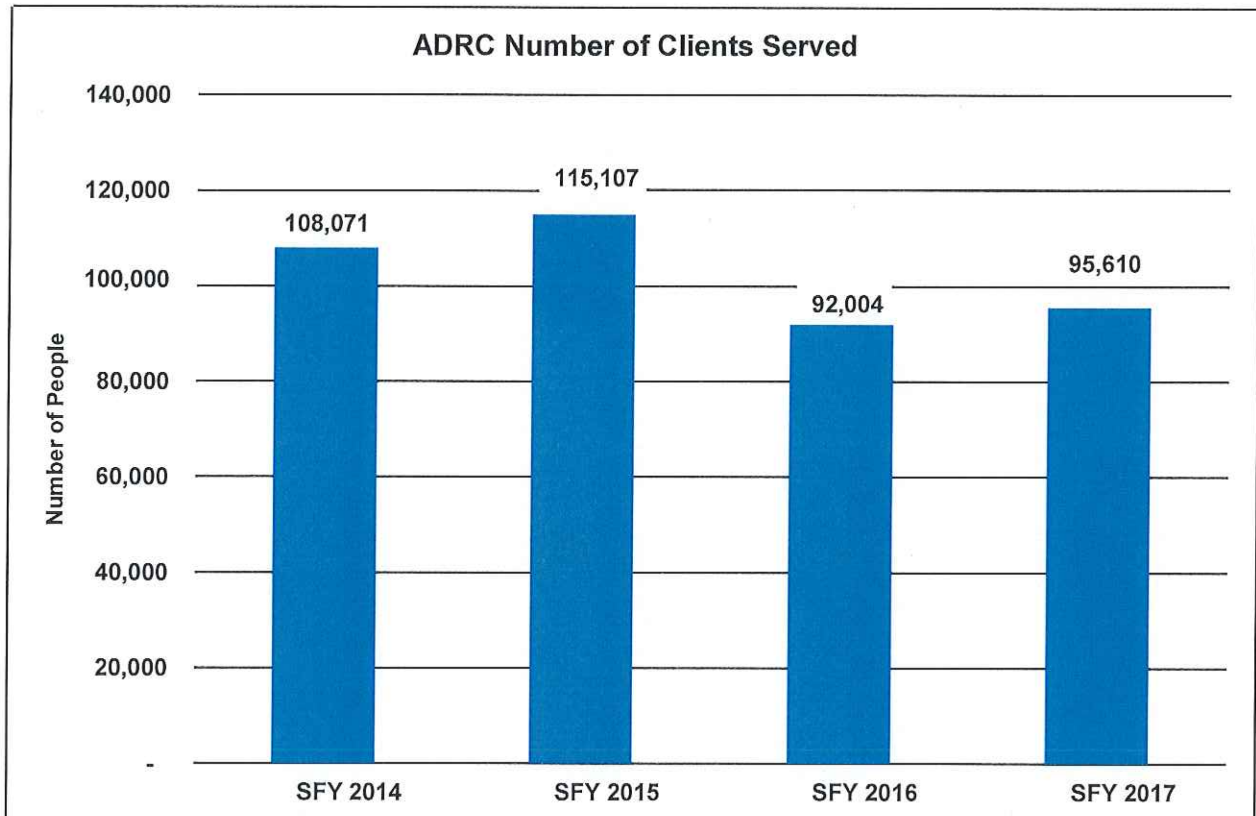
ADRCs have partnerships on the state and local level with agencies such as the DHS Division of Family and Children Services (DFCS), Department of Community Health, Office of the Long-Term Care Ombudsman, GeorgiaCares, Georgia Tech Tools for Life, the Alzheimer's Association, Centers for Independent Living, the Department of Public Health, the Brain and Spinal Injury Trust Fund Commission, the Georgia Hospital Association, the Georgia Council on Aging, and Adult Protective Services.

ADRC Regions



Information, Referral and Assistance

- In SFY 2017, the 12 ADRC sites served 72,617 older individuals looking for a variety of home and community-based services.
- Nearly 23,000 individuals with physical, developmental or behavioral disabilities contacted the ADRC in SFY 2017 seeking information about long-term care options.
- Combined, the ADRC sites served more than 95,610 clients seeking long-term care options for seniors and individuals with disabilities.



ADRC Options Counseling

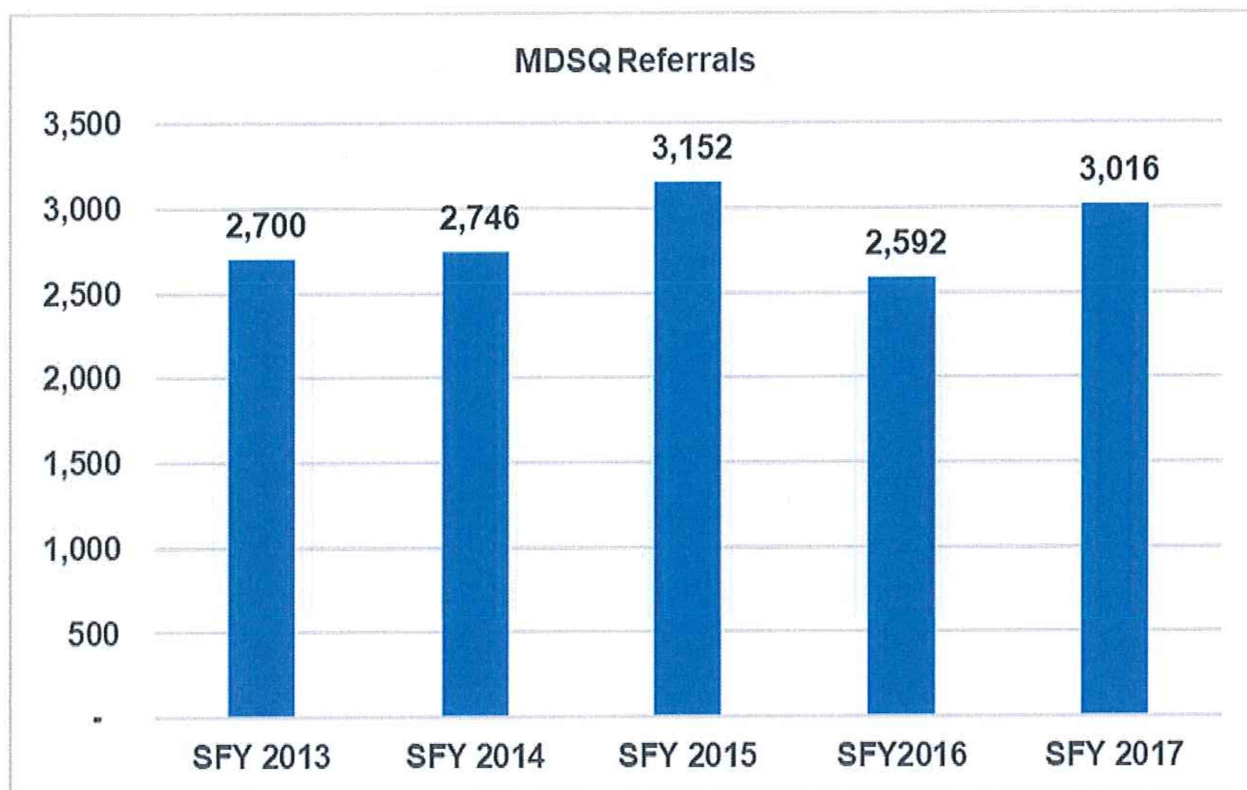
Options counseling is a person-centered, interactive, decision-support process for individuals who are considering long-term support. The process encourages choices made in the context of one's own

preferences, strengths and values. It includes developing action steps toward a goal or long-term services-and-support plan and, when requested, assistance with accessing support options, as well as follow-up. It is available to all regardless of income or financial assets.

In partnership with Boston University's Center for Aging and Disability Education Research, DHS/DAS has created a required Options Counseling Certification process. It includes six online courses, each worth 3 to 5 continuing education units, which are completed with a written and oral exam.

Two Categories of Options Counseling

- Minimum Data Set Section Q (MDSQ) Options Counseling: Each of the ADRCs has full-time staff designated as MDSQ Options Counselors to provide options counseling to individuals residing in nursing homes who have indicated an interest in potentially returning to the community to live. Georgia has approximately 360 nursing homes that participate in the Section Q referral process. (See chart below for SFY 2017 MDSQ referral data statewide).
- Community Options Counseling: Each of the ADRCs has staff dedicated as Community Options Counselors. These staff work with individuals still residing in the community who show a higher risk of institutional placement based on key risk factors identified through the Centers for Disease Control and Prevention (CDC). Community Options Counselors work with these individuals in a holistic manner to find ways to prolong community living.



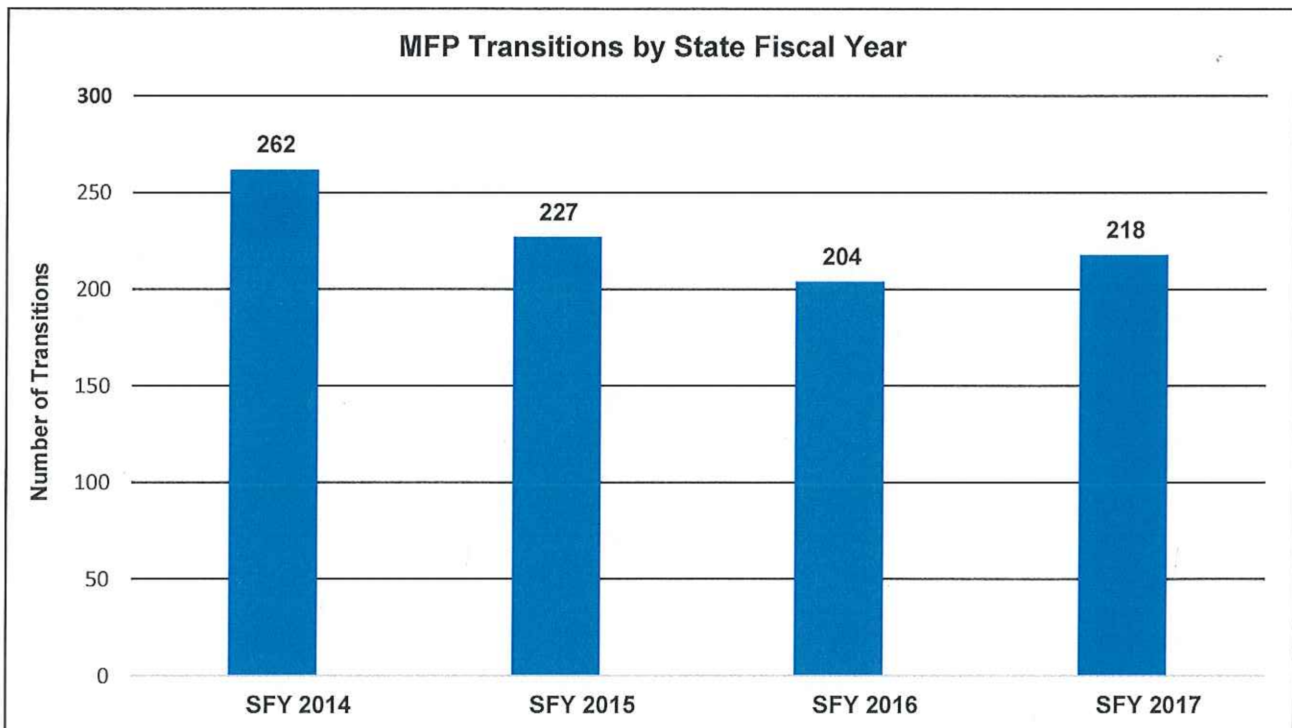
Money Follows the Person (MFP)

The purpose of the Money Follows the Person (MFP) Program, authorized by the 2005 Deficit Reduction Act, is to transition eligible individuals from long-term inpatient facilities back into community settings. The program, made possible by a demonstration grant through the Centers for Medicare and Medicaid Services (CMS), is administered in Georgia by the Department of Community Health (DCH). The first MFP transitions in Georgia occurred in 2008.

DCH currently partners with the Department of Behavioral Health and Developmental Disabilities (DBHDD) and DHS/DAS to execute the program statewide. DHS/DAS has been a part of MFP since July 2011.

MFP Transitions

DAS uses the AAAs to coordinate local transitions with 19 transitional coordinators across the state.



Accomplishments

MFP transitioned 218 participants in SFY 2017. This means 218 individuals have an opportunity to lead a more fulfilling life in a setting of their choosing.

Evaluation of the MFP program is done through a quality-of-life survey. This survey was developed for CMS by Mathematica Policy Research, which publishes yearly reports on the quality of the MFP program. Data is analyzed locally by the Georgia State University Health Policy Research Center. Currently, MFP participants in Georgia report that they are happier and more satisfied with their lives after leaving the nursing home. The survey is separated into seven major categories, and MFP participants indicate that they are more satisfied in nearly every category. Also, respondents who are contacted after their second year in the community report that they are happier and more able to see family and friends than they did prior to their transition. These results support the value that nursing home transitions provide to the state.

DHS/DAS and the AAAs have partnered with Centers for Independent Living (CILs) as the MFP transition coordination agents in their areas. CILs have performed nursing home transitions for many years, and their expertise has enhanced statewide capacity to provide MFP Transition Coordination.

The Departments of Community Affairs (DCA), Community Health (DCH), Behavioral Health and Developmental Disabilities (DBHDD), and DHS/DAS are partnering on three housing initiatives for individuals transitioning from long-term care facilities. Three voucher programs that provide housing subsidies in every Georgia county are targeted to the transitioning population, enabling them to have safe, affordable and accessible housing on the day they return home.

Nursing Home Transitions

The Nursing Home Transitions Program (NHT) was funded by the Legislature in 2017. These funds were designated to help individuals who are not eligible for the Money Follows the Person Program to transition from nursing homes to the community. To be eligible for NHT funds, individuals must be 55 years old or older, have lived in a nursing home for at least 30 days and have a barrier preventing their returning or staying at home.

AAAs and Centers for Independent Living (CIL) contract with DHS/DAS for transitions services. Some of the activities they administer include purchasing wheelchair ramps to make homes accessible, shower bars and chairs to make bathing safer and assistive technology to increase independence in bathing, dressing and meal preparation.

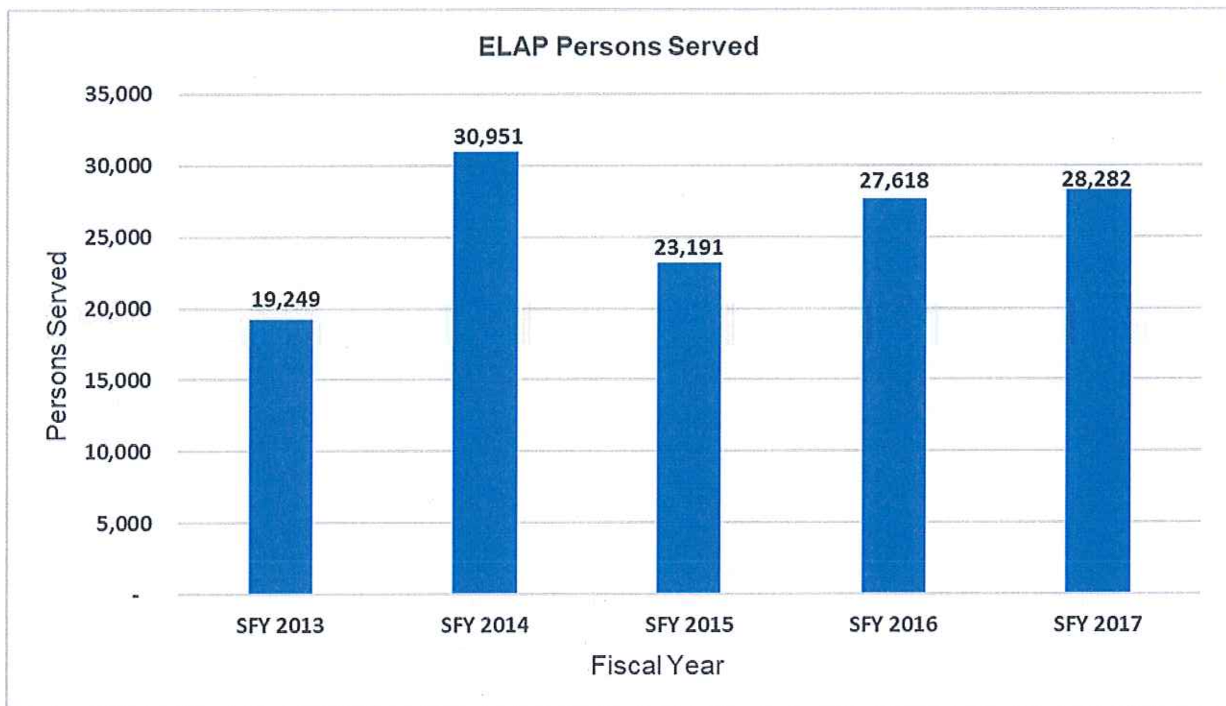
NHT transitioned 165 individuals who were living in nursing homes to community settings. This means these individuals can live in a less restrictive and less costly environment of their choosing. In addition to the 165 individuals transitioned, another 22 left nursing homes after receiving information about community resources but did not receive direct transition services.

Elderly Legal Assistance Program (ELAP)

The Georgia Elderly Legal Assistance Program (ELAP) serves people ages 60 and older by providing legal representation, information and education in civil legal matters throughout Georgia. Participating legal services providers contract with Georgia's 12 AAAs.

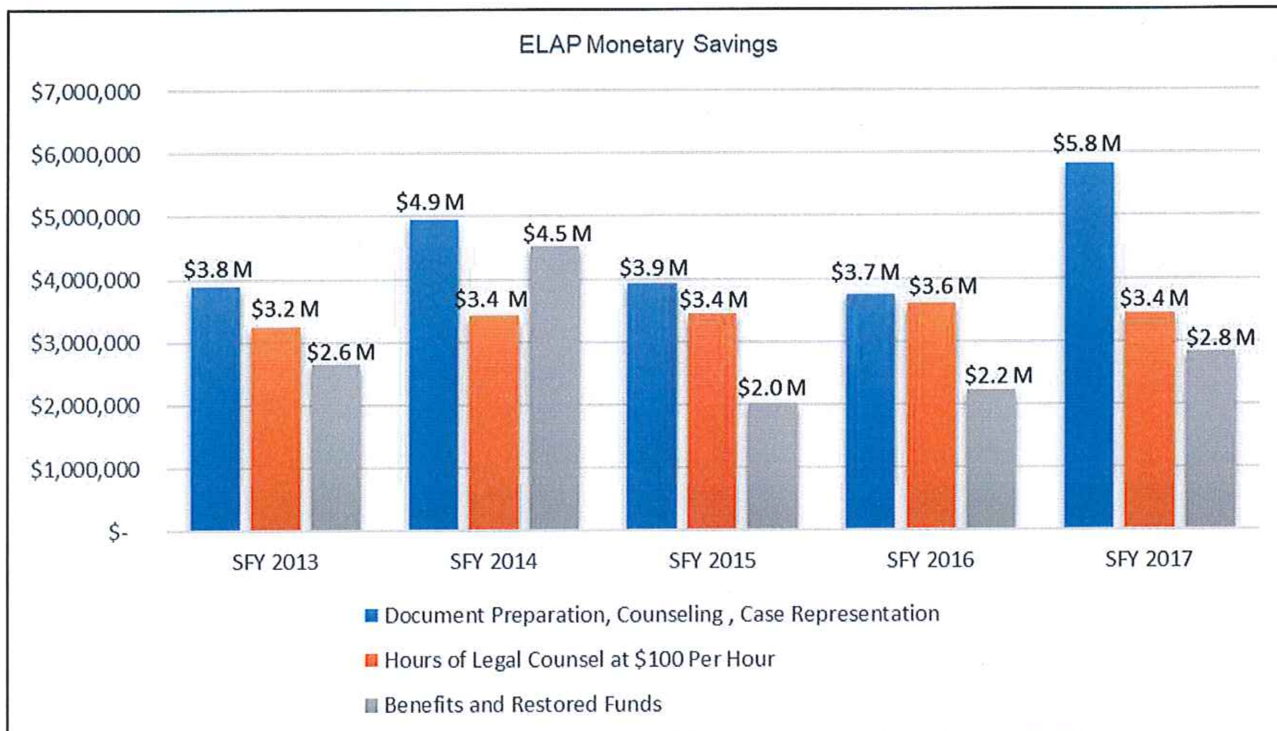
Persons Served

Legal representation, information and/or education was provided to more than 28,000 seniors during SFY 2017.



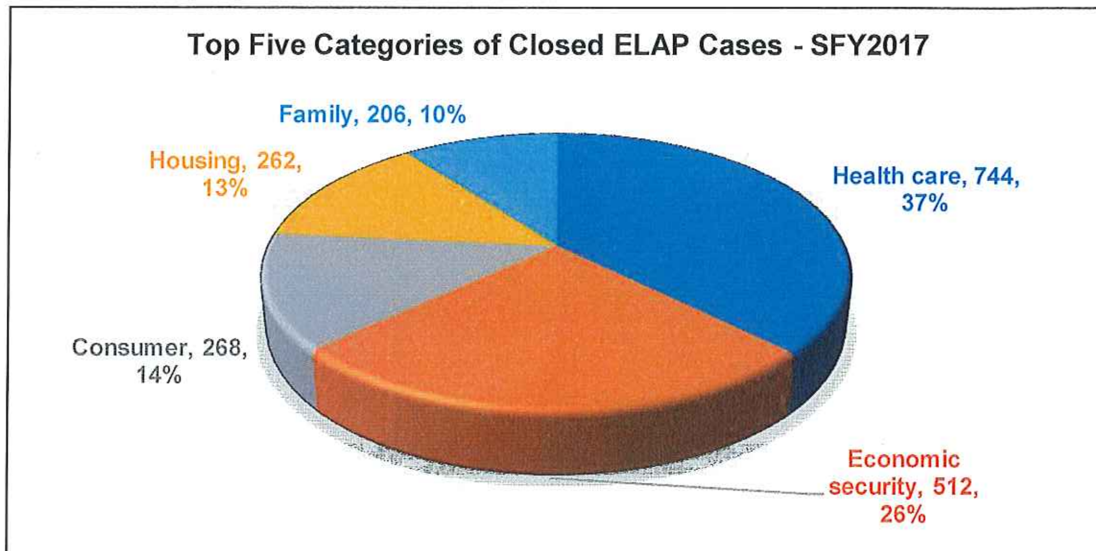
Monetary Benefits Realized

In SFY2017, ELAP saved older Georgians $12,102,234 by providing document preparation, legal counseling and case representation. Included in total savings was $3,448,100 obtained by providing approximately 34,481 hours of legal counseling, calculated at a conservative $100 per hour.



Top Five Primary Case Types Closed – SFY 2017

- **Health care** – Medicaid eligibility; nursing home Medicaid eligibility; qualified Medicare beneficiaries
- **Economic security** – Supplemental Nutrition Assistance Program (SNAP) / Food Stamps; Social Security and retirement; Low-Income Home Energy Assistance Program (LIHEAP) / public utility
- **Consumer** – Collections; contracts; bankruptcy / debt relief
- **Housing** – Homeowner/real property; mortgage foreclosure; other housing
- **Family** – Family violence temporary protective orders; guardianship of children; birth certificates



ELAP Community Education Offered

Community Education is a method of prevention that helps seniors avoid more costly, time consuming legal problems. In SFY 2017, 426 legal education sessions were conducted by ELAP.

The top eight topics covered in community education sessions in SFY 2017 were:

1. Medicare / Medigap / Part D
2. Consumer scams / fraud
3. Advance directives
4. Legal needs (ELAP, Georgia Legal Services Program, Senior Citizen Law Project)
5. Affordable Care Act / health care
6. Collections
7. SNAP / Food Stamps / medical deduction
8. Financial powers of attorney

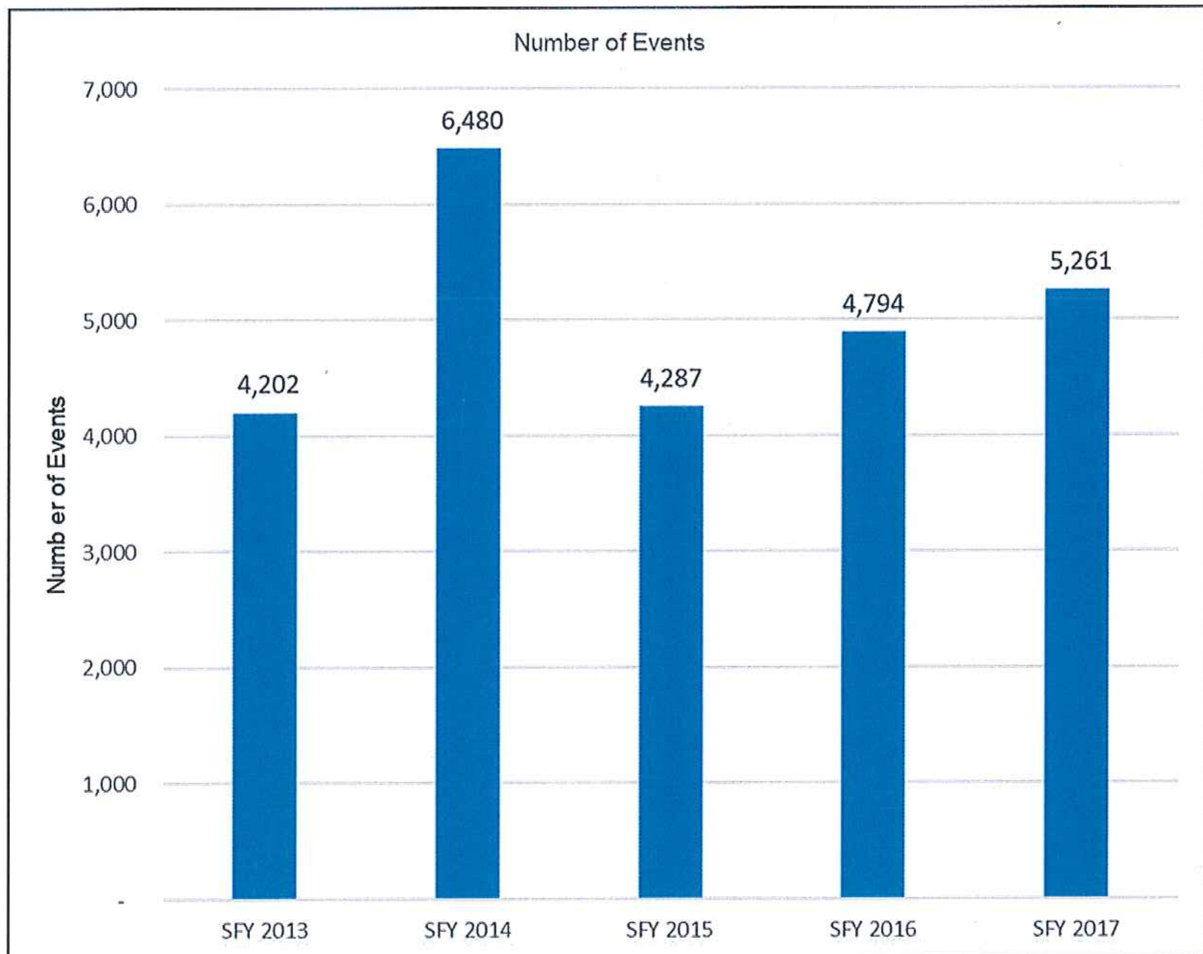
GeorgiaCares Program

GeorgiaCares is Georgia's State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP), with services available to Georgia's 1.5 million Medicare beneficiaries.

- GeorgiaCares SHIP is a volunteer-based program that provides free, unbiased and accurate information and assistance to Medicare beneficiaries and their caregivers with health and drug plans.
- GeorgiaCares SMP is a volunteer-based program to empower and assist Medicare beneficiaries, their families and caregivers to prevent, detect and report health care fraud, errors and abuse through outreach, counseling and education.

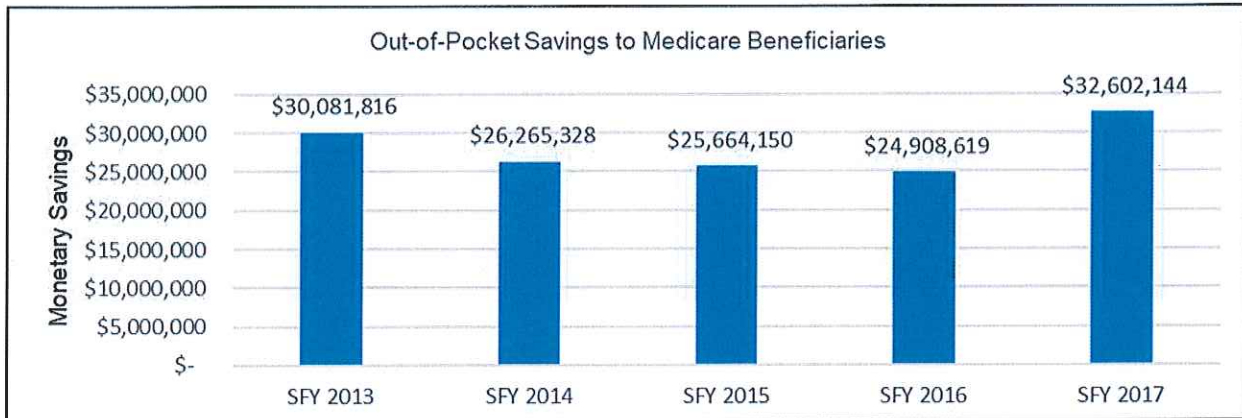
In SFY 2017, GeorgiaCares conducted a total of 5,261 outreach events and 1,271 media events (duplicative TV/cable, radio, newspaper viewership), reaching 11,152,199 individuals regarding health insurance information on Medicare, Medicaid, prescription assistance, Medigap, long-term care services and other health insurance needs, and Medicare fraud prevention.

In SFY 2017, 237 trained volunteers served Medicare beneficiaries and donated over 21,394 hours to counsel the public.



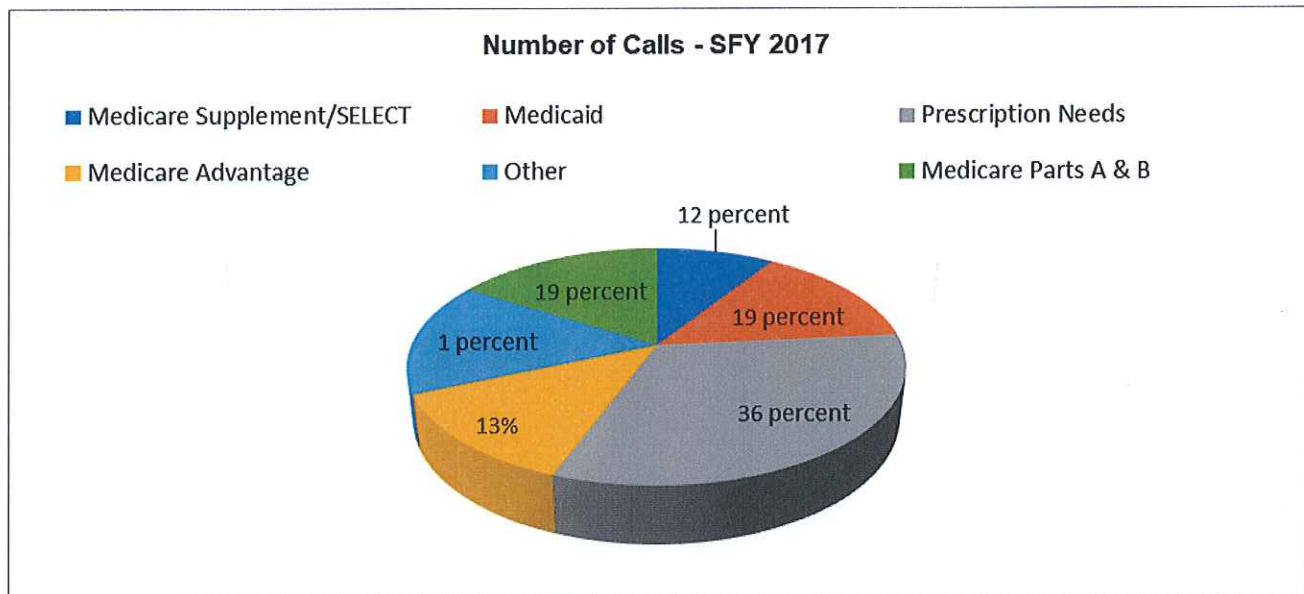
A total of 23,183 clients received one-on-one counseling on Medicare health and drug benefits, health care rights and protection, and help in applying for financial assistance programs.

In SFY 2017, GeorgiaCares saved beneficiaries $32,602,144 in out-of-pocket expenses.



Topics Discussed with GeorgiaCares Clients

In SFY 2017, 36 percent of GeorgiaCares calls dealt with Medicare beneficiaries needing prescription assistance through Medicare Part C, Part D, and patient assistance programs.



GeorgiaCares Program Highlights

- It is administered through DHS/DAS which, in turn, contracts with nine AAAs and the Georgia Legal Services Program to provide services locally.
- It has established 113 Off-Site Counseling Stations to assist Medicare beneficiaries, increased face-to-face contacts, and established community partnerships.
- In its sixth year of partnership with Fort Valley State University (FVSU), GeorgiaCares completed 12 joint outreach and education events for Medicare beneficiaries in hard-to-reach rural areas. FVSU's mobile technology unit is equipped with 20 computer stations with internet access, enabling GeorgiaCares counselors to complete customers' enrollment in Medicare health and drug plans and/or apply for money-saving programs.
- The monthly GeorgiaCares Referring Educating and Training News (G.R.E.A.T.) e-newsletter and Medicare Messenger publications provide information on Medicare, statewide outreach and enrollment events, and help Medicare beneficiaries identify health care scams.

Adult Protective Services (APS)

The Adult Protective Services (APS) Program is mandated under the Disabled Adults and Elder Persons Protection Act to address situations of domestic abuse, neglect or exploitation of persons with disabilities age of 18 and older, and elders over the age of 65 who are not residents of long-term care facilities. The purpose of the APS program is to investigate reports alleging abuse, neglect or exploitation and to prevent recurrence through the provision of protective services interventions.

Central Intake

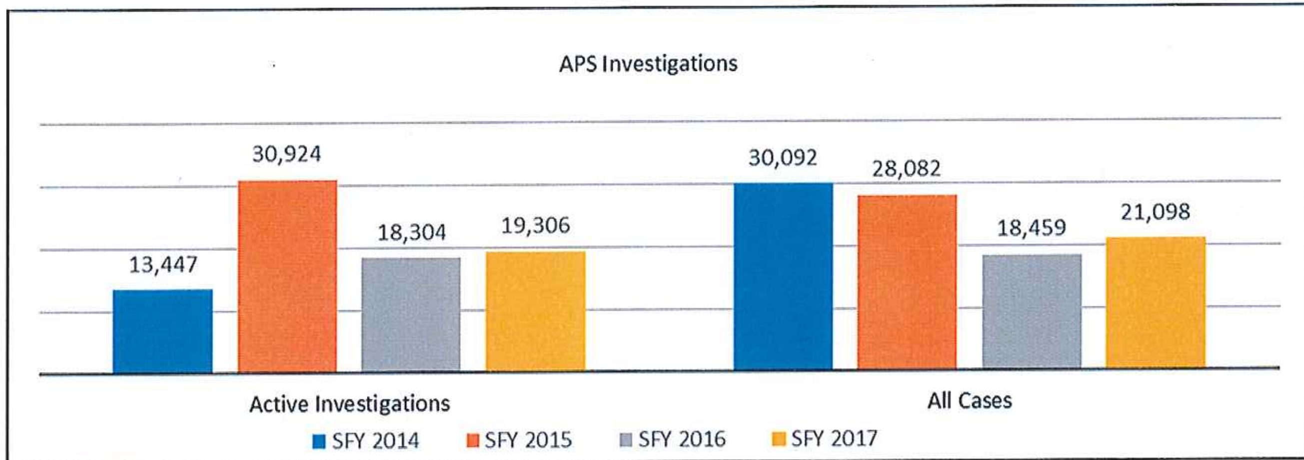
The APS Program receives reports of abuse, neglect and/or exploitation through its Central Intake Unit. Twelve APS Specialists handle calls through a statewide toll-free number (1-866-552-4464) and respond to fax- and web-based reports from the community to determine whether reports meet criteria for investigation. Central Intake staff also provide limited telephone case management and/or make referrals to community resources, including those in the aging network.

During SFY 2017, Central Intake staff received a total of 32,440 calls on the toll-free hotline, 4,544 faxed reports and 7,046 web reports.

- A total of 19,306 new reports were investigated.
- Central Intake staff provided limited case management intervention services on reports that did not meet APS criteria for investigation.
- The majority of the call volume managed by Central Intake consisted of handling information from reporters and coordinating referrals to community resources and other service providers to ensure callers' issues were addressed.
- APS averaged 3,291 active investigations during SFY 2017.

APS Field Operations

APS uses a regionally based, multidisciplinary approach to meet the needs of vulnerable disabled and senior adults in the State of Georgia. APS regions, which are aligned with the aging network planning and service areas, comprise three districts. Statewide, 155 APS case managers handle investigations as well as case management services.



APS Emergency Relocation Funds

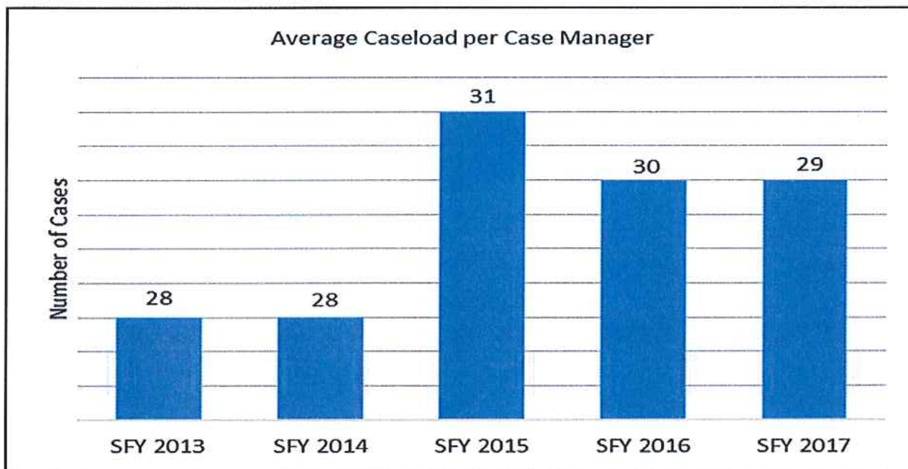
The APS program receives $400,000 each year from the Legislature to provide emergency relocation services (ERF) to individuals who need relocation from an abusive situation. ERFs can be used to relocate APS clients or DHS wards to safe places, or to provide for their needs in an emergency situation to allow them to remain at home.

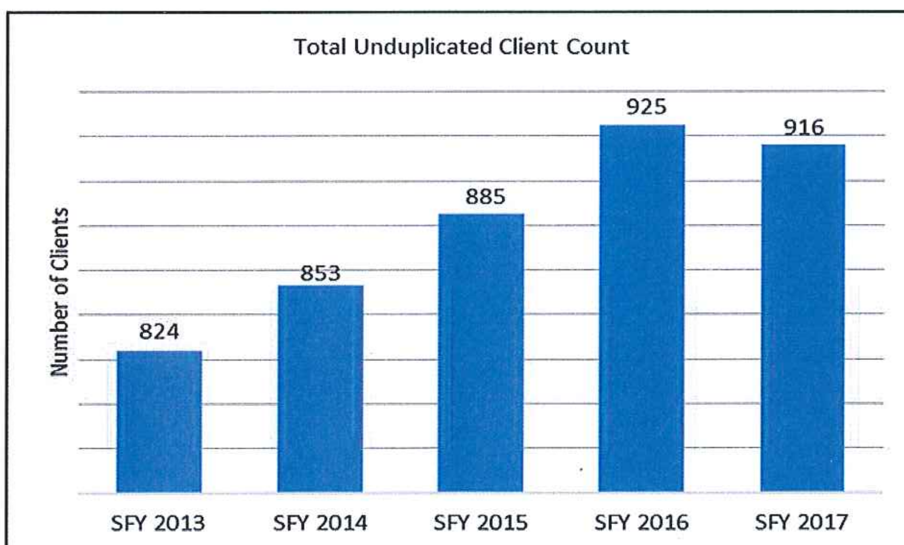
Public Guardianship Office (PGO)

When there is no willing or suitable person to act as guardian for an adult whom the probate court has determined lacks sufficient capacity to make or communicate significant responsible decisions concerning health or safety, DHS may be appointed as the guardian of last resort. The Public Guardianship Office (PGO) of DHS/DAS is assigned oversight and delivery of guardianship case management services on behalf of DHS.

Guardianship case managers act as surrogate decision-makers and advocates for persons under guardianship. They also coordinate and monitor all services needed for the support, care, education, health and welfare of guardianship clients. During SFY 2017, PGO managed 916 guardianship cases. PGO case managers average caseloads of 29 clients.

PGO, which is led by a program administrator and a field operations manager, is supported by a resource and training specialist and one program assistant. In addition, three supervisors manage a team of 34 case managers.





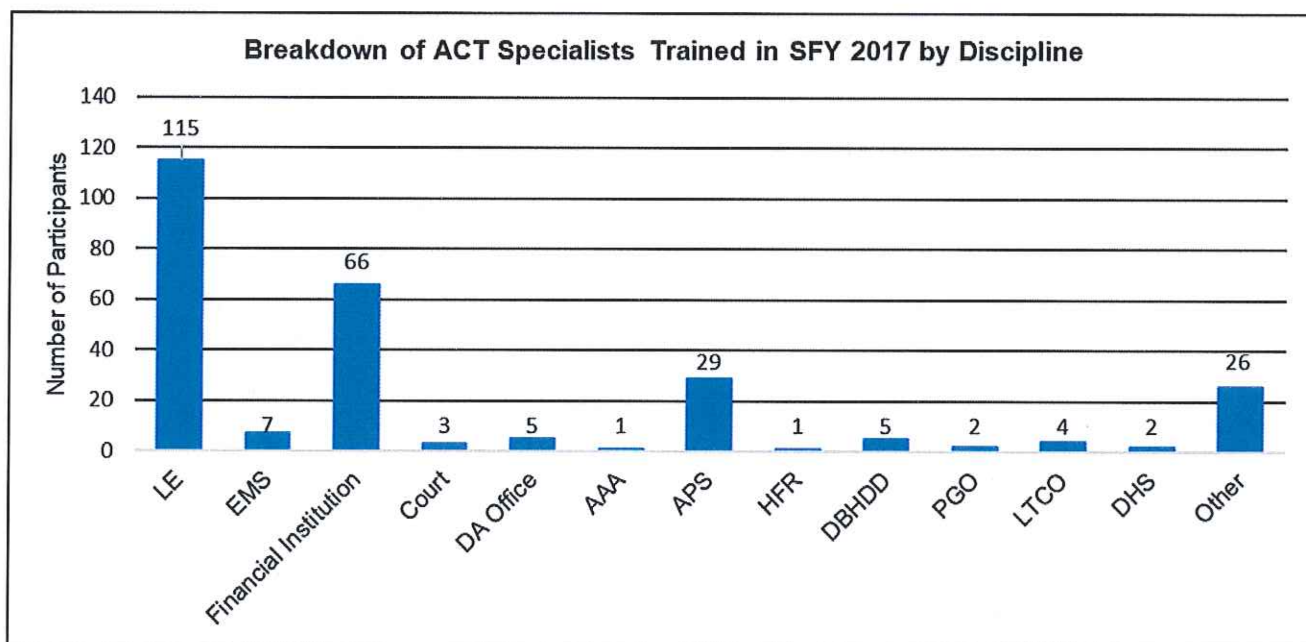
DHS/DAS is not authorized by law to serve as a conservator of adults or as a temporary medical consent guardian.

Forensic Special Initiatives Unit (FSIU)

The Forensic Special Initiatives Unit (FSIU) provides support to DHS/DAS and other partners by identifying and addressing system gaps and developing process improvements to protect Georgia's at-risk adults from abuse, neglect and exploitation. Some of the services provided by FSIU include training, outreach, technical assistance, and case consultation and review.

FSIU Program Accomplishments for SFY 2017

- In April 2011, FSIU deployed the At-Risk Adult Crime Tactics (ACT) Certification training program. ACT provides participants with basic knowledge and skills needed to respond to crimes involving the abuse, neglect and exploitation of older adults and adults with disabilities. During SFY 2017, 267 participants became certified ACT Specialists. A breakdown of ACT Specialists certified during SFY 2017 by professional discipline is presented in the chart below.



Definition of Acronyms: LE- Law Enforcement, EMS - Emergency Medical Services, DA Office – District Attorney's Office, AAA – Area Agency on Aging, APS - Adult Protective Services, HFR - Healthcare Facility Regulation DBHDD – Department of Behavioral Health Developmental Disabilities, PGO - Public Guardianship LTCO - Long Term Care Ombudsman, DHS - Department of Human Services

- At-risk adult abuse, neglect and exploitation training/outreach was provided to 5,130 people through the Georgia Banker's Association, Emory School of Nursing, Georgia Public Safety Training, the Georgia Retailers Association Conference, the Victim Witness Assistance Program Conference and others. People trained included law enforcement officers, judges, prosecutors, medical examiners/coroners, financial service employees, social workers, long-term care providers, allied professionals and the general public. Videos available on the DAS YouTube channel continue to be viewed across the state.

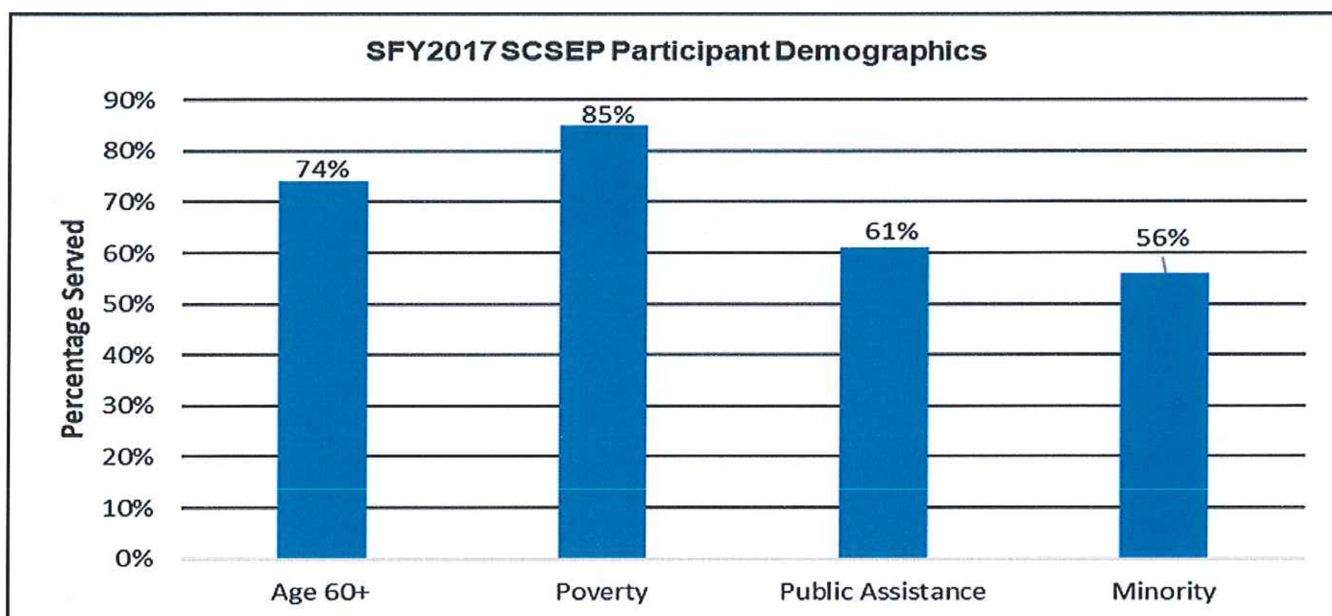
- Technical assistance and case reviews were provided to more than 198 people. As a result of training, technical assistance and case consultation/review, FSIU has been able to track outcomes of several law enforcement cases during SFY 2017. Of these cases, individuals were charged and/or prosecuted with various crimes, including exploitation and intimidation of a disabled adult, elder person or resident; operating an unlicensed personal care home; false imprisonment; financial transaction card fraud; identity theft; unauthorized use of a financial card; criminal receipt of goods and services fraudulently obtained, and forgery. In addition to these cases, FSIU has received numerous communications from law enforcement and other professionals crediting ACT training for assisting in cases. FSIU continues to request specific case outcomes to track the increase in these cases.

- FSIU has presented at local and national conferences on the issue of unlicensed care homes and benefits trafficking. These presentations have resulted in ongoing case assistance on unlicensed care home cases.

The Senior Community Service Employment Program (SCSEP)

The Senior Community Service Employment Program (SCSEP) provides useful part-time community service assignments and training for unemployed, low-income older Georgians, and helps them obtain paid employment. While participants develop job-related skills and earn minimum wage, the community directly benefits from the work they perform.

Persons Served:



- Although participants can be as young as 55 years of age, 74 percent were over the age of 60.
- 85 percent had incomes below the federal poverty level.
- 60 percent were receiving public assistance.
- 56 percent were minorities, compared with 44 percent nationally.

Some Outstanding Accomplishments

The U.S. Department of Labor (DOL) establishes indicators for each state to measure SCSEP program performance. The performance indicators measure six performance categories. In Program Year 2016*, Georgia exceeded or came close to achieving the following DOL targets. *(*Program Year and SFY run on the same period, but the official year number lags.)*

- **Community Service Goal:** This measure reports the number of hours of community service provided by the SCSEP program. For Program Year (PY) 2016, the DOL target goal for Georgia was 77.8 percent (participants should provide a minimum of 75 percent of the total community

services hours funded by the DOL for Georgia). This goal was not computed for PY 2016 due to a change in the modified positions that were revised in the middle of the third quarter of PY 2016 to reflect 1) the awards made to national grantees by the 2016 competition and 2) revisions to the Equitable Distribution based on the latest Census data.

- **Entered Employment Goal:** This measure reports the rate of participants who exit the program because they obtained employment, compared with those who exited for other reasons. The DOL target rate for Georgia for PY 2016 was 45.3 percent (38.4 percent of all participants who exit the program did so because they became employed). Georgia did not reach this goal but is within 80 percent of the target.

- **Employment Retention Rate Goal:** This measure reports the rate of participants who retain employment for at least six months after their work start date. The DOL target goal was 66.9 percent (66.9 percent of all participants who found employment in a given quarter retained their employment for at least six more months). Georgia exceeded this goal, achieving 69.4 percent employment retention rate.

- **Service Level Goal:** The service level goal shows the percent of enrollment in Georgia's 198 authorized SCSEP positions for PY 2016. The DOL goal for Georgia was 151.8 percent enrollment. This goal was not computed for the same reason that was indicated in the Entered Employment section.

- **Earnings Goal:** DOL sets this goal to determine the average earnings of participants who enter and retain employment for three quarters after their exit. The DOL average earnings goal for Georgia for PY 2016 was $7,500. Georgia's average earnings of $6,895 fell short of the goal.

- **Most-In-Need Goal:** The most-in-need measure reflects the average number of employment barriers a participant faces, such as disability, veteran status, age 65 or older, limited English proficiency, or low literacy skills. DOL requires that participants with these employment barriers be given priority as "most-in-need" participants. Georgia achieved an average number of 2.51 barriers, which fell short of the DOL goal of 2.78 barriers.

Community Benefits

Participants' training wages contribute to the local economy and reduce their dependence on public benefits programs. Participants provided 164,470 hours of service to community organizations, including 55,628 hours of service to organizations that serve older adults. Three percent of PY 2016 participants were individuals with disabilities, and 21 percent were homeless or at risk of homelessness at time of enrollment.

Directions for the Future

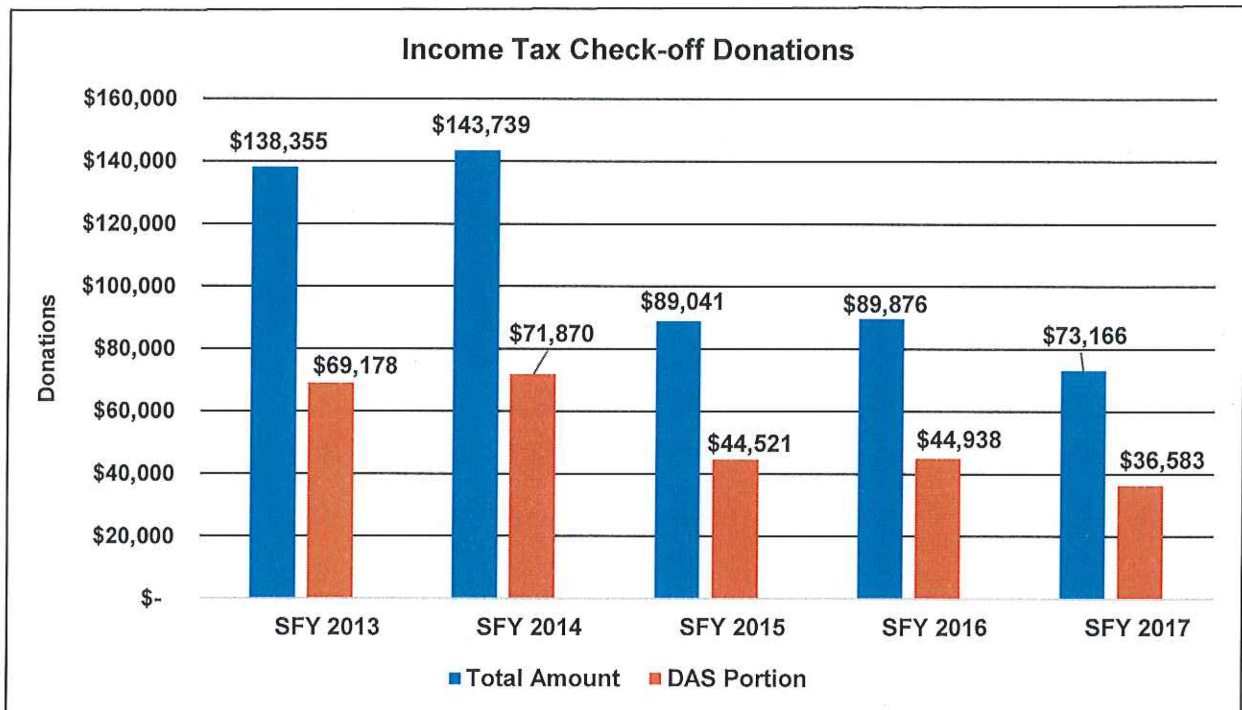
DHS/DAS, SCSEP grantees and sub-projects will undertake the following strategies to improve SCSEP services:

- SCSEP grantees and sub-projects will identify agencies that can provide technical assistance to SCSEP projects about entrepreneurship and microenterprises.
- DHS/DAS will provide intensive training and technical assistance to SCSEP staff about specific core performance goals, tools to diagnose performance, and strategies to improve performance.
- SCSEP grantees and sub-projects will identify agencies and organizations to implement area specific outreach and recruitment methods to increase services to underserved populations, such as: Hispanic/Latino, Asian and Veteran older adults.

Georgia Fund for Children and Elderly

DHS/DAS co-administers the fund with the Department of Public Health's Maternal and Child Health Program Division. DHS/DAS receives 50 percent of the Fund's donations each year, and those monies are distributed to AAAs for home-delivered meals and senior transportation, as mandated by the Legislature. The remaining 50 percent is allotted to the Department of Public Health to provide grants for programs that serve children and youth with special needs.

Income tax check-off donations received between calendar years/income tax years 2013 and 2017 are shown below.



Georgia State Plan to Address Senior Hunger

Georgia Department of Human Services

Division Of Aging Services

December 18, 2017

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Executive Summary

Food insecurity is influenced by multiple factors and impacts a person's health, well-being, and quality of life. A 2016 report places Georgia ninth in the nation for the prevalence of food insecurity among people ages 60 and older. The number of older adults in Georgia who currently face the threat of hunger is more than 300,000.

> Georgia defines food insecurity as a person or household facing the threat of hunger, lacking safe and adequate food to sustain health and quality of life, and unsure of the accessibility of or the capability to obtain suitable foods in socially acceptable ways.

Good nutrition is a key factor for older adults to maintain well-being and an independent, healthy lifestyle, and in recovering from an illness or an injury. Reasonably priced, wholesome foods are not always accessible to older adults because of the lack of transportation, health problems and disabilities, and the lack of food stores within close proximity for shopping. One-third of Georgia is a food desert, which makes it problematic for older adults living in these areas to obtain fresh, nutrient-dense food.

The projected growth of older adults aged 65 and over in Georgia is expected to increase 17% by 2032. This rate of growth will push the state's older adult population to over 2 million, which will place the prevalence of food insecurity at more than 360,000 people if the state maintains its current 17.8% growth in older adults facing the threat of hunger. Food insecurity increases negative health outcomes by contributing to and exacerbating disease conditions, and increases medical costs and hospitalizations.

This issue is worthy of attention considering 80% of older adults have at least one chronic disease and 68% have at least two. A person who is not eating a balanced diet with the recommended amounts of calories, protein and essential micronutrients is at a greater risk of

malnutrition, especially if the person has a chronic disease. Adequate nutrition and physical activity are well-documented in the role of the prevention and management of chronic health conditions and malnutrition.

Five areas of impact are selected to address and remedy food insecurity issues in Georgia. These areas are: a) Today's Seniors, b) Health Impact of Senior Hunger, c) Food Access, d) Food Waste and Reclamation, and e) Meeting the Community's Needs. Changing the direction of food insecurity in Georgia requires the coordination, cooperation and communication of health care professionals, faith-based and civic groups, communities, government and other resources all working together for the common good of the state's older adult population.

Glossary

Activities of Daily Living (ADLs): Basic activities of daily living refer to those activities and behaviors that are the most fundamental self-care activities to perform and are an indication of whether the person can care for one's own physical needs. The activities and behaviors are; eating, bathing, grooming, dressing, transfer in and out of a bed/chair, and bowel/bladder continence. (Determination of Need-Revised (DON-R) Training Manual 1998 Georgia Training and Deployment)

Chronic health condition: Those conditions lasting a year or more and requiring ongoing medical attention or limiting activities of daily living. (National Blueprint: Achieving Quality Malnutrition Care for Older Adults, p. 10)

Comorbidities: The simultaneous presence of two or more chronic medical conditions or diseases that are additional to the initial diagnosis (Mosby's Medical Dictionary)

Cost-related medication nonadherence: Taking less medication than prescribed by a health care professional due to cost (Bengle, *et al,* 2010, p. 171)

Disability: A disability attributable to a mental and/or physical impairment that results in substantial functional limitation in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, cognitive functioning, and emotional adjustment. (Older Americans Act, Section 102(8))

Food bank: A nonprofit, charitable organization that collects donated or surplus foodstuffs and distributes it free or at a low cost to programs or organizations that are serving people in need of assistance. (Compilation of e-dictionaries)

Food desert: a neighborhood or rural town that lacks access to fresh, healthy and reasonably priced food or in which food sources are not within a reasonable proximity to the resident's home.

Food insecurity (United States Department of Agriculture [USDA]): "Food insecurity is a household-level economic and social condition of limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways." (Economic Research Service of the USDA)

Food insecurity (Georgia's working definition): A person or household is considered food insecure when facing the threat of hunger and lacking safe and adequate food to sustain health and quality of life, and is unsure of access or the capability to obtain suitable foods in socially acceptable ways.

Hunger: "Hunger is an individual-level physiological condition that may result from food insecurity. It refers to a potential consequence of food insecurity that, because of prolonged, involuntary lack of food, results in discomfort, illness, weakness, or pain that goes beyond the usual uneasy sensation." (Economic Research Service of the USDA)

Instrumental Activities of Daily Living (IADL): The more complex activities associated with daily life, which are essential to being able to live independently in the community. The IADLs include; managing money, telephoning, preparing meals, laundry, housework, outside home,

routine health, special health and being alone. (Determination of Need-Revised (DON-R) Training Manual 1998 Georgia Training and Deployment)

Malnutrition: A state of deficit, excess, or imbalance in energy, protein or nutrients that adversely impacts an individual's own body form, function, and clinical outcomes. (National Blueprint: Achieving Quality Malnutrition Care for Older Adults)

Obesity: $\geq$ 30 BMI. Weight that is higher than what is considered healthy for a given height is described as overweight or obese. Body Mass Index, or BMI, is used as a screening tool for overweight or obesity. It is not an indicator of a person's overall health. (CDC.gov)

Quality of Life (QoL): The degree to which a person is able to function at a usual level of activity without -- or with minimal -- compromise of routine activities; QoL reflects overall enjoyment of life, sense of well-being, freedom from disease symptoms, comfort and ability to pursue daily activities. (McGraw-Hill Concise Dictionary of Modern Medicine, 2009)

Seniors/Older Adults: Individuals who are aged 60 years of more are considered older adults for the majority of Older American's Act programs. However, some programs begin this designation at 55 and others at 65. For the purpose of the Georgia Senior Hunger State Plan, 60 years old or older is the designation.

Undernutrition: A form of malnutrition characterized by a lack of adequate calories, protein or other nutrients needed for tissue maintenance and repair.

Brief National Overview of Senior Hunger

Growth of older adult population and most common health conditions

It is well-documented that the U.S. population is aging in greater numbers than ever before in history. By the year 2030, the number of adults age 65 and older is expected to reach 74 million (Avalere & Defeat Malnutrition, 2017). (See Appendix I)

The older adult population is projected to reach 82.3 million (21.7% of the total population) by the year 2040 (Administration for Community Living [ACL], 2016, p. 6). (See Appendix II)

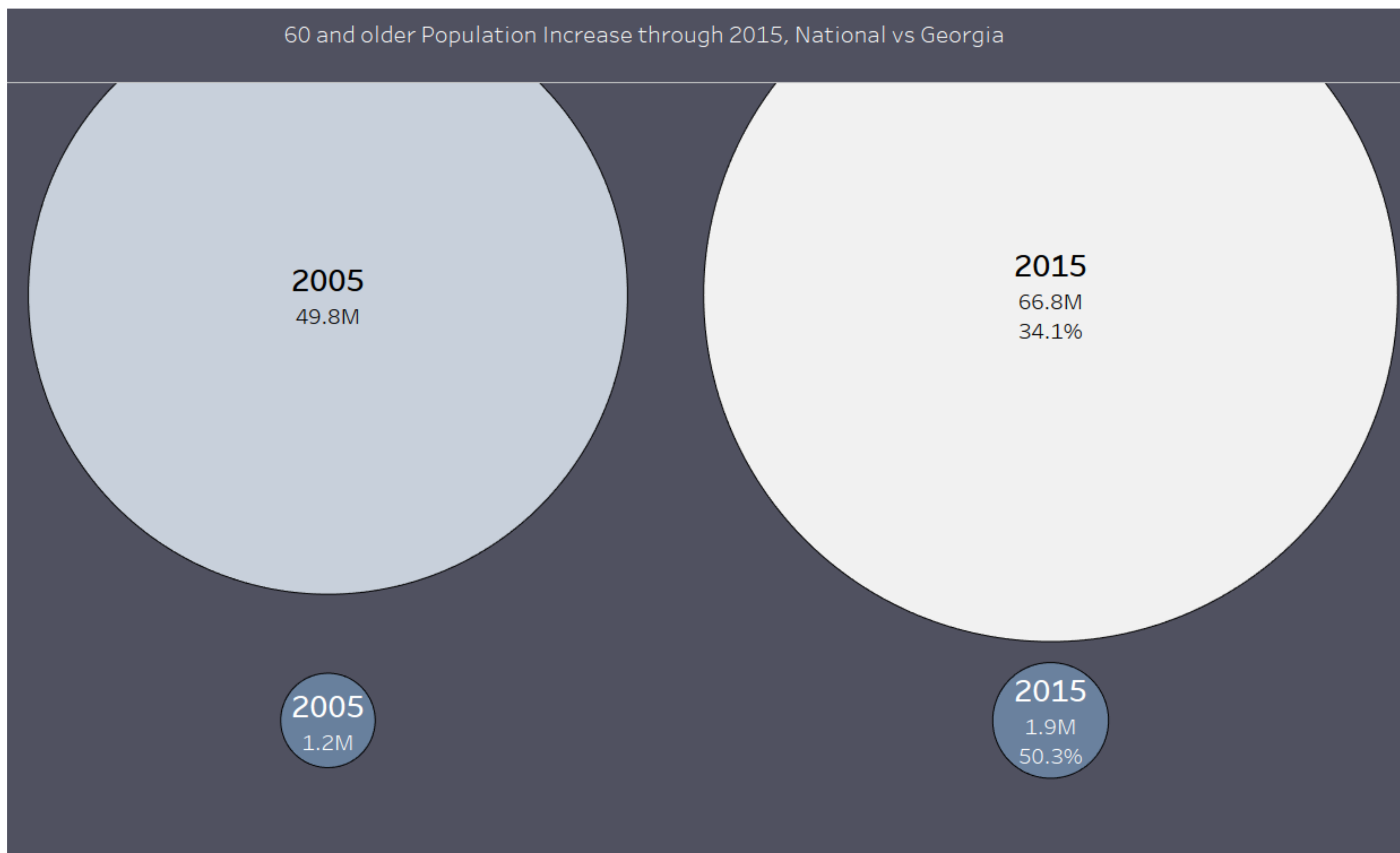
The report compiled by ACL, “A Profile of Older Americans: 2016,” provides the following data regarding the growth of the older adult population in the United States:

- About 1 in 7 -- or 14.9% -- of Americans are age 60 or older.
- Between 2005 and 2015, this population increased 34% -- from 49.8 million to 66.8 million. It is projected to be 98 million by 2060. (See Figure 1)
- The number of Americans age 45 to 64 who will reach 65 over the next two decades increased by 14.9% between 2005 and 2015.
- Adults reaching age 65 have an average life expectancy of an additional 19.4 years (20.6 years for women and 18 years for men.)

This change in demographics is noteworthy, considering that most older adults have at least one chronic health problem, and many have multiple health conditions. The 2016 Profile shows that seniors spend a larger proportion (12.9%) of their total expenditures on personal health care compared with other age groups. A compilation of data and reports indicate the health problems frequently increased when coupled with food insecurity in the older adult population are:

- Depression (233%)
- Hypertension (Men 72%, Women 80%)
- Diabetes (22%)
- Any cancer (32%),

Figure 1



Profile of Older Americans: 2016, Administration on Community Living (ACL) (See Appendix 2)

- Diagnosed arthritis (53%)
- All types of heart disease (35%)
- Limitations in activities of daily living (32%)
- Asthma (2%),
- Poor gum health (68%)
- Malnutrition (46%)

(ACL, 2016; Centers for Disease Control and Prevention [CDC], 2016; Kaiser et al., 2010; Ziliak & Gundersen, 2014)

The prevalence of food insecurity exacerbates these health problems. Food insecurity has been linked to inadequate nutrition and worsening of disease. Seniors with low intake of calories, protein and essential micronutrients are at a greater risk for an increase in osteoporosis, infections, an undesirable weight, restricted physical activity, cognitive impairment and malnutrition. The lack of adequate nutrition negatively affects diseases that can be effectively managed with diet and medication, and it may lead to unforeseen health crises. Heart disease, high blood pressure and diabetes are examples of conditions that can be managed with balanced diet and appropriate medication.

Food insecurity often leads to undesirable behaviors such as medication nonadherence, which in turn may lead to early hospital readmission and extended hospital stays. Food insecurity potentially has greater consequences for older adults when health status and disease are considered. Authorities on healthy lifestyle choices recognize and support the role that nutrition and physical activity play in the management and prevention of chronic health conditions and malnutrition.

Impact of food insecurity on individual health and health care system

Prior to 1995, the terms hunger, poverty and unemployment were used interchangeably in public policy and public health discussions even though they addressed different problems. The Task Force on Food Assistance appointed in 1983 by President Ronald Reagan concluded that hunger referred to the physiological condition and was separate and distinct from food insecurity. The current standardized measure of food insecurity was developed in 1995 and is

used in official publications and most other research on this topic. The Economic Research Service (ERS) of the U.S. Department of Agriculture (USDA) defines hunger and food insecurity as follows:

> *Hunger* is an individual-level physiological condition that may result from food insecurity. It refers to a potential consequence of food insecurity that, because of prolonged, involuntary lack of food, results in discomfort, illness, weakness or pain that goes beyond the usual uneasy sensation. (ERS USDA)

> *Food insecurity* is a household-level economic and social condition of limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. (ERS USDA)

The number of seniors experiencing food insecurity in 2016 exceeded 15%, more than 10 million people. This was 600,000 more people than in 2013, according to the June 2016 annual report, “Hunger in America in the Senior Population,” prepared for NFESH (Ziliak & Gundersen, 2016). (See Appendix IV)

Households with limited resources and food insecurity are forced to choose between the basic necessities of food, housing, medical care and medications. Routine visits to the doctor may be postponed until the individual is in a health crisis, and must therefore be seen in acute care or the emergency room, or potentially is admitted to the hospital. Cost-related medication nonadherence behaviors, such as skipping or reducing doses, delaying medication refills or avoiding filling new prescriptions, can lead to a health crisis for an individual and the exacerbation of disease. These situations result in detrimental health consequences and an increase in health care costs, which place an increased burden on the health care system. The costs associated with food insecurity warrant examination considering three-fourths of people

age 65 or older have a chronic health condition (Avalere & Defeat Malnutrition Today, 2017).

(See Appendix I, p.10)

Food Insecurity National Demographics

Research has identified multiple risk factors associated with senior food insecurity. These include: race, ethnicity, employment status, age, gender, metropolitan versus non-metropolitan, income, having a disability, and marital status. Older adults who live alone are at a greater risk for food insecurity. Reports indicate that at least 1.2 million seniors in the U.S live alone. The possibility of an older adult being food insecure increases when the person lives in a rural area. A grandchild living in the household with an older adult increases food insecurity to more than twice that of a household without a grandchild, because the grandchild is given priority for having food. Ziliak and Gundersen’s 2014 report revealed that food insecurity among people between ages 60 and 64 are approximately 50% higher than those over age 80. Seniors living in the South and the Southwest are consistently at greater risk for food insecurity. Food insecurity is shown to be 8.3% when at least one member of the household is age 65. Racial or ethnic minorities, people with a high school education or less, households with lower incomes and people with a disability are most likely at risk to be food insecure. However, Ziliak and Gundersen’s 2016 report reveals that food insecurity also occurs in households with incomes above the poverty line and is present in all races.

Senior Hunger in Georgia

The 2017 Ziliak and Gundersen report “The State of Senior Hunger in America 2015” places Georgia as tenth in the nation for the prevalence of a threat of hunger in older adults. This report compares aspects of hunger and food insecurity across the nation. It has been produced annually in partnership with the National Foundation to End Senior Hunger since 2008. (See Appendix IV, p. 6) Georgia considers food insecurity a priority for current and future public health at large, program developers, health care professionals and policy makers. The state recognizes the consequences of food insecurity and is developing a state plan to end senior hunger in Georgia. At the initiation of this project Georgia was ranked ninth in the nation (Ziliak and Gunderson 2016)

Georgia Senior Hunger Initiative Definitions: Food Insecurity and Seniors

The USDA food insecurity definition is just one of many in use by various agencies and organizations. Here is how the Georgia Senior Hunger initiative defines food insecurity:

> A person or household is considered food insecure when facing the threat of hunger and lacking safe and adequate food to sustain health and quality of life, and is unsure of access or the capability to obtain suitable foods in socially acceptable ways.

NFESH annual reports characterize food insecurity into the following categories:

- Fully food secure
- Threat of hunger
- Risk of hunger
- Facing hunger

The category of food insecurity in a household is determined by the number of affirmative responses to questions on the Core Food Insecurity Module (CFSM). (See Appendix IV, p. 3)

The CFSM is considered the standard tool for measuring household food insecurity rates. Georgia utilizes the CFSM 6-item battery of questions. (See Appendix V). For example, a person who answers yes to one or more questions on the CFSM is in the marginally food insecure category of facing the threat of hunger. Georgia defines the terms "senior" and "older adult" as age 60 and over and uses the threat of hunger throughout the proposed Georgia Senior Hunger plan to designate a person food insecure.

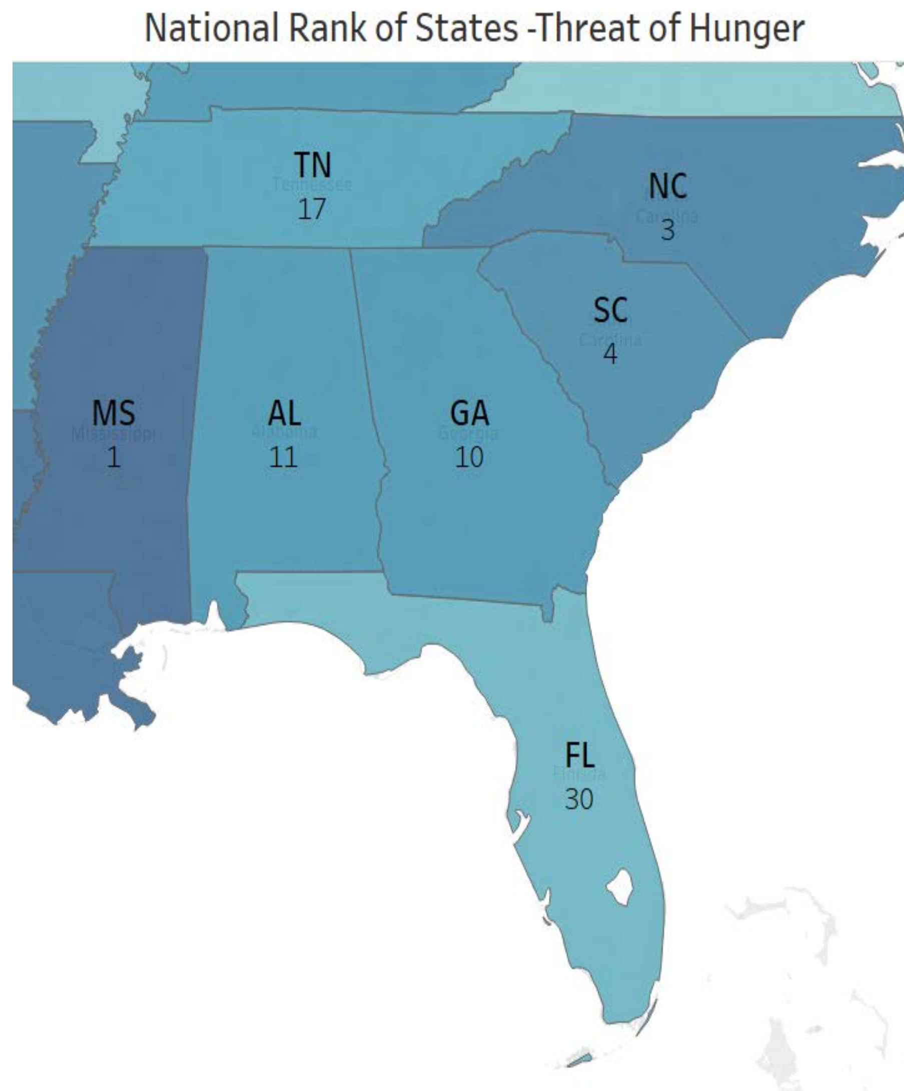
Georgia's Senior Population and Food Insecurity

Georgia currently ranks fourth in growth rate of older adults age 65 and older when comparing the state's population in 2010 with 2015 based on the Census Bureau American Community Survey data. Utilizing the same data source, the projected growth of the same demographic group is 17% by 2032 and 18.9% by 2050. The 2009 Ziliak and Gundersen report that examined hunger in rural and urban areas on behalf of the Meals on Wheels Association of America Foundation (MOWAAF), revealed Georgia as one of the top five Southern states with the highest average rates of food insecurity over a six-year data collection time-period (2001 to 2007). (See Appendix VI, p. 21) (See Figure 2)

When compared nationally with other states in 2015, Georgia's 65-and-older population ranked 14th (9.7%) in poverty, 17th (36.5%) in 65-and-older individuals with at least one disability, and sixth (7%) for 60-and-older grandparents living with grandchildren.

Three risk factors for food insecurity are: low income, disability, and grandchildren living in the household. Combining two or more of these risk factors within a single household has a

Figure 2



Ziliak, J.P., Gundersen, C. (2017). The state of senior hunger in America 2015: An annual

report. Report submitted to the National Foundation to End Senior Hunger. *Lexington, KY: UK Center for Poverty Research, University of Kentucky.*

multiplier effect, increasing a person's risk for being food insecure. According to the 2015 American Community Survey (ACS) Census data, 11.3% (191,610) of 60-and-older adults in Georgia live in poverty. Overall, 33% (559,561) of Georgia's 60-and-older population have at least one disability. Seniors who are living below the poverty line and are responsible for grandchildren is 23.7%. Of this population, 34% of grandparents 60 and older have a disability. Disabilities add a special constraint to the ability to gain access to and prepare food.

Social isolation is also recognized as a factor that increases the risk of food insecurity. The 2015 ACS Census data for Georgia indicates that 300,000 adults age 65 and older live alone, more than a quarter of that population. (See Appendix VII). The same report revealed that more than 15.7% (186,900) live in rural areas. In 2017, the percentages of people living below the federal poverty level ranges from 12.3% to 30.3%. The percentage of people living at 100% to 200% of the poverty level were 27.8% and 48.1%, respectively. (See Appendix VII)

The Georgia maps indicate people living in poverty are primarily in the rural areas and not in major cities.

Isolation affects the ability to obtain food, as the area may not have available transportation or an easily accessible grocery store with reasonably priced, wholesome foods. Neighbors or family members may not live close by to assist with food shopping or meal preparation for an older adult who is not well or has a disability and is unable to cook. A person is less likely to prepare food and eat alone if another person who lived in the household has died or no longer lives there. Ziliak and Gundersen's 2008 report reveals that social isolation created by the loss of access to emotional and financial support due to changes in life events increases the "likelihood of being at-risk of hunger that is of comparable magnitude to living in poverty" (p. 41). (See Appendix VIII)

Health Impact of Food Insecurity in Georgia

Food insecurity influences a person's well-being and health care from multiple perspectives. Older adults in food insecure households often use medication nonadherence as a coping strategy. Bengle, *et al.* (2010) conducted a statewide study of low-income food insecure individuals who reported cost-related medication nonadherence, and found that the percentage of adherence range between 42.9% for those with drug coverage insurance and 52.6% among those without coverage. A significant number had a previous diagnosis of diabetes and coronary heart disease. Food insecurity exacerbates these chronic conditions, for which expensive prescriptions and dietary treatments are required.

A balanced, nutritious diet, appropriate exercise, a suitable medication regimen and good medical care affect heart disease and diabetes, both of which are leading causes of death in Georgia. Frequently, obtaining foods that provide the required nutrients is problematic for food-insecure households due to lack of accessibility to grocers and/or reasonably priced wholesome foods. The available low-cost food choices are commonly limited to high-calorie, low-nutrient dense foods. The prolonged intake of high-calorie, nutritionally inadequate foods leads to weight gain and establishes an undesirable food intake pattern. A nutritionally inadequate diet may leave a person without enough energy to exercise or complete routine daily tasks. A consistent lack of exercise combined with steady weight gain can lead to obesity, which is frequently seen in low-income populations. Multiple adverse health conditions such as diabetes, arthritis, hypertension, heart and cardiovascular diseases and physical disabilities are prevalent in persons who are obese. It is important to recognize that obesity does not equate to nutritional adequacy or the overconsumption of food.

The combination of disease and food insecurity can increase the risk of or add to the already existing condition of malnutrition that is frequently seen in the older adult population. Diseases can cause lack of absorption, a decrease in appetite, and a decline in the ability to obtain and prepare food for oneself. Medications can have side effects such as nausea,

vomiting and altered taste sensation so a person loses the desire to eat. A person who is malnourished does not have the proper nutrients required to maintain health, to heal from an injury or to recover from an illness. Malnutrition increases the chance of infections, worsening diseases and disability. It also increases the possibility of an emergency room visit or hospitalization.

Cost Impact of Food Insecurity in Georgia

A study conducted by Goates, Braunschweig and Arensberg (2016) estimated Georgia's direct medical cost of disease-associated malnutrition for 65-and-older adults at $125,373,000. Protein/calorie malnutrition increases the cost of a hospital stay by approximately $25,200, based on 2016 prices. A malnourished older adult who is admitted to the hospital has a four- to six-day longer length of stay, more comorbidities, a 50% higher readmission rate, and five times the likelihood of death compared with hospital stays of adults without malnutrition.

Recognizing the rise in costs when a malnourished older adult is admitted to the hospital, the Centers for Medicare and Medicaid Services have proposed to adapt the 2017 recommendations of the Malnutrition Quality Improvement Initiative (mqii.today) into a future Hospital Inpatient Quality Reporting Program. "A Profile of Older Americans: 2016" showed Medicare as the primary method of payment for health-care-related expenditures for adults 65 and older. (See Appendix II, p. 13)

Older adults with chronic diseases and/or malnourishment use Medicare more than people who are healthy. Recent research strongly suggests that "up to one out of every two older Americans is at risk for malnutrition" (See Appendix I, p. 11). Addressing the risk factors that perpetuate food insecurity, a decreased quality of life, malnutrition and escalating health care costs within the state's communities, and improving the programs and policies that influence these risk factors, are necessary measures to bring an end to the detrimental conditions that an estimated 307,983 older adults living in Georgia are facing.

Gaining a Statewide Perspective

To ensure that this plan reflects Georgia both regionally and as a unified state, four groups of stakeholders participated in collecting data. Those groups are: the Senior Hunger Summit Planning Committee, the Senior Hunger Fighter Workgroups, the participants in 12 regional listening sessions and conference attendees at two statewide aging conferences.

The Senior Hunger Summit Planning Committee initiated the work. The committee represented multiple areas of the state and different aspects of the provision of nutrition services. The group included meal service providers, food banks, directors of Area Agencies on Aging, advocates, county-based agencies, and staff from the Department of Human Services Division of Aging Services (DHS DAS). This group reviewed the state and national research and decided upon the five primary focus areas:

- Access to food
- Impact of senior hunger on health
- Food waste and reclamation
- Today's seniors
- Meeting the needs of the community

The group also worked to develop the senior hunger summit agenda and ensure that outreach was as broad as possible.

During the first Georgia Senior Hunger Summit, the Senior Hunger Fighter Workgroups convened as the final session facilitated discussion groups, and the information was recorded and disseminated to the group. Meetings and conference calls were held for each of the five workgroups reviewing and developing the information. A final conference call was held to distill the initial information into some actionable recommendations. (See Appendix IX)

Following the Senior Hunger Summit in 2016, 12 listening sessions were conducted across the aging network planning and service areas through a partnership with the North Highland consulting group and the Georgia Area Agencies on Aging (AAAs). (See Appendices X, XI, XII). Each AAA publicized and hosted the event. Copies of the five topic areas were provided to the attendees ahead of time. The North Highland consultants conducted the listening sessions using multiple methods to capture the information (computer recording of the conversations, Post-it note collections from the participants and follow-up survey).

The final outreach and data collection was held at two statewide aging conferences -- the Aging and Disability Resource Connection (ADRC) Healthy Communities Summit 2017, and the Georgia Gerontology Society Annual Conference 2017. During these two sessions, the five focus areas were presented along with emerging themes from the listening sessions. The session attendees were then able to add their comments, concerns and ideas to the information collected. (See Appendices XIII, XIV)

Common Themes in Each Focus Area

Food Access	
Transportation	Door-through-door service is needed for more frail seniors.
	Transportation availability is lacking in urban and rural areas.
	Communication between resources needs improvement.
Food Deserts	
	Some rural counties are lacking grocery stores.
	Distance to grocery stores for seniors without cars is too great.
	Alternatives such as general/convenience markets with healthy options need to be explored.
	Food delivery services are an option.

	Farmers markets and other agricultural options to meet needs.

Today's Seniors	
	We need to have an understanding of who is considered a senior for various programs and what generational differences exist.
	Many seniors care for grandchildren and may defer to their nutritional needs first.
	Services tend to be offered during week days. Today's seniors need more options.

Food Waste and Reclamations	
	Clear and consistent policy is needed.
	Stronger outreach for food collection agencies is needed.
	Enhancing partnerships may allow for greater reach.

Meeting the Needs of the Community	
	Better communication of available services needed to prevent duplication.
	Better communication and partnership with the faith-based community is needed.
	Partnerships with schools could be helpful.

Five Impact or Focus Areas

Five areas of focus were selected by the Senior Hunger Summit Planning Committee. These areas were selected after review of the national hunger reports with the purpose of creating actionable items for Georgia. They are: Today's Seniors, Impact of Senior Hunger on Health, Food Access, Food Waste and Reclamations, and Meeting the Needs of the Community.

Today's Seniors

One significant challenge that communities, agencies and program administrators working with the older adult population face are the differences in needs/requirements and likes/dislikes among various generations. The young-old (ages 60 to 69) and middle-old (70-79) may have different dietary and health needs than the oldest-old, (80 and older). Advances in health care are allowing people to live longer but not always independently. Even though some of the oldest-old are very active and healthy, many others are dependent on someone for transportation, meal preparation and more. The young-old also may be taking care of an aging parent while continuing to work and run a household.

Rural areas are experiencing a migration of youth away from small towns to larger cities. This creates a shortage of people in rural areas and small towns to take care of and help older adults who are dependent on assistance. Food stores may be in near proximity, but an older adult may not be physically able to grocery shop or to prepare meals if groceries are available.

Georgia's growing cultural diversity also affects food security. Older adults who come from other countries and cultures may not be familiar with available local foods and may not know how to prepare them, creating a situation of food insecurity for them. Food stores catering to a specific culture may not be in the area. Communication can be limited if there is not a common language between older adults and the people helping them. Agencies or

organizations distributing food to those in need may not be able to accommodate the culturally diverse needs of the older population.

There are vast differences in interest and skill level in technology among older adults. The younger-old are more likely to have the interest and the skills to utilize computers to order food items online, whereas the oldest-old may not.

Health Impact of Senior Hunger

It is well-documented that nutrition affects a person's health. Heart disease, diabetes and kidney disease are influenced by diet. The only choices a food-insecure person may have available are high-salt, high-fat, high-sugar, low-nutrient dense foods if resources for fruits, vegetables, and quality protein are limited or not accessible in the area. Special dietary requirements are usually recommended by a health care professional as one component of treating the patient. Frequently, the professional does not consider whether the special dietary requirements are within the patient's finances or whether the special items are available where the patient buys food. The professional may not be aware of community resources to recommend to the older adult when assistance is needed in acquiring the proper food.

Disease conditions become more complex when an individual is obese. Georgia ranks 19th in the nation for prevalence of obesity. A food-insecure older adult might be limited to high-calorie, nutrient-deficient foods, which can contribute to obesity. Obesity can lead to arthritis and other joint problems which affects the ability to perform IADLs, such as grocery shopping and food preparation.

Older adults who are food insecure are not eating sufficient amounts of calories, protein and micronutrients, which can contribute to frailty. Calcium, magnesium, vitamin D and iron are micronutrients required to maintain muscle strength and bone integrity. Muscle weakness, osteoporosis and weight loss are often found in frail individuals. This, in turn, can lead to the inability to perform IADLs, an increase in falls, disability, the worsening of diseases and

hospitalizations. Frailty and the risk of falling are concerns for older adults. Falls are the leading cause of injury-related emergency room visits, hospitalizations and deaths for Georgians 65 and older. Falls affect quality of life and are costly in terms of well-being, cost and time spent recuperating.

Older adults who are food insecure are 60% more likely to experience depression. Worry, anxiety and stress associated with threat of hunger and lack of suitable foods to sustain health have negative outcomes on well-being, quality of life and mental health for older adults. Seniors who are food insecure self-reported poor or fair health when compared to food-secure seniors. Fruits and vegetables are commonly lacking in food-insecure households. Fruits and vegetables contain the micronutrients vitamin C, vitamin B, iron and a form of vitamin A. These nutrients are known to be effective against depression and to enhance overall well-being.

Food Access

The availability of local food sources strongly impacts food insecurity. Neighborhoods and rural areas with limited access to food make it difficult for older adults to obtain nutritionally rich foods for a healthy diet. Areas that are void of food sources within a reasonable distance to an individual's home are called food deserts. Georgia food deserts occur both in urban and rural settings. A food desert is defined as a neighborhood or rural town that lacks access to fresh, healthy and reasonably priced food, and food sources are not within a reasonable proximity to the resident's home. Georgia considers a half-mile as reasonable proximity. One-third of Georgia is considered food desert.

For older adults, transportation can be a significant barrier to food access. Even when food resources such as congregate meal sites, community gardens, food banks or farmers' markets are in their area, older adults may not be able to drive, and public transportation is often not available in rural or less-populous areas. In a low-income neighborhood or for an older adult who is frail or has a disability, public transportation may be available but not manageable. The

cost of a private taxi service or ownership of a vehicle may be prohibitive when there are financial constraints in the household. Many communities do not have services that provide transportation at a reduced cost for older adults.

Many seniors are eligible for the Supplemental Nutrition Assistance Program (SNAP) benefits but do not sign up because the enrollment process for the program can be confusing or difficult to an older adult. Enrollment is available online, but that is not a viable option if the older adult does not have internet access, does not own a computer, or does not have computer skills. Many older adults do not apply for SNAP benefits even if they are eligible because they view them as degrading and a form of dependency.

Food Waste and Reclamation

Food is wasted daily in communities. For example, grocery stores that have strict "sell by" dates throw food away, as do restaurants that have unserved leftovers. Crops are plowed under and left to rot in the fields by farmers who have more than they can sell or personally use. Local schools discard opened cases of canned goods rather than donating the items to food-insecure households. Each of these sources could provide food to people in need. Unfortunately, businesses and organizations do not have a clear understanding of the laws addressing the donation of food, so they hesitate to do so out of concern for liability.

Federal laws exist to encourage and support the donation of unused food that is kept at proper temperatures and is safe to consume. The Bill Emerson Good Samaritan Food Donation Act provides liability protection to donors of food and grocery products to qualified nonprofit organizations. The Internal Revenue Code 170(e)3 provides tax deductions to businesses that donate wholesome food to qualified nonprofit organizations serving the poor and needy. Gleaning programs can be implemented to collect fresh foods from farms, gardens, and farmer's markets. The food is then distributed to food-insecure households.

Communities may have farmers or businesses willing to donate food, but the appropriate transportation may not be available. Certain food items must to be transported under refrigeration to keep them safe for consumption. An appropriate vehicle may be available during “off hours,” but the farmer or business may not be aware of the availability.

It is important for individuals, organizations and community groups to work together to support efforts in eliminating senior hunger. Collaboration is also critical to avoid duplication of services to food-insecure households while other people in need of food are overlooked.

Meeting the Community’s Needs

Addressing food insecurity is a community affair. Communication and coordination among businesses with food to donate, agencies distributing food, transportation businesses and officials, health care professionals, public safety officials, policy makers and the faith-based community are key in assuring a healthy, food-secure future for older adults. Different types of community organizations may be addressing the same issue while unaware of each other’s programs. Faith-based groups, civic groups, colleges, universities, neighborhoods and local government all have resources that may overlap while some areas go unserved. Improved communication and partnerships may be in order to share resources and identify service gaps.

Recommendations

- **Develop Regional Coalitions** in 12 regions of the state to bring together the aging network with for-profit, nonprofit, faith-based, civic, health care and other organizations, older adults and their caregivers. These coalitions would address a number of concern areas found during the data collection phase and would track the number of deliverables each year, including but not limited to:
  - Reduction of duplication of services
  - Conducting community needs assessments
  - Shared knowledge of regional and local issues
  - Shared knowledge of regional and local resources
  - Locally designed interventions such as community gardens, pantry programs and volunteer transportation services
  - Hold a minimum of four meetings each year
  - Annual report
  - Daylong pre-conference intensive at the ADRC Healthy Communities Summit

- **Establish DHS DAS Senior Hunger Position** to perform the following duties at a minimum:
  - Coordinate the 12 regional coalitions
  - Coordinate a Policy Review Council
  - Develop and disseminate nutrition education and other education resources
  - Develop toolkits for statewide use
    - Assistive Technology to help with food needs
    - Outreach to community programs
    - FAQs and “How to talk” about the issue
  - Coordinate with Universities and other partners for data analysis and other hunger prevention projects
  - Coordinate waste prevention initiatives and ongoing best practice sharing
  - Coordinate the Senior Hunger Track at the Healthy Communities Summit
  - Manage implementation of the State Plan for Senior Hunger

- **Establish Policy Review Council** to review policy that impacts a variety of aspects of senior hunger, from food reclamation to information sharing. This recommendation addresses the following concern areas; better communication across programs, consistent policy development to support state plan initiatives, adaptation as needed in a changing environment. This council would include state departments and divisions such as DHS DAS and the departments of Public Health, Community Health and Agriculture
  - Meet quarterly to review issues that arise in regional coalition meetings
  - Review current and proposed policy to suggest changes to allow great efficiency in food processes
  - Share enrollment in state programs to alleviate some of the paperwork for older adults across SNAP, Public Housing, Senior Community Programs, etc.

- **<u>Coordinate Data Collection and Analysis</u>** to measure the success of the state plan on senior hunger across organizations
    - Health Care Utilization Data
    - The Food Security Survey (expand to other agencies using the six-question survey for consistency)
    - Total number of food-insecure seniors current vs. projected
    - Rural vs. urban needs and resources
    - Return on investment for health impact
    - Ensuring service delivery to those in the greatest need
    - Others…

- **<u>Develop and Provide Education and Training for Agencies, Stakeholders and Individuals across a variety of topics</u>**
    - WebEx trainings and discussions held regularly
    - Regular nutrition education meetings to develop and disseminate senior appropriate nutrition education
    - Healthy Communities Summit Pre-Conference Intensive and Senior Hunger Track
    - Meeting in Macon at the DHS training center to keep conversations moving and idea-sharing open annually
    - Host workshops
        - Review state statistics
        - Review state and federal policies
        - Develop understanding of the current issue and programs in need of expansion

- **<u>Continue and Expand the What a Waste Program with the National Foundation to End Senior Hunger</u>.** This recommendation addresses the food waste and reclamation focus area and allows better use of the resources already available.

- **<u>Provide Entrepreneurial Mini-Grants</u>** to support creative initiatives that alleviate the issues of senior hunger, food deserts and isolation. These would be small grants designed to stimulate local problem solving at the local level
    - Food Mobile Ideas
    - Others…

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III. February 2014, Ziliak & Gundersen; The Health Consequences of Senior Hunger in the United States: Evidence from the 1999-2010 NHANES – Report submitted to The National Foundation to End Senior Hunger (NFESH)

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V. Core Food Security Module (CFSM) 6-item battery of questions

Research article supporting validity of CFSM:
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VI. September 2009, Ziliak & Gundersen; Senior Hunger in the United States, Differences Across States and Rural and Urban Areas – Report submitted to Meals On Wheels Association of America Foundation (MOWAAF)

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GEORGIA
HEALTH POLICY CENTER

AT A CROSSROADS: EXPLORING TRANSPORTATION FOR OLDER GEORGIANS IN A RAPIDLY CHANGING LANDSCAPE

Presented to the Georgia Department of Human Services, Division of Aging Services

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ACRONYMS AND ABBREVIATIONS

AAAs	Area Agencies on Aging
AARP	American Association of Retired Persons
ACL	Administration for Community Living
ACS	American Community Survey
ADA	Americans with Disabilities Act
ARC	Atlanta Regional Commission
CBS	Community-based services
CEO	Chief executive officer
CTAA	Community Transportation Association of America
DAS	Division of Aging Services
DCH	Department of Community Health
DHS	Department of Human Services
DOT	Department of Transportation
FAST	Fixing America's Surface Transportation Act
FTA	Federal Transit Administration
FY	Fiscal year
GDOT	Georgia Department of Transportation
HCBS	Home- and community-based services
HSP	Human service provider
MBTA	Massachusetts Bay Transit Authority
MoNI	Mobility Need Index
MPO	Metropolitan planning organization
NADTC	National Aging and Disability Transportation Center
NEMT	Non-emergency medical transportation
OFSS TSS	Office of Facilities and Support Services Transportation Service Section
SMART	Suburban Mobility Authority for Regional Transportation
SSGB	Social Services Block Grant
TCRP	Transit Cooperative Research Program
TNC	Transportation network company
TRIP$	Transportation Request and Information Processing System
TSS	Transportation Services Section
UZA	Urbanized zoning area

EXECUTIVE SUMMARY

The Georgia Department of Human Services (DHS), Division of Aging Services contracted with the Georgia Health Policy Center to respond to a request from the Georgia General Assembly to assess the current unmet transportation need for older adults across the state by DHS' planning and service region. In addition, this report provides context regarding the infrastructure and delivery of transportation services, considers the future through the presentation of population projection data, and highlights promising practices that can be explored as opportunities to meet older adults' unmet transportation needs. Key findings include:

Population Characteristics and Considerations

- The proportion of the population that is 65 and older will grow substantially from 1.3 million in 2016 to 2.9 million in 2040, with the greatest rate of change among those 85 and older.
- Every DHS region will experience growth in the older adult population, but the change will not be equally experienced across regions. The percent change in population is projected to be the smallest in the Heart of Georgia region (2016-2025: 41%, 2025-2040: 21%), while the Atlanta region is expected to see the largest percent change (2016-2025: 77%, 2025-2040: 61%).
- It is estimated that, on average, older adults will outlive their driving ability by 11 years for women and six years for men.
- Great heterogeneity exists within the older adult population, and those with poor health, low income, and suburban or rural residence experience inequities in transportation access. While fixed-route services play an important role in transportation for older adults, demand-response services can be better suited for some older adults, particularly those with limited mobility and those living in less populated areas where fixed-route services are not feasible.
- Through the application of driving prevalence estimates by age and gender to Georgia's 2016 population, it is estimated that 263,582 individuals aged 70 and older had ceased driving. Based on this estimate of the nondriving population, approximately 34% of individuals aged 70 and older in the state were no longer driving. After considering the number served through DHS and Department of Community Health (DCH) programs, and assessing the use of alternative transportation modes, it is estimated that approximately 200,000 Georgians aged 70 and older may have unmet transportation needs.

Responsible Agencies and Funding

- The three state agencies responsible for the planning and delivery of the majority of transportation services for older adults in Georgia each have unique planning and service areas, also described as regions or districts.
- Public transit services are available in 123 out of 159 counties in the state, though service features, area covered, and capacity vary widely by county.
- The non-emergency medical transportation program, administered by DCH, is the largest provider of transportation for older adults. The program served an estimated 26,664 individuals 60 and older eligible for Medicaid in state fiscal year (FY) 2018.
- The majority of the DHS' Coordinated Transportation System providers are transit systems operated with Georgia Department of Transportation-administered Federal Transportation Authority Section 5311 funds.
- The DHS Coordinated Transportation System served 7,761 unduplicated individuals over age 60 in state FY 2018, and the majority of the trip destinations were to senior centers, where meals, programming, and socialization opportunities are provided.
- The DHS Coordinated Transportation System's most widely offered services, core trips (trips during regular operating hours) and noncore trips (trips after regular operating hours), operate at an average rate of $6.09 and $21.02 respectively across all regions.
- An estimate of the capital and operating costs for the primary transportation programs serving older adults included $7.1 million for non-emergency medical transportation (limited to the expenditures for beneficiaries aged 60 and older), $9.3 million for the DHS Coordinated Transportation System (limited to clients aged 60 and older), and $22.7 million for Section 5311 funds from the Federal Transportation Authority (not limited to older adults, but focused on all nondrivers). There are a few additional transportation services available, but the three provided by DCH, DHS, and Georgia Department of Transportation are by far the largest.

Assessment of Access and Needs

- Transportation services targeting older adults provided in addition to the three largest programs are more abundant in the Atlanta region than in other areas. Regardless of region, currently available programs funded or supported by the Area Agencies on Aging (AAAs) are typically delivered through transportation vouchers.
- Driver safety programs are readily available throughout the state and support keeping older adult drivers driving safely for longer.
- Travel training programs are not well advertised or accessed by older adults in the state but aim to increase use of public transportation as an alternative to driving.

- Three cycles of State Plan on Aging assessments have found that stakeholders consistently rank transportation as a priority for ensuring individuals have the opportunity to age in place and remain in the community setting for as long as possible.
- Transportation requests to DHS that cannot be met are not tracked or maintained on a waiting list, as it is historically rare for new transportation funding to become available and it is unlikely that the need will stay constant. Therefore, DHS administrative data could not be used to capture unmet need for the current study.
- Unmet transportation needs described by providers and older adults include regional medical trips, recurring trips (e.g., trips to dialysis treatment), trips beyond the public transit service area and out-of-county trips, and evening trips.
- Quality-of-life trips, which range from trips to the grocery store to social events, emerge as a significant, persistent unmet need from the perspective of service providers and consumers.
- Interest in addressing unmet needs through volunteer programs exists, but a lack of startup funding and insurance liability concerns have hindered these efforts.
- Some AAA regions are exploring new modes of service to provide quality-of-life trips through a fixed-route shuttle service to destinations such as the grocery store, pharmacy, and post office.
- Inadequate infrastructure, provider capacity, and information about services are persistent barriers across the state.
- The greatest current and projected future concentrations of older adults with high mobility needs are in urban and adjacent suburban areas.

Opportunities for Exploration

- Supportive relationships between state entities, regional and/or local providers, and the communities they serve are critical for creating and managing transportation supply for older adults.
- Allowing the flexibility to innovate at the local level is valuable, but it must be done in a way that allows for diffusion of promising ideas across communities and acknowledges some innovations may not be successful.
- Coordinating multiple funding streams and maintaining collaborative partnerships are the foundations of promoting local mobility through a variety of transportation options. This is the case for serving older adults, and it is also true for serving the broader community.
- A rapid environmental scan of promising practices in transportation solutions for older adults produced information regarding organizations that have sought to tackle similar issues as those facing Georgia and may offer options for addressing unmet need for the state.

INTRODUCTION

This report was prepared by the research staff at the Georgia Health Policy Center in collaboration with Georgia Department of Human Services (DHS) Division of Aging Services (DAS) to respond to a request from the Georgia General Assembly to assess the current unmet transportation need for older adults across the state by DHS planning and service region. In addition, the report provides context regarding the infrastructure and delivery of transportation services, considers the future through the presentation of population projection data, and highlights promising practices that can be explored as opportunities to meet older adults' unmet transportation needs.

Population of Focus

For the purposes of this report, older adults are defined as individuals aged 60 and older. When county-level information for individuals aged 60 to 65 years was incomplete in a primary data source used for this report, the American Community Survey (ACS), the age group 65 years and older was selected for analysis.

Unmet Need

Unmet need for transportation is defined differently throughout both the academic literature and in transportation planning practice. The concept of unmet need is complex, and needs vary widely across the older adult population. As resources are limited, unmet need often must be defined relatively narrowly and encapsulate only those needs that are considered reasonable to be met within the current climate. For this report, the research team adopted a broader definition of unmet need that attempts to acknowledge the spectrum of unmet need as experienced by older adults in the state. Therefore, unmet need for this report is defined as the inability of older adults to reach desired destinations due to a lack of reliable, affordable, or accessible transportation.

Background

The older adult population in Georgia experienced significant growth over the past decade and, like the rest of the United States, is projected to increase rapidly in size as the baby boom generation transitions into older age (Colby & Ortman, 2015; GDHS, 2015). Consequently, careful attention to the planning and allocation of resources for older adults is imperative to ensure that the supply of services and supports meets this increase in demand.

Of the services and supports available, transportation represents a unique challenge for the older adult population. Research indicates that in the United States, most older adults' primary mode of transportation is driving a private vehicle (Kostyniuk & Shope, 2003; Pucher & Renne, 2003). However, many older adults lack an alternative form of transportation, particularly as the majority of older adults live in suburban or rural areas, which typically lack accessible public transportation and/or built environments that are conducive to active transportation (Dye, Willoughby, & Battisto, 2011; Dickerson et al., 2017; Rosenbloom, 2012). This reliance on driving is complicated by the declines in physical, cognitive, and other abilities that accompany aging. Foley, Heimovitz,

Guralnik, & Brock (2002) found that, on average, older adults will outlive their driving ability by approximately 11 years for women and six years for men.

Despite the challenges associated with driving into advanced age, studies have also found that driving cessation significantly impacts health and quality of life for older adults, and that cessation is associated with depression, reduced access to goods and services, and social isolation (Bergen et al., 2017; Ragland, Satariano, & MacLeod, 2005; Satariano et al., 2012). These risks associated with immobility are augmented by declines in the availability of informal supports, especially adult children, to whom older adults have historically turned for transportation once they cease driving (Adler & Rottunda, 2006; Choi, 2012; Hendrickson & Mann, 2005; Johnson, 2008; Kostyniuk & Shope, 1999; Rosenbloom, 2003). Decreasing fertility rates and the geographic dispersion of families have left many older adults without a source of informal support, which, paired with the paucity of public and active transportation options, significantly restricts older adults' mobility once they cease driving. Thus, a significant and unmet need for transportation services among older adults exists, and planning that incorporates age-friendly transportation services and enhancements to the built environment is warranted to curb adverse outcomes.

Report Organization

This report is organized into six sections. A brief synopsis of the report sections follows.

Introduction
This section of the report provides the context and framing, including the population of focus, concept of unmet need, infrastructure, service delivery, and a grounding in the need for mobility support for older adults.

Transportation Services for Older Adults in Georgia
The primary transportation services available to older adults in Georgia are described. In addition, information regarding driver safety programs and travel training programs is provided in order to understand the broad range of available approaches to meet the mobility needs of older adults.

Measuring Transportation Need and Unmet Need for Older Adults in Georgia: Current and Future Trends
The authors describe the approaches currently utilized to measure transportation need and unmet need through a review of the literature, recent work within the state to improve transportation, and a summary of the available quantitative and qualitative data that depict current and future trends.

Promising Practices in Transportation Solutions Serving Older Adults
The transportation challenges facing Georgia are not unique to the state. The authors present ideas and approaches tested by organizations across the nation that may provide examples of solutions for further study and local application.

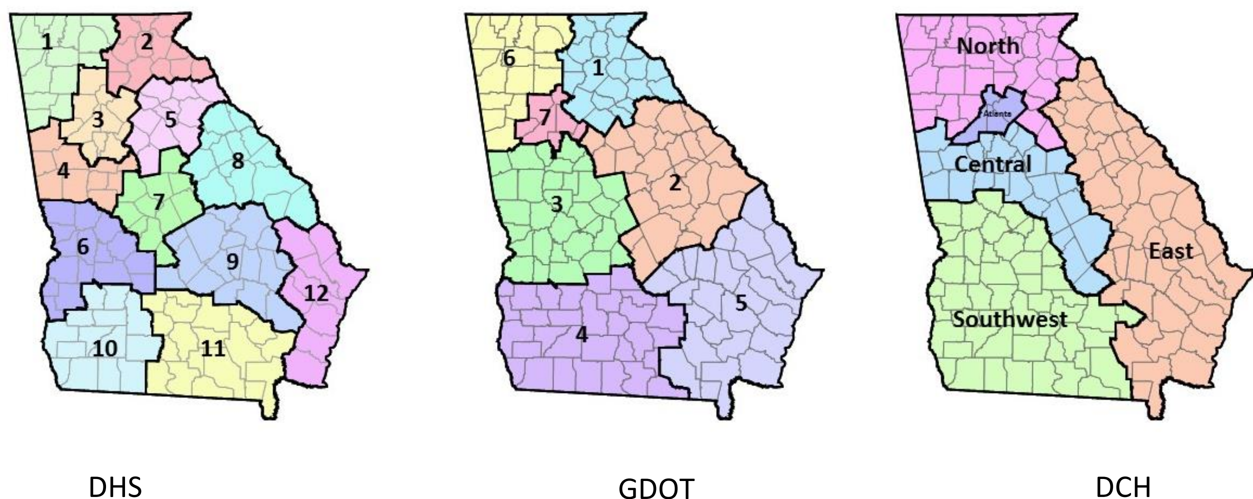
Limitations and Opportunities for Further Research
Limitations of this report are explained, which include the difficulty of determining a precise estimate of unmet transportation need due to the complexity of the transportation delivery system and the absence of integrated data sets. Additionally, this section describes the opportunities to address the transportation system more holistically, recognizes the changes related to the diffusion of technological innovation, and identifies opportunities for further research that include an integration of local knowledge regarding the needs of the community and assessment of solutions.

Conclusion
The authors summarize the main points.

Overview of Transportation Services

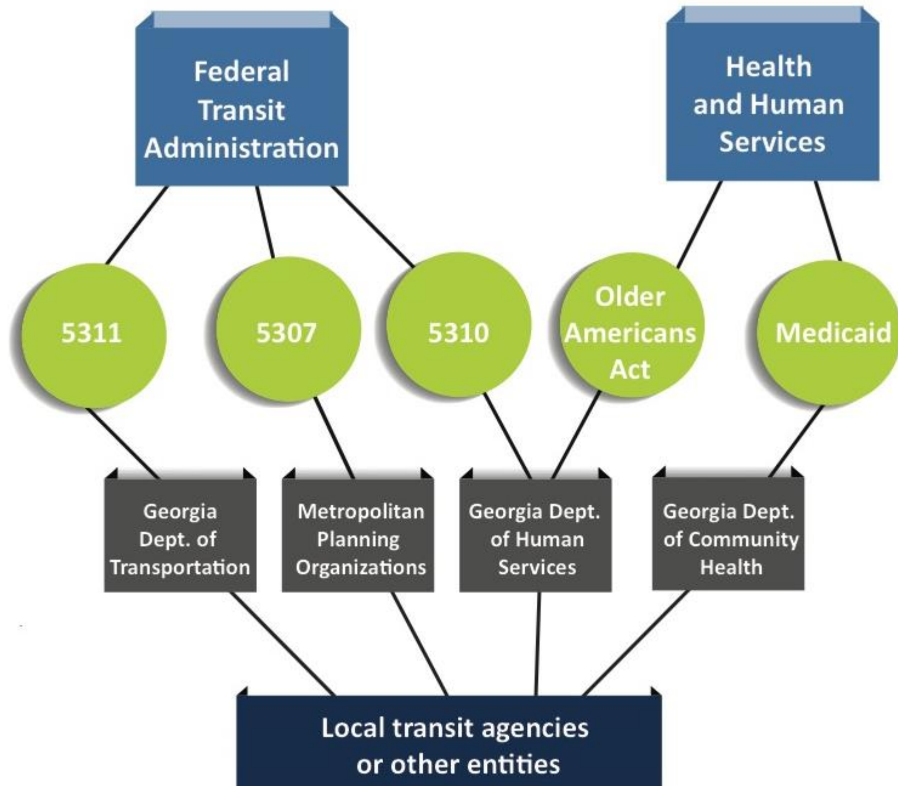
Three state agencies are responsible for the planning and delivery of the majority of transportation services for older adults in Georgia: Georgia Department of Transportation (GDOT), Department of Community Health (DCH), and DHS. Each agency currently operates very differently. For instance, the planning and service areas are unique to each agency, as depicted in Figure 1. For a list of the counties within each agency's planning and service area, see Appendix A.

Figure 1: Planning and Service Area by Agency



In addition, program service eligibility, program regulations, service tracking, and provider reimbursement methods vary for each agency. These differences, in part, are due to the flow of funding for each of the transportation programs from various federal agencies, as depicted in Figure 2.

Figure 2: Flow of Federal Transportation Funding



Georgia Department of Transportation

GDOT is the state agency responsible for the planning, construction, and maintenance of Georgia's transportation system; the planning and programming of transportation funding; and the distribution and oversight of the Federal Transit Administration (FTA) grants authorized under the Fixing America's Surface Transportation (FAST) Act (GDOT, 2015). As presented in Figure 1, GDOT divides the state into seven districts for planning and service delivery: (1) Northwest Georgia; (2) East Central Georgia; (3) West Central Georgia; (4) South Georgia; (5) Southeast Georgia; (6) Northwest Georgia; and (7) Metro Atlanta (GDOT, 2017). GDOT also works closely with the state's 19 Metropolitan Planning Organizations (MPOs), 12 regional commissions, rural transit planning agencies, and other local entities in transportation service planning (GDOT, 2017).

MPOs are federally mandated policy-making organizations that represent localities in each urbanized zoning area (UZA; defined as having a population over 50,000 people, as determined by the U.S. census), while regional commissions represent nonmetropolitan areas (U.S. Department of Transportation [U.S. DOT], 2016). Regarding FTA funding, MPOs are direct recipients of certain grants, while GDOT receives and distributes other grant funding to transit subrecipients (e.g., regional commissions, transit agencies, etc.). Of the transportation services that fall under GDOT and the MPOs, those particularly relevant for older adults include public fixed-route transit,

demand-response services, and Americans with Disabilities Act (ADA) Complementary Paratransit/Paratransit services. Two specifically relevant funding sources for which GDOT is the recipient are the FTA Section 5307 Urbanized Area Formula Funding program and FTA Section 5311 Formula Grants for Rural Areas program.

Fixed-route transit follows a regular route with set or fixed stops and operates on a set schedule (Community Transportation Association of America, n.d.). Buses and trains commonly operate as fixed-route services. Demand-response services, in contrast, do not follow a fixed route, but pick up and drop off consumers at different points in response to individual requests. Typically, demand-response services require consumers to reserve a ride in advance, often 24-48 hours prior to the scheduled ride (National Aging and Disability Transportation Center, 2018). The availability of public fixed-route and demand-response transit services varies widely both across and within Georgia's regions. In rural and suburban areas, services may be very limited in terms of operating hours, days, and service area, or may not operate at all (GDOT, 2011). Further, even where services are available, they may not be accessible to older adults due to a number of factors, including cost, lack of amenities, and geographic gaps in service (Atlanta Regional Commission, 2016). Despite these barriers, fixed-route and demand-response transportation represent some of the only public alternative transportation options for older adults. The ADA, which sets requirements for both of these types of transportation services, has significantly impacted public transportation for older adults and will be discussed in more detail later in this section.

The Section 5307 program of the U.S. DOT provides funding to UZAs and states for public transportation capital projects, operating assistance, job access and reverse commute projects, and transportation-related planning (U.S. DOT, 2014). UZAs are differentiated as large or small by population; large UZAs have 200,000 or more in population, while small UZAs have between 50,000 and 200,000 (U.S. DOT, 2016). The Transit Program, within GDOT's Division of Intermodal, manages and ensures compliance for Georgia's 24 planning subrecipients, seven small urban (population under 200,000) transit systems, and 85 rural transit systems (GDOT, 2017). The Section 5307–funded programs in large UZAs (Metro Atlanta, Savannah, Columbus, and Augusta) are also relevant with respect to transportation for older adults, as these programs also provide the fixed-route and demand-response services often utilized by older adults. However, these programs are managed and coordinated directly by the large UZAs within the FTA, and do not fall under GDOT's purview.

The Section 5311 program of the FTA provides capital, planning, and operating assistance to support public transportation in rural areas, defined as areas with a population less than 50,000 (U.S. DOT, 2018). Funding is available to states and federally recognized Indian Tribes for a period of three fiscal years and is apportioned using a statutory formula that includes land area, population, revenue vehicle miles, and low-income individuals in rural areas (U.S. DOT, 2018). Currently the Rural Transit System covers 120 of Georgia's 159 counties, as well as three cities (GDOT, 2017). While the Section 5311 program does not specifically fund services for older adults, it serves as an important transportation option for nondrivers, including older adults, across the state.

Georgia Department of Community Health

Georgia DCH administers the largest transportation program that serves older adults in the state, Medicaid non-emergency medical transportation (NEMT; GDOT, 2011). Federal regulations require that state Medicaid agencies ensure qualified beneficiaries have transportation to and from medical services (Centers for Medicare and Medicaid Services, 2016). Each state, however, is responsible for determining eligibility for NEMT services, and qualifying unmet needs can include not having a driver's license; not having a working vehicle available; being unable to travel or wait for services alone; and having a physical, cognitive, mental, or developmental limitation (Centers for Medicare and Medicaid Services, 2016). Georgia DCH specifies that to be eligible, "members must have no other means of transportation available and are only transported to those medical services covered under the Medicaid program" (Georgia DCH, 2018).

DCH uses a brokerage system to deliver NEMT services and currently uses Logisticare and Southeastrans to coordinate NEMT services for Georgia's regions. Unlike GDOT, DCH divides the state into five regions: North, Atlanta, Central, East, and Southwest, as presented in Figure 1 (Georgia DCH, 2018). DCH pays the NEMT brokers a monthly capitated rate based on the number of eligible Medicaid members residing in their contracted region(s). Also of note, while Medicaid funds a substantial proportion of transportation services for older adults, Medicare does not typically cover transportation aside from ambulance transportation (CMS, 2018).

Georgia Department of Human Services

The Office of Facilities and Support Services Transportation Service Section (OFSS TSS) within DHS manages the state's Coordinated Transportation System. TSS administers coordinated transportation services to a range of consumers of human services, including older adults, through partnerships with a variety of human service providers in the state. The DAS is the state agency that partners with TSS to provide Coordinated Transportation services for older adults in Georgia. Services provided for DAS clients are funded through a combination of sources, including Older Americans Act Title IIIB and FTA Section 5310 Enhanced Mobility of Seniors and Individuals with Disabilities Program funds, as well as local contributions and additional state-administered fund sources, such as the Social Services Block Grant (SSBG). Older Americans Act and Section 5310 apportionments are both formula-driven and allocated based on the distribution of older adults residing within a given region. Two fund sources — Older Americans Act and SSBG — have local match requirements of 10% and 12%, respectively (Georgia DHS, 2017).

DHS is the designated recipient of FTA Section 5310 grant funding in Georgia. The FTA provides this grant to assist states in providing transportation to older adults and people with disabilities "when the transportation service provided is unavailable, insufficient, or inappropriate to meeting these needs" (U.S. DOT, 2018). The program seeks to enhance mobility for these two populations by removing barriers to accessing transportation services and expanding transportation mobility options (U.S. DOT, 2018). The FTA allocates Section 5310 funding based on the state's share of older adults and persons with disabilities, and supports activities in all geographical areas — large urbanized (over 200,000), small urbanized (50,000-200,000), and rural (under 50,000). States are

eligible recipients for rural and small urban areas funding, while recipients of funding for large urban areas are designated by the governor of the state.

In addition to formula grants, discretionary grants, known as Rides to Wellness Demonstration and Innovative Coordinated Access and Mobility Grants, are also available to Section 5310 grantees. Rides to Wellness is a pilot program that was established by Section 3006(b) of the FAST Act and funds innovative projects that aim to improve the coordination of transportation services and NEMT services (U.S. DOT, 2018).

In addition to Section 5310 funding, Older Americans Act funding is used across the state to provide transportation services for older adults. The Older Americans Act supports a range of community social services for older adults, and the 2006 reauthorization of the act contains specific provisions for states and Area Agencies on Aging (AAAs) to implement coordinated systems for home- and community-based services (HCBS), including transportation (Administration on Community Living, 2017). AAAs are the coordinating entities for all community-based services for older adults in each of the 12 DHS regions (Georgia DHS, 2015). Specifically, grantees can use Older Americans Act Title IIIB funds to transport seniors. Further, grantees have the option to use Title IIIB funds to meet match requirements for programs administered by the FTA, such as Section 5310 and 5311 programs (Administration for Community Living, 2017).

SSBG funding is also heavily utilized to support transportation services for older adults across the state. The SSBG is federal funding that the U.S. Department Health and Human Services allocates annually to states and territories to support social services for vulnerable children, adults, and families (U.S. Office of Community Services, 2018). SSBG funding is relatively flexible with regard to the specific services states can choose to support with the funds, and states can also modify the funds over time in response to changes in the needs of the populations served. Many states, including Georgia, use SSBG funds to support transportation services for vulnerable populations. SSBG funding supports Coordinated Transportation System services in each Georgia DHS region of the state.

Community-Based Services (CBS) Program funding is another source of funding used to provide transportation services for older adults in some of the Georgia DHS regions. DAS receives CBS funding from the state legislature, then allocates it to the AAAs in each region to support a number of services, including transportation. AAAs can then elect, based on the needs within their respective region, whether or not to utilize CBS funding to support transportation services.

Key Approaches to Transportation Services for Older Adults

Apart from driving, older adults utilize a number of transportation services provided by both public and private entities throughout the state. The extent to which these services are geared toward older adults varies, and some services may not accommodate the specific needs of all older adults. Further, the availability, accessibility, and quality of each of these types of transportation differ both across and within regions.

As previously discussed, public fixed-route transit and demand-response services are critical transportation resources for older adults, particularly nondrivers. Providers of fixed-route services, including bus and rail, that receive FTA Section 5307 Urbanized Area Formula Grant funding are required to provide discounted fares for older adults (reduced so that older adults, defined as at least age 65 and older, pay half (or less than half) the normal peak hour fare amount) during nonpeak hours (49 U.S.C. Section 5307(d)(1)(D) of the Federal Transit Act). This fare reduction is intended to aid public transportation in meeting its objective of increasing mobility for disadvantaged populations (Newmark, 2014) and can mitigate financial barriers to transportation access for some older adults.

While fixed-route services play an important role in transportation for older adults, demand-response services can be better suited for some older adults, particularly those with limited mobility and those living in less populated areas where fixed-route services are not feasible. Demand-response services do not involve stops or require transfers, as fixed-route services often do, and take consumers directly from their home to their destination (ARC, 2017). Thus, older adults who need more assistance or specialized accommodations than may be available for fixed-route services can greatly benefit from demand-response systems.

In some areas, hybrid fixed-route and demand-response services, also known as deviated fixed-route services, are available. Deviated fixed-route services have some components of fixed routes but can deviate from the predetermined route to accommodate special requests (e.g., can drop a rider off at home) (ARC, 2017). These systems vary in service area and the amount of time required to schedule a deviated stop but can increase access to more traditional transportation systems for some older adults.

The ADA, which applies to almost all providers of transportation services, both public and private, requires that providers deliver accessible services and prohibits these entities from discriminating against persons with disabilities (National Rural Transit Assistance Program, 2016). The ADA requires transit agencies that run fixed-route services to provide supplementary paratransit services for individuals who are unable to access fixed-route services or independently navigate the system (National Rural Transit Assistance Program, 2016). The regulations stipulate that providers operate a complementary and comparable ADA paratransit service within three-fourths of a mile of the fixed-route that is available during the same hours as the fixed-route services (National Aging and Disability Resource Center, 2018). These services typically involve the use of smaller vehicles and provide demand-response service that is curb-to-curb or door-to-door (Community Transportation Association of America, 2018; Disability Rights Education & Defense Fund and TranSystems Corp., 2010).

The ADA establishes minimum eligibility requirements for paratransit but does not prescribe the process by which transit agencies determine eligibility, nor does it prohibit agencies from providing paratransit services to additional individuals (e.g., older adults with limited mobility but who do not qualify for paratransit) (U.S. DOT, 2015). Thus, some transit systems with broader

eligibility requirements may serve more older adults than others. Nonetheless, where it is available, paratransit plays an important role in transportation for older adults, and many who are eligible depend heavily upon the services. Further, the ADA's requirements regarding accessibility features have made transportation systems more accessible for all older adults, including those who do not qualify for paratransit.

Shared ride services or transportation network company (TNC) services are transportation services provided using a mobile application or online platform to connect passengers with drivers who are using their personal vehicles (American Association of Motor Vehicle Administrators, 2018). These services represent an emerging approach in providing transportation services for older adults. Many well-established TNCs, such as Uber and Lyft, now offer accessible options for older adults and have also developed features that enable individuals without TNC accounts (i.e., do not have the application) and/or smart phones to book rides via phone using an operator (NADTC, 2017).

Additionally, companies that further facilitate the ride-ordering process have become more prevalent in recent years. For instance, GoGo Grandparent, which was designed specifically for older adults, enables users to dial a toll-free number and arrange a ride using the keypad (e.g., users can dial 1 to request a car to their home) or by speaking with an operator (GoGo Grandparent, 2018). Other features include using preprogrammed locations, voice commands, setting a fixed pickup schedule, and sending text updates to family members regarding trips. These services and features aim to make TNC services more accessible for older adult users and may contribute to increases in TNC use as an alternative to driving among older adults in the future.

Another important strategy in the delivery of transportation services for older adults is through the use of transportation vouchers. Voucher programs provide reduced-fare or free rides to eligible, often low-income individuals. Riders receive vouchers that can be exchanged for transportation services (NADTC, 2018). Some voucher programs may offer vouchers for more traditional services, such as public transportation or taxis, or may restrict use to a specific trip type, such as a medical appointment (National Association of Area Agencies on Aging, 2018). Some programs, however, may enable older adult riders to use friends, family members, or volunteers for transportation services (Rural Health Information Hub, 2018b). These models can increase options for older adults, particularly those with less access to public transportation or taxi services, such as those living in rural areas.

Volunteer driver programs, which are often operated by nonprofit or faith-based organizations, provide free transportation services to individuals in need and play an integral role in filling gaps in transportation need in many communities (CTAA, 2018). Volunteer programs are particularly well suited for older adults, as drivers typically provide door-to-door service and, in some programs, may offer additional assistance (e.g., assisting older adult consumers during shopping trips) (Rural Health Information Hub, 2018a). Additionally, volunteer services typically have fewer constraints than traditional transportation services and may, for instance, accommodate multiple stops or cross county lines, and can address barriers to access that conventional transportation services

cannot (Kerschner, 2015). Existing programs vary significantly with regard to size, scope, and operation but, where they are available, can greatly enhance older adults' mobility.

In addition to directly providing transportation services, some programs, namely transportation safety and travel training programs, supplement existing systems and aid older adults in remaining independently mobile. Most transportation safety programs aim to enhance older adults' capacity to drive and can entail a range of both medical and behavioral assessments and interventions (Satariano et al., 2012). In contrast, travel training programs help consumers develop knowledge and self-efficacy with regard to alternative transportation options to increase the likelihood that they will utilize these services to meet their mobility needs (Transit Cooperative Research Program, 2014).

Older Adult Population Demographics

Generally, aging is associated with deteriorating physical and cognitive ability, with the most pronounced, rapid declines occurring during advanced age (Sprague, Phillips, & Ross, 2017). Consequently, within the older adult population, distinct segments emerge with differing mobility needs (Ettleman et al., 2017). These segments have been defined relatively inconsistently in the literature but are often divided into ages 60 or 65 to 74 years, 75 to 84 years, and 85 and older, especially within the area of driver safety (U.S. DOT, 2009). The marked differences with respect to vision, hearing, disease and illness, cognition, and other factors critical to the mobility of individuals in each segment are important to consider when characterizing transportation service and support needs among older adults (Satariano et al., 2012). Broadly, low mobility and an accompanying decrease in quality of life have been consistently observed among the oldest older adults (Hjorthol, 2013). As the absence of support is often the most detrimental for this subgroup, the needs of the oldest older adults warrant heightened attention when evaluating and addressing unmet transportation need and will be discussed in greater detail throughout this report.

TRANSPORTATION SERVICES FOR OLDER ADULTS IN GEORGIA

Existing transportation-related services and supports vary markedly within and across regions of the state. Available services include those that aim to maximize the amount of time older adults can drive safely and those that enable older adults to utilize alternative modes of transportation. Funding sources and amounts also differ by region, as do eligibility requirements per program. This section will provide an overview of the service expenditure, cost, and utilization data available at the state level for each of the major transportation providers and also describe the availability of driving support services, specifically driver safety and travel training programs.

Key Findings

- The three state agencies responsible for the planning and delivery of the majority of transportation services for older adults in Georgia each have unique planning and service areas, also described as regions or districts.
- Public transit services are available in 123 out of 159 counties in the state, though service features, area, and capacity vary widely by county.
- Through the NEMT program, DCH is the largest provider of transportation for older adults, serving an estimated 26,664 individuals 60 and older eligible for Medicaid in state FY 2018.
- The majority of the DHS Coordinated Transportation providers are transit systems operated with GDOT-administered FTA Section 5311 funds.
- The DHS Coordinated Transportation System served 7,761 unduplicated individuals over 60 in state FY 2018, and the majority of the trip destinations were to senior centers, where meals, programming, and socialization opportunities are provided.
- The DHS Coordinated Transportation System's most widely offered services, core trips (trips during regular operating hours) and noncore trips (trips after regular operating hours), operate at an average rate of $6.09 and $21.02 respectively across all regions.
- An estimate of the capital and operating costs for the primary transportation programs serving older adults included $7.1 million for NEMT (limited to the expenditures for beneficiaries aged 60 and older), $9.3 million for DHS Coordinated Transportation System (limited to clients aged 60 and older), and $22.7 million for Section 5311 funds from the FTA (not limited to older adults, but focused on all nondrivers). There are a few additional transportation services available, but the three provided by DCH, DHS, and GDOT are by far the largest.
- Transportation services targeting older adults provided in addition to the three largest programs are more abundant in the Atlanta region than in other areas. Regardless of region, currently available programs funded or supported by the AAAs are typically delivered through transportation vouchers.

- Driver safety programs are readily available throughout the state and support keeping older adult drivers driving safely for longer.
- Travel training programs are not well advertised or accessed by older adults in the state but aim to increase use of public transportation as an alternative to driving.

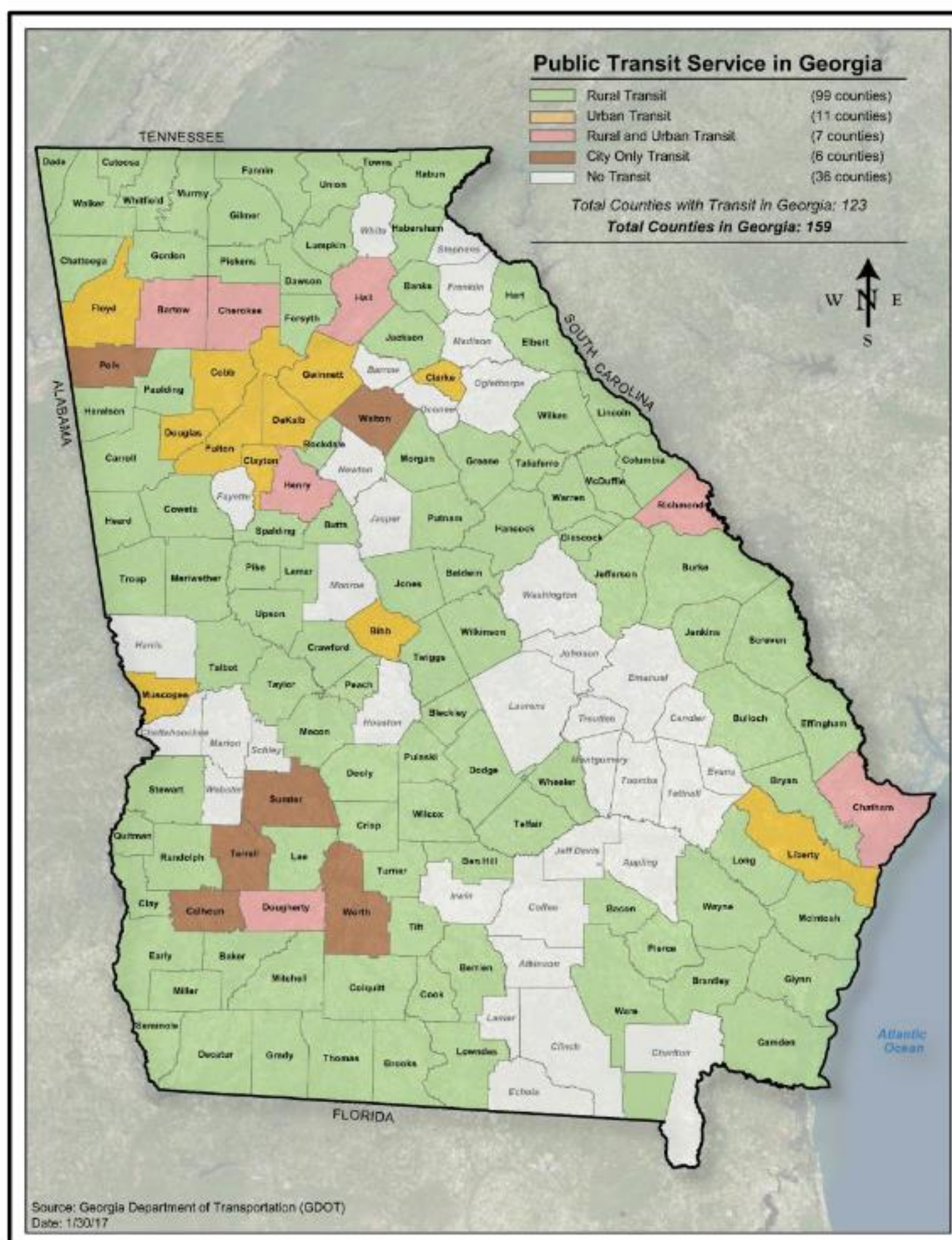
Public Transportation

GDOT is the state entity that has the responsibility for both the state's roads, bridges, and interstate highways and other modes of transportation, including rail, transit, general aviation, bicycle, and pedestrian programs. In FY 2017, the total budget for GDOT between state and federal funding sources was $3.65 billion, with state fees, taxes, and bond funds making up 56 percent and federal sources 44 percent (GDOT, 2017).

The services that are particularly relevant to meeting the needs of older adults who are not driving fall under the GDOT Intermodal Division. The division focuses on ensuring there are multiple modes of transportation with connectivity to one another, including rail, transit, aviation, and waterways. Regarding these modes of transportation, GDOT provides both planning and financial support. One of the offices within the division is the Transit Office, which has the mission to "identify and support cost effective, efficient and safe transportation systems." In FY 2017, $58 million of the GDOT budget was utilized to support transit capital projects, facilities, services, and shuttle buses and vans. The majority of the funds were federal funds (54%), followed by local (40%) and state funds (5%) (GDOT, 2017). Federal funding for transit is provided to the state by the FTA, an agency within the U.S. DOT. Of the FTA funding allocated to GDOT for transit, Section 5311 grant funding comprises a significant proportion. In FY 2017, GDOT received $21,857,873 in Section 5311 grant funding, which was then distributed to rural transit providers throughout the state (U.S. DOT, 2017).

GDOT partners with, and provides funds to, 91 transit systems operating across the state, including 80 rural, seven small urban, and four large systems. The existing systems are largely organized to serve individuals residing within a county. Services are available in 123 out of 159 counties, with a quarter of counties lacking any public transit service (GDOT, October 2017). Figure 3 provides a map of public transit coverage, including the breakout by system type.

Figure 3: Public Transit Coverage in Georgia



Source: Georgia Department of Transportation (2017)

The available transit systems provide one or more transportation services, including public, fixed-route transit, demand-response services, and ADA paratransit services. The service coverage within counties varies by system, with a spectrum of robust to limited service. Focusing on three

modes of service that are most relevant to older adults, bus, demand-response, and heavy rail, 146 million trips were provided across the state in FY 2016 (U.S. DOT, 2016). Table 1 provides additional details regarding the services provided by transportation mode through the transit agencies across the state of Georgia.

Table 1: Transit Data Elements by Transportation Mode for Georgia Providers

DATA ELEMENT	BUS (N = 14)	DEMAND RESPONSE (N = 95)	HEAVY RAIL (N = 1)
Operational Cost per Hour, Average and Range	$81.75 ($40.10-$162.47)	$36.69 ($11.92-$191.56)	$270.08
Cost per Passenger, Average and Range	$9.40 ($3.00–$42.50)	$21.71 ($5.85–$83.09)	$3.15
Fare Revenues Earned, Total	$73,853,712	$4,666,601	$75,717,593
Operating Expenses, Total	$295,028,907	$76,996,339	$225,438,652
Passengers per Hour, Average and Range	15.8 (2.0-34.2)	1.9 (0.5–4.6)	85.8
Unlinked Passenger Trips, Total	74,004,573	30,274	71,945,326
Vehicle Revenue Miles, Total	36,381,357	283,320	22,267,826

Source: U.S. DOT FTA National Transit Database, 2016
Notes: The sample size (n) is based on the number of providers for that mode that report data through the National Transit Database. All bus mode and demand-response services were included, with the exception of the University of Georgia Transit System.

A breakout of the recipients of transit funds indicates that there is significant variation in capacity and cost by recipient. For example, Brantley County provided 359 unlinked passenger trips, driving 16,618 miles, while Thomas County provided 89,653 unlinked passenger trips, driving 511,109 miles.

Non-Emergency Medical Transportation

For those eligible for Medicaid across the state, transportation to medical services and the pharmacy are provided when other transportation options are not available. Specifically, transportation is available to individuals in a fully covered eligibility category for Medicaid-covered services including medical treatment, medical evaluations, prescription drugs, and medical equipment (Georgia DCH, 2017). As shown in Table 2, there are two transportation brokers in the state, Logisticare and Southeastrans, covering the five regions structured by DCH. Each organization seeking to provide the broker service must serve the entire region(s) for which they are bidding. The contracts are negotiated every six years. The awarded broker is paid a capitated rate for each eligible Medicaid member that resides within the region(s) (DCH, 2018).

Table 2: Medicaid Non-Emergency Medical Transportation Broker, by Region

REGION	BROKER
North	Southeastrans
Atlanta	Southeastrans
East	LogistiCare
Central	LogistiCare
Southwest	LogistiCare

Source: Georgia DCH, 2018

To request transportation, a Medicaid member or person assisting the member calls the broker that serves the county where the beneficiary resides. The request must be made by telephone weekdays between 7 a.m. and 6 p.m., three days in advance of the trip needed, with exceptions for urgent situations. The brokers utilize a variety of modes and contract with transportation providers to deliver the transportation services to beneficiaries. According to a DCH fact sheet, the broker will use the most appropriate and cost-effective mode of transportation, which may include a minibus, wheelchair van, stretcher van, public transportation (including paratransit), gas reimbursement, or taxi services (Georgia DCH, 2018).

Current Medicaid policy sets minimum access standards for health care services based on geography as follows: 30 miles in urban communities, 50 miles in rural communities, 15 miles for adult day health care in urban and 30 miles in rural communities, and 15 miles for pharmacies in urban and 30 miles in rural communities (Georgia DCH, 2018). The transportation provider may expand the mileage length based on a health care provider's referral or on a case-by-case basis (Georgia DCH, 2018).

Data utilized in this report regarding NEMT use and expenditures were requested and provided through the DCH Medicaid data request portal. In state FY 2018, there were an average of 2.1 million Medicaid beneficiaries each month, with approximately 11% of those individuals aged 60 or older. Of the Medicaid beneficiaries over 60, there were an average of 238,315 members eligible for transportation services, and an average of 26,664 (11.2%) utilized transportation. Of the $104 million spent on transportation services, $7.1 million (6.9%) was spent serving individuals 60 and older. There were a total of 1.9 million one-way trips provided, with 814,115 (41.2%) of those provided to individuals 60 and older. For information regarding Medicaid NEMT services for each region, please see the regional profiles in Appendix B-M.

DHS Coordinated Transportation System

The DHS Coordinated Transportation System delivers services in each of the 12 DHS regions through a series of purchase-of-service contracts with a variety of providers, including governmental entities, for-profit organizations, and private nonprofit organizations (Georgia DHS, 2017). Notably, the majority of these providers are transit systems operated with FTA Section 5311 funds administered by GDOT (GDOT, 2017). In many regions, a prime contractor, which is often the regional commission, manages the contract in coordination with the Regional Transportation Office and subcontracts with service providers. Contractors are reimbursed for service provision through a fee-for-service methodology in the form of one-way trip rates (Georgia DHS, 2017).

The Coordinated Transportation System's policies and procedures are unique within each region and are established by a Regional Transportation Coordinating Committee composed of regional division representatives, human service providers, and other stakeholders. The Regional Transportation Coordinating Committee also approves new contracts annually and oversees contractors within each region (Georgia DHS, 2017). The program also divides the most populous DHS region — the Atlanta Regional Commission (ARC) — into four subregions, which are managed separately and participate in the program at varying levels.

The program utilizes the Transportation Request and Information Processing System (TRIP$) to track services and provide reports on system usage. TRIP$ was designed by DHS' Office of Information Technology and is used by human service providers (HSPs) to order services and provide approvals through a reconciliation process (e.g., the HSP orders the trip, then re-enters the system once the trip is provided to verify that the service was delivered) (GDHS, 2017b). The system validates requests and generates manifests to track trips, and transportation providers generate invoices through TRIP$ based on the number of completed and approved trips each month (GDHS, 2017b).

Funding and Services: Regional Analysis

While the Coordinated Transportation System operates in each of the 12 DHS regions, some counties within a region may not participate to provide services for older adults or may participate only in specific services (e.g., a county may only purchase bus passes through the program). Consequently, the types and availability of services delivered through the program differ by region.

The program offers a range of trip types, including core trips; noncore trips; long-distance trips; group or field trips; wheelchair trips; and, in some areas, vouchers for alternative transportation services, taxis, and fixed-route transit. The program also operates shuttles in several regions. The rate for core trips, which are trips offered during regular operating hours (6 a.m. to 6 p.m. in most regions), averages $6.09 across all regions. The rate for noncore trips averages $21.02. Noncore trips, which are trips delivered outside of regular operating hours, are available in many regions,

although they may not be available in specific counties of a region. Long-distance trips, the parameters for which differ by contractor, range from 25 to 75 miles or more and vary widely in cost and availability by region. Similarly, the rates for group field trips and wheelchair trips differ, as does the availability of these trip types by region. As the cost to provide each type of service and the specific sources and respective amounts of funding for Coordinated Transportation vary by region, the service profiles for each region of the state are fairly diverse.

Overall Program Funding and Service Delivery

For state FY 2018, the Coordinated Transportation System operated on an overall budget of $9,273,740.08, delivered a total of 815,364 one-way trips, and served a total of 7,761 unduplicated clients. The combined subregions of the ARC had the largest total budget of $2,236,015.97. Regionally, the Three Rivers region had the largest total budget of $1,007,531.79, followed by subregion 3A of ARC and the Central Savannah River Region, with $906,869.47 and $801,432.16, respectively. In contrast, the regions with the smallest total budgets were subregion 3B of ARC ($70,169 total budgeted, 16,229 one-way trips, 130 clients), Heart of Georgia ($414,920.50 total budgeted, 25,430 one-way trips, 91 clients), and Middle Georgia ($440,668.38 total budgeted, 33,301 one-way trips, and 167 clients).

The programs with the highest service delivery across funding sources in terms of one-way trips were the Central Savannah River Area (97,654), Northeast Georgia (77,187), and the Georgia Mountains Region (75,968). With regard to total unduplicated clients, Three Rivers served the most unique clients (1,026), followed by subregion 3A of ARC (972) and Central Savannah River Area (895). The regions with the lowest numbers of total, one-way trips were subregion 3B (Cherokee, Cobb, Douglas) of ARC (16,229), subregion 3B (C, F, H) of ARC (24,121), and Heart of Georgia (25,430). Regarding unduplicated clients served, Heart of Georgia served the fewest total clients through the program (91), followed by subregion 3B (Cherokee, Cobb, Douglas) of ARC (130), and Middle Georgia (167).

The HSPs that provide transportation services undergo a yearly contract evaluation process to determine their renewal eligibility. This evaluation is a compilation of surveys, data, and information that is gathered by the Regional Transportation Office. Each HSP is required to obtain consumer satisfaction surveys that are used to assess client satisfaction and maintain quality of service and will contribute to the TSS' evaluation summary. The surveys measure factors such as the consumers' attitude toward the HSPs' responsiveness, professionalism, flexibility with scheduling, and timeliness. In state FY 2018, a total of 10,535 consumer surveys were disseminated, and 5,640 were completed (54% response rate). Overall, 96% of the consumers who completed the survey felt that the HSPs met or exceeded their expectations.

FTA Section 5310

For FY 2018, the state of Georgia received a total of $7,873,700 in Section 5310 grant funding (U.S. DOT, 2018) across all Section 5310 funding categories. The categories of Section 5310 funding (large UZA, small UZA, and nonurbanized rural) are apportioned to different recipients by the FTA. Per federal regulations, the state is the recipient of small UZA and nonurban rural Section 5310

funding, which it allocates via the Intrastate Funding Formula, while large UZA funding goes to a direct recipient as designated by the governor (Georgia DHS, 2017). The Atlanta, Augusta, Columbus, and Savannah MPOs are each designated direct recipients of large UZA Section 5310 funds (GDHS, 2017). Of note, there is a state match requirement for FTA Section 5310 funding, which Georgia DHS meets via a soft match. Specifically, DHS reports usage of other fund sources in Coordinated Transportation to the FTA to compensate for the required match (Georgia House of Representatives Transit Governance & Funding Commission, 2018).

For state FY 2018, the combined ARC regions expended the most Section 5310 funding ($674,820.84 between all four subregions). Regionally, Central Savannah River Area, Northeast Georgia, and subregion 3A of ARC expended the largest amounts of Section 5310 funding, with $482,365.52, $333,812.80, and $329,230.95, respectively. The regions that expended the lowest amounts of Section 5310 funding were ARC subregion 3B (Cherokee, Cobb, Douglas) ($32,606.22), Coastal Georgia ($66,020.77), and Northwest Georgia ($100,207.06). Regarding trips funded through Section 5310, Central Savannah River Area delivered the highest number of trips, with a total of 62,805, followed by Northeast Georgia and Three Rivers, which provided 31,770 and 24,817 trips, respectively. The regions with the lowest numbers of Section 5310–funded trips were Coastal Georgia (7,126 trips), subregion 3B of ARC (9,969 trips), and Middle Georgia (10,324).

Older Americans Act Title IIIB

Older Americans Act Title IIIB funding is allocated by the state to the AAAs in each region using the Intrastate Funding Formula. This formula is updated decennially and draws on the most current census data to distribute funding based on the geographical distribution of older adults, as well as the proportion of older adults with the greatest economic and social needs (with a particular focus on low-income minorities) within each AAA region (GDHS, 2015). Per Older Americans Act Title III regulations, AAAs are to utilize these funds to develop or enhance comprehensive and coordinated community-based systems, which include transportation (Administration for Community Living, 2017). Title IIIB funding has a nonfederal match requirement of 15%, which is then shared between the state and local area as determined by the state division (ACL, 2017).

For state FY 2018, a total of $1,864,117.33 was expended and 199,253 trips were delivered across all 12 regions using Title IIIB funding. Coastal Georgia expended the highest amount of Title IIIB funding on transportation services at $267,649.30, followed by Georgia Mountains ($266,433.42) and subregion 3A of ARC ($192,841.97). The regions that expended the lowest amounts of Title IIIB funding on transportation services were subregion 3B (Cherokee, Cobb, Douglas; $15,928.07), subregion 3B (C, F, H) of ARC ($20,594.97), and Heart of Georgia ($42,390.10). Coastal Georgia delivered the highest number of trips funded through Title IIIB, with 29,082, followed by Georgia Mountains (26,043) and Southwest Georgia (24,642). The subregions of the ARC delivered the lowest numbers of trips using Title IIIB funding, with ARC 3B (C, F, H) providing 1,844 trips, ARC 3B (Cherokee, Cobb, Douglas) totaling at 2,652 trips, and ARC 3B (Gwinnett) delivering 3,274 trips.

Additional Funding Sources

As described previously, several other funding sources play a role in funding program services by region, including SSBG, CBS, 5316, and 5317. Of these sources, SSGB funding is the largest and most widely used to support program services. SSBG funding is allocated to DAS by the state Legislature and is then distributed to the AAA in each region. The AAA can then decide, based on regional need, how to best distribute the allocation across services, including transportation. A total of $2,727,557.63 was expended across all regions on program services for state FY 2018. The largest SSBG expenditures by region were made by subregion 3A of ARC ($346,478.47), Three Rivers ($323,004.87), and subregion 3B of ARC (Gwinnett; $272,375.88). Subregion 3B (Cherokee, Cobb, Douglas) of ARC had the lowest SSBG expenditures with $21,632.71, followed by subregion 3B (C, F, H) of ARC ($45,761.43) and Middle Georgia ($93,874.48). Regarding total trips funded through SSBG, Northwest Georgia (28,244), subregion 3A of ARC (27,215), and Three Rivers (26,604) delivered the most trips, while subregion 3B (Cherokee, Cobb, Douglas) of ARC (3,608), subregion 3B (C, F, H; 5,194), and Heart of Georgia (5,581) delivered the fewest.

The remaining funding sources, CBS, 5316, and 5317, are not used across all regions to fund program services for older adults, and AAAs or other planning/service delivery organizations may determine whether or not to utilize certain available funds for transportation services. Four regions drew on CBS funds in state FY 2018 to support program services: Three Rivers ($157,010.90; 12,995 trips), Northeast Georgia ($23,940; 2,704 trips), River Valley ($27,926; 2,660 trips), and Coastal Georgia ($111,344; 12,345 trips). Sections 5316 and 5317 are both expired FTA programs for which additional funds remain and have been carried over to fund services in several regions. Specifically, Northeast Georgia and River Valley drew on 5316 and 5317 funds to provide program services during state FY 2018.

DHS Transportation Services Delivered Outside of the Coordinated Transportation System

Outside of the Coordinated Transportation System, very few DHS-funded transportation services for older adults exist in any region of the state. Where they are operating, these services are predominantly financed using Older Americans Act funds and range in service mode and purpose. The types of services supported include voucher and volunteer programs, as well as demand-response type services, which are often limited to a specific purpose (e.g., medical appointments). These services are typically restricted to DHS clients, and some target specific areas of a region, such as rural counties without a public transit system.

Within the state, the vast majority of programs operated outside of the Coordinated Transportation System using DHS funding are located in the Atlanta region. For state FY 2018, six programs that were jointly funded through Section 5310 and through Section 5316 and 5317 grants provided services in six counties within the ARC region. The programs vary in size and scope, but are largely voucher programs offered through county senior centers. These programs enable older adults to purchase transportation vouchers at a discount for use with traditional public transit providers, private transportation providers (e.g., taxis or car services), or volunteers, depending on the program. In addition to the voucher programs, ARC funds a pilot program

offered through a nonprofit, Common Courtesy, in partnership with Uber and Lyft, as well as Checker Cab within the Metro Atlanta area. Common Courtesy acts as a liaison between riders and transportation providers and coordinates each trip, and also follows up with riders once the trip is complete to ensure safe arrival (Common Courtesy Inc., 2018).

Driver Safety Programs

A number of driver safety programs are offered for older adults throughout the state, both in person and online. Each program includes unique features and topic areas ranging from defensive driving techniques to safe medication use while driving. One of the largest programs available in the state is the American Association of Retired Persons' (AARP's) Smart Driver Course, which is available both online and in person. In-person trainings are provided in various locations, including senior centers, faith-based organizations, and libraries, and while they are most concentrated in the metropolitan areas of the state, they are also offered in many suburban and rural areas (AARP Smart Driver Course Locator website available in the references). Similar to the AARP program, the American Automobile Association offers Roadwise Driver, which is also available both online and in person. The Roadwise Driver program focuses on refreshing participants' driving knowledge, providing comfort and safety tips, learning to adjust to changes in reflexes and vision, and several other topics (American Automobile Association, 2018). The American Automobile Association also developed Roadwise Rx, which is a tool that enables users to record all of their medications, and the tool will provide customized feedback regarding interactions and how the medications can affect safe driving (American Automobile Association, 2018).

In addition to AARP's course, Georgia Department of Public Health's Older Driver Safety Program represents one of the largest driver safety efforts within the state. The program is funded by the Governor's Office of Highway Safety and is led by the Georgia Older Drivers Task Force, which is a multidisciplinary partnership between the Governor's Office of Highway Safety, DAS/AAAs, academic and research centers, and occupational and physical therapists (Georgia Department of Public Health, 2017). The program's focus is on reducing the number of injuries and fatalities experienced by older drivers and, where possible, enhancing mobility options for older adults through a number of activities, including education, policy enforcement, and building partnerships (e.g., with law enforcement emergency responders) (GDCH, 2017). The program also provides CarFit training to enable interested individuals to become CarFit technicians or event coordinators. CarFit is a national educational program that hosts educational events for older adults to assess how well they fit their vehicles, make adjustments and recommendations regarding vehicle fit to enhance safety and comfort, and also provide community resources for driver safety (CarFit, 2018).

Travel Training Programs

Travel training programs available through public transit providers are relatively scant throughout the state and are mostly offered by providers in the Atlanta area. Two examples within the Atlanta area include Gwinnett County Transit and Cobb County Transit. Gwinnett's program, How to Ride the Bus with Us, walks riders through the process of riding on an active bus and also provides information on how to pay a fare, read a bus schedule, utilize the program's app, and other related topics (Gwinnett County Transit, 2018). Cobb County Transit, known as CobbLinc, provides travel seminars, trainings, and tours targeted at older adults, persons with disabilities, and students (Cobb County Transit, 2018). Overall, travel training programs aim to increase the uptake of public transportation but are not widely available and may not be easily accessible to many older adults throughout the state.

MEASURING TRANSPORTATION NEED AND UNMET NEED FOR OLDER ADULTS IN GEORGIA: CURRENT AND FUTURE TRENDS

While an understanding of existing unmet need among older adults is important to inform transportation planning, little agreement on definitions, measures, and methodologies exists among academics and practitioners. Thus, a diverse and relatively inconsistent body of literature is available to guide efforts to quantify this construct. Consequently, the authors utilized an approach that draws on several methodologies to best characterize current and future need among older adults in the state. This section will include a literature review, description of relevant studies conducted in the state, characterization of disproportionately impacted populations, and methods used and main findings for the current study.

Key Findings

- Great heterogeneity exists within the older adult population, and those with poor health, low income, and suburban or rural residence experience inequities in transportation access.
- Transportation need, number served, and unmet need is difficult to precisely quantify. Current practices of managing waiting lists for tracking unmet need is not utilized, nor feasible, for estimating transportation unmet need.
- Unmet transportation needs described by providers and older adults include regional medical trips, recurring trips (e.g., trips to dialysis treatment), trips beyond the public transit service area and out-of-county trips, and evening trips.
- Quality-of-life trips, which range from trips to the grocery store to social events, emerge as a significant, persistent, unmet need from the perspective of service providers and consumers.
- Interest in meeting unmet needs through volunteer programs exists, but a lack of startup funding and insurance liability concerns have hindered these efforts.
- Some AAA regions are exploring new modes of service to provide quality-of-life trips through a fixed-route shuttle service to destinations such as the grocery store, pharmacy, and post office.
- Inadequate infrastructure, provider capacity, and information about services are persistent barriers across the state.
- The proportion of the population that is 65 and older will grow substantially from 1.3 million in 2016 to 2.9 million in 2040, with the greatest rate of change among those 85 and older.

- Every AAA region will experience growth in the older adult population, but the change will not be equally experienced across regions. The percentage change in population is projected to be the smallest in the Heart of Georgia region (2016-2025: 41%, 2025-2040: 21%), while the Atlanta region is expected to see the largest percentage change (2016-2025: 77%, 2025-2040: 61%).
- Through the application of driving prevalence estimates by age and gender to Georgia's 2016 population, it is estimated that 263,582 individuals aged 70 and older had ceased driving. Based on this estimate of the nondriving population, approximately 34% of individuals aged 70 and older in the state were no longer driving. After considering the number served through DHS and DCH programs, and estimating the use of alternative transportation modes, it is estimated that approximately 200,000 Georgians aged 70 and older may have unmet transportation needs.
- The greatest current and projected future concentrations of older adults with high mobility needs are in urban and adjacent suburban areas.
- Three cycles of State Plan on Aging assessments have found that stakeholders consistently rank transportation as a priority for ensuring individuals have the opportunity to age in place and remain in the community setting for as long as possible.

Review of the Literature

Identifying transportation need and unmet need, both current and future, is a component of the traditional public transportation planning process. According to the U.S. DOT (2007), the overall planning process should include:

- Monitoring existing conditions;
- Forecasting future population and employment growth;
- Identifying current and projected future transportation problems and needs, and analyzing, through detailed planning studies, transportation improvement strategies to address those needs;
- Developing long-range plans and short-range programs of alternative capital improvement and operational strategies;
- Estimating the impact of recommended future improvements to the transportation system on environmental features, including air quality; and
- Developing a financial plan for securing sufficient revenues to cover the costs of implementing strategies.

This process traditionally takes place within a defined geographic area and is led by an MPO for urbanized areas, while the state, in partnership with local officials and transit providers, carries out planning activities in nonmetropolitan areas (U.S. DOT, 2018).

As stated above, the identification of current and projected future transportation problems and needs occurs through detailed studies within the larger public transportation planning process. In practice, studies of public transportation need can vary substantially depending on the study's focus. Problems and needs considered can range from road safety to environmental impacts and involve myriad measures and methodologies both within and between topics. Accessibility studies, which are becoming more common in transportation planning practice, evaluate people's ability to reach desired goods, services, and activities via the transportation system (Levinson and El Geneidy, 2006). These too can differ in focus and may involve evaluating existing transit services; identifying needs through activities such as field observations, on-board rider surveys, demographic analyses, and input from community stakeholders; and identifying strategies, such as improving travel options and encouraging the use of alternative modes of transportation (Litman, 2012). Transportation assessments that focus specifically on unmet need and access in the public sector may also examine service gaps that exist for transit-dependent or transit-disadvantaged populations, who are generally defined as individuals who cannot provide their own transportation due to age, disability, or income constraints (U.S. Government Accountability Office, 2015), and thus rely on the public system. These assessments typically include multiple transit-dependent subpopulations, such as older adults as well as persons with disabilities, and can involve similar steps to transportation needs assessments for the general population, but narrow in on the specific subpopulation(s) of focus in their characterization of services, needs, projections, and strategies (Jiao, 2013).

Although more traditional transportation planning assessments of unmet need can yield important findings, current research on the travel behaviors and mobility of older adults indicates that these types of assessments may not capture the intricacy of older adults' needs (Hjorthol, 2013). Studies have found that, in addition to differences between age groups (i.e., 60 or 65 to 74, 74 to 84, and 85 and older), great heterogeneity in transportation-related need exists within these groups regarding factors such as health, socioeconomic status, and gender (Siren & Hakamies-Blomqvist, 2004). Consequently, researchers have struggled to find consensus in defining need and unmet need, and studies have varied considerably with regard to measures, variables, and samples (Luiu, Tight, & Burrow, 2017).

Many evaluations of transportation need specifically among older adults have relied heavily on qualitative methods, such as surveys, interviews, and focus groups. Of these, survey methods are particularly common and examine different individual characteristics, as well as aspects of transportation need. For instance, Dobbs & Pidborochynski (2016) administered three separate assessments that evaluated unmet need in relation to (1) sociodemographic characteristics, such as age, sex, marital status, income, and health status; (2) urban versus rural setting and the availability of alternative and specialized transportation services; and (3) the need for and availability of intermunicipal and regional medical transportation. In an analysis of survey data collected in Norway on travel and participation in activities in old age, Nordbakke & Schwanen (2014) studied the impact of sociodemographic characteristics and accessibility-related variables

(e.g., supply of public transportation), as well as the relationship between respondents' social support and network and unmet need.

In addition to, and sometimes in combination with, surveys and other qualitative methods, many assessments have utilized demographic data available through the U.S. Census Bureau to geographically identify areas where need is likely to be concentrated. In a needs assessment of Clinton County, N.Y., for example, TranSystems Corp. used 2009 U.S. Census Bureau ACS data to map the density of transit-dependent populations within the county, including older adults, low-income households, zero-vehicle households, and persons with disabilities (TranSystems, 2011). The authors also compared relative transit need to the location of important trip generators (locations to which the general public, especially transit-dependent populations, need access, such as nursing homes and adult day centers, accessible and low-income housing, and major employers) within the county.

In a different vein, but also often to supplement qualitative findings, some evaluations have included mathematical modeling to capture transportation need among older adults. The Denver Regional Council of Governments' Transit Needs Assessments and Alternatives Analysis (2005) utilized three mathematical models to estimate demand for specialized transportation. The methodology drew on a previous survey of travel patterns of older adult/disabled residents and used factors such as daily trip rate and transportation mode of choice for various subgroups (e.g., for one calculation, those who would use specialized transit under any circumstances, those who would not use specialized transit, and those who do not use transit now but would if it were available to them) to calculate total estimated demand. The Denver Regional Council of Governments complemented these quantitative findings with results from surveys of different consumer groups and transit providers.

Another approach used to capture unmet need within Georgia, though not specifically for transportation services, is through the use of DHS' administrative database. The database is used by AAA staff to document requests, services received, and waiting lists for several home- and community-based services. However, the database is seldom used to capture unmet transportation needs, as if the request cannot be met it is unlikely that additional funding will become available to meet the need or that the need will stay constant (e.g., a client in need of transportation to a medical appointment the following week would no longer need that trip beyond the scheduled appointment date). Thus, transportation requests that cannot be met are not tracked or maintained on a waiting list. Due to this fact the authors were not able to draw on administrative data to capture unmet need for the current study.

The methodology used for this study and described in more detail in subsequent sections of this report most closely aligns with access-oriented transit planning methodologies. Though these methodologies are more appropriate for the current study than those used for traditional congestion- or safety-oriented planning, they can miss some of the nuances of older adult transportation need. Consequently, the authors supplemented the access-oriented, quantitative methodology used with qualitative data, which includes surveys and interviews with consumers

and aging services professionals. The authors sought to examine unmet need among older adults more comprehensively through the use of these combined approaches, and, while these approaches are imprecise, they aimed to yield more accurate findings than would be possible using any singular approach.

A Closer Look at Unmet Need

Addressing transportation-related unmet need among older adults is inherently challenging, as determinants of unmet need are complex and interrelated. Consequently, a singular solution to this growing problem does not exist. Within the older adult population, specific subgroups are disproportionately disadvantaged and should be considered with regard to service planning and policy design. Subgroups identified through both a review of the existing literature and input from providers and consumers across the state include older adults with poor health status, low-income, and low-density suburban or rural residence. Additionally, certain trip types, such as medical trips, are often prioritized over trips for other purposes, such as social and community events. Although trips to medical appointments are inarguably critical, the restriction of resources for other trips often reduces or even eliminates opportunities for social inclusion and activities that promote well-being for many older adults. Thus, transportation to quality-of-life-enhancing trips is a persistent unmet need for many across the state and should also be recognized, as unfulfilled social, leisure, and related needs regarding out-of-home activities have been found to have deleterious effects on older adults' health and wellness (Nordbakke & Schwanen, 2014).

In a systematic review of the literature, Haustein & Siren (2014) found that health status was a main predictor of driving cessation among older adults. Furthermore, poor health has been consistently reported as affecting travel behavior, to include not only driving but also mobility broadly, especially among the oldest old (adults 75 years old and older) and women (Luiu, Tight, & Burrow, 2017). Research indicates that poor health, both mental and physical, medical diagnoses, and perceived health-related mobility limitations can impact self-efficacy regarding mobility and can prevent some older adults from engaging in any out-of-home activity, irrespective of actual mobility (Webber, Porter, & Menec, 2010). Of the vast array of health conditions that affect older adults, dementia, frailty, physical disabilities, and chronic conditions requiring frequent medical visits have repeatedly emerged as determinants of mobility.

Among older adult drivers, an estimated 4% of those over 75 years of age have dementia, and many will continue to drive as the disease progresses (Wadley, Okonkwo, & Crowe, 2009; Foley, Masaki, Ross, & White, 2000). A dementia diagnosis can also cause older adults to limit activities outside of the home due to fear of getting lost and wandering (Adler & Silverstein, 2008; Cotter, 2007). Similarly, older adults who have experienced a fall or report fear of falling are more likely to restrict their mobility outside of the home (Webber, Porter, & Menec, 2010). Dementia, frailty, and physical disabilities can also inhibit older adults' use of public transportation services, as they may experience difficulties boarding and alighting vehicles, navigating transportation systems, or accessing transit stops (Hjorthol, 2013; Luiu, Tight, & Burrow, 2017). Within the state, particular concern surfaced among aging services professionals regarding older adults who require recurring

specialized transportation for conditions such as chemotherapy or dialysis treatment. Across the state, many older adults, especially nondrivers who lack informal supports, struggle to access treatment for these chronic conditions largely due to financial constraints or inadequate public transportation service coverage. Therefore, a multitude of health conditions can affect access to transportation and mobility among older adults, including driving, utilizing alternative transportation options, and making decisions regarding activities outside of the home.

Income is also among the most significant determinants of mobility among older adults and impacts access in many ways. The literature suggests that people with lower incomes are more likely to be transportation-disadvantaged and that income-related mobility restrictions can impact psychosocial, physical, and environmental factors related to well-being (Webber, Porter, & Menec, 2010). Perhaps the most obvious way an individual's financial resources can impact access to transportation is in one's ability to own a personal vehicle or afford alternative transportation options (e.g., pay for a bus fare). However, income can also dictate decisions regarding the location of one's home, which influences a host of access-related factors, such as proximity to services, cost to travel, and neighborhood characteristics (e.g., presence of sidewalks). Income-related mobility restrictions can severely limit older adults' access to basic needs, including one's ability to engage socially and maintain relationships outside of the home (Webber, Porter, & Menec, 2010). Further, isolation can compound immobility, as older adults with social connections may be able to leverage those relationships to help meet mobility needs, whereas isolated older adults lack that potential. Income is worth highlighting within the context of older adult need, as older adults are particularly vulnerable financially due to fixed incomes and competing expenses (e.g., payments for health care). Therefore, income factors heavily into older adults' mobility and has immense capacity to impact health and wellness.

Low-density suburban and rural residence also presents multifaceted challenges with respect to transportation access among older adults. These communities often have limited public transportation systems or lack public transportation altogether. According to a White House report (2010), rural and small communities tend to have smaller tax bases due to decreased economic opportunities and lower standards of living and, as a result, typically have insufficient resources to support a public transportation program. Inadequate public transportation can quickly isolate older adults in these communities once they cease driving, as viable alternatives to driving may not exist, especially among individuals without informal supports, such as a child, spouse, or neighbor, to assist.

Therefore, several subpopulations of older adults are more likely to experience transportation disadvantage at present and warrant attention in current planning and policy efforts, as well as continued focus moving forward. The potential for shifts in factors that impact life in older adulthood, such as technology, make it unclear whether the disparities observed among these subgroups will persist. Technological advances and the increased likelihood of their adoption among future generations of older adults have the potential to ameliorate some of the challenges faced by these subgroups, as well as older adults broadly at present. However, as the aging population grows, the prevalence of many of these determinants of mobility, such as health

conditions and financial insecurity, is also anticipated to increase. Therefore, it is imperative that actions are taken to address existing inequities in access among these subgroups of older adults, as, otherwise, the effects of transportation disadvantage are likely to worsen over time.

Past and Current Work within Georgia

Efforts to address unmet transportation need for different groups have been made in recent years within the state, including work that is currently underway. A major focus within the state over the past decade has been on the development and improvement of the rural transportation system. The Rural Human Services Transportation Committee of the Governor's Development Council was established as a result of HB 277 to oversee rural and human services transportation coordination (HNTB, 2011). A significant body of work exists as a result of the committee's activities, including a series of reports comprising the Georgia Rural Human Services Transportation Plan 2.0. Beginning in 2011, HNTB Corp. began publishing these reports, which detail recommendations based on a thorough needs assessment of rural transportation in the state, data collected during two sets of workshops held in each of the state's 12 regional commissions, and national research (HNTB Corp., 2011). The goal of this specific project was to design an enhanced rural and human services transportation model that increases coordination among public and human services transportation providers and, ultimately, increase capacity, efficiency, and cost-effectiveness.

The House Commission on Transit Governance and Funding, established through HR 848 during the 2017 legislative session, has also initiated important activities regarding rural transportation in the state. The commission is working with Deloitte on the Georgia Transit Governance and Funding Study, which is currently aiming to establish the design and legislative support for a new governance and funding model for rural transit in the state (Deloitte, 2018). The commission's work, along with that of the Governor's Development Council's Rural Human Services Transportation Committee, has contributed significantly to the understanding of operations and identification of deficiencies within the state's rural transportation system, and both bodies are actively shaping the future of rural transportation in Georgia.

Another significant area of work relevant for transportation-disadvantaged groups in the state, including older adults, is occurring at the local and regional level. The Rural Transit Need and Demand Spreadsheet, developed by the Transit Cooperative Research Program of the Transportation Research Board, is an approach that is currently used in some rural areas of the state to quantify the need for passenger transportation services and the demand that is likely to be generated if passenger transportation services are provided (Transit Cooperative Research Program, 2013).

Using the tool, planners and transit operators can estimate need, which is defined as the number of people likely to need passenger transportation and the number of trips required to provide individuals without personal vehicles with a level of mobility equal to those having access to

personal vehicles. Demand is estimated by four markets: (1) general public services (5311); (2) social services or other program-sponsored trips; (3) fixed-route service in small urban towns in rural areas; and (4) travel on commuter services from rural counties to urban areas. The tool uses demographic data (preferably ACS data), including number of persons living below the poverty level, number of persons residing in households owning no vehicle, and population 60 years of age and older, to compute an estimate for the number of persons within the study area who are in need of passenger transportation services. The tool also uses the mobility gap, which is defined as the total number of trips not taken because members of households without a vehicle do not have the ease of mobility available to members of households with a vehicle (TCRP, 2013). The mobility gap is derived from 2009 National Household Travel Survey data and is calculated for each of the nine census regions individually. The estimate generated using the mobility gap quantifies the resources that would be needed to meet unserved demand. These estimates are paired with the knowledge of local need among planners and service providers to address unmet transportation need in areas of rural Georgia.

The study described in this report drew on several methods, including a literature review, surveys with consumers and aging services providers, interviews with transportation providers and experts, estimation of nondriving by age and gender, and use of the Mobility Need Index for aging populations. The index, which was developed by Ettleman et al. (2017), allows for the geographical identification of areas of the state where higher mobility needs exist. Detailed descriptions of the methodologies used in the statistical analyses included in this report are available in Appendices N, O, and P.

Survey of Georgia AAA Staff

To gain local insights about transportation issues specific to older adults, as well as potential solutions, the study team conducted a statewide survey with follow-up telephone contacts with AAA staff from each region. The AAA staff are knowledgeable regarding the transportation services available and have significant awareness of the unmet needs of older adults in the region they serve. Common themes emerged across regions with regard to unmet needs, key issues, underserved subpopulations, and opportunities to mitigate barriers to access. From the perspective of the AAA staff, shopping trips, local and regional medical trips, specialized recurring trips (e.g., trips to dialysis treatment), trips beyond the public transit service area and out-of-county trips, and evening trips were most frequently cited as unmet needs. As senior center and medical trips are often prioritized within the DHS Coordinated Transportation System, quality-of-life trips, which can be trips ranging from the grocery store or pharmacy to trips to social events, are seldom available to nondriving older adults who lack informal supports or financial resources. Additionally, although medical trips are prioritized, many respondents noted that unmet need for medical transportation persists and that current funding is inadequate to bridge gaps in access, especially for conditions requiring recurring treatment visits.

With respect to barriers, respondents reported that limited public transportation availability, hours, and affordability; the availability and accessibility of information about services; and

inadequate demand-response services most often inhibit access to transportation. Regarding underserved populations, older adults not connected to senior centers were identified as a subgroup with significantly less access to services and information about transportation. Additionally, respondents indicated that older adults residing in rural areas are particularly disadvantaged. For instance, the paucity of medical providers in rural counties often requires residents to travel outside of their county of residence for treatment, which many transportation providers cannot accommodate. Thus, pervasive issues, such as inadequate transportation for medical appointments, can be augmented for older adults residing in rural areas. Respondents also reported that older adults with specialized transportation needs (e.g., door-to-door service), especially dementia patients, frail elderly, and those with sensory impairments, are underserved across the state, as many regions lack the capacity to transport these individuals.

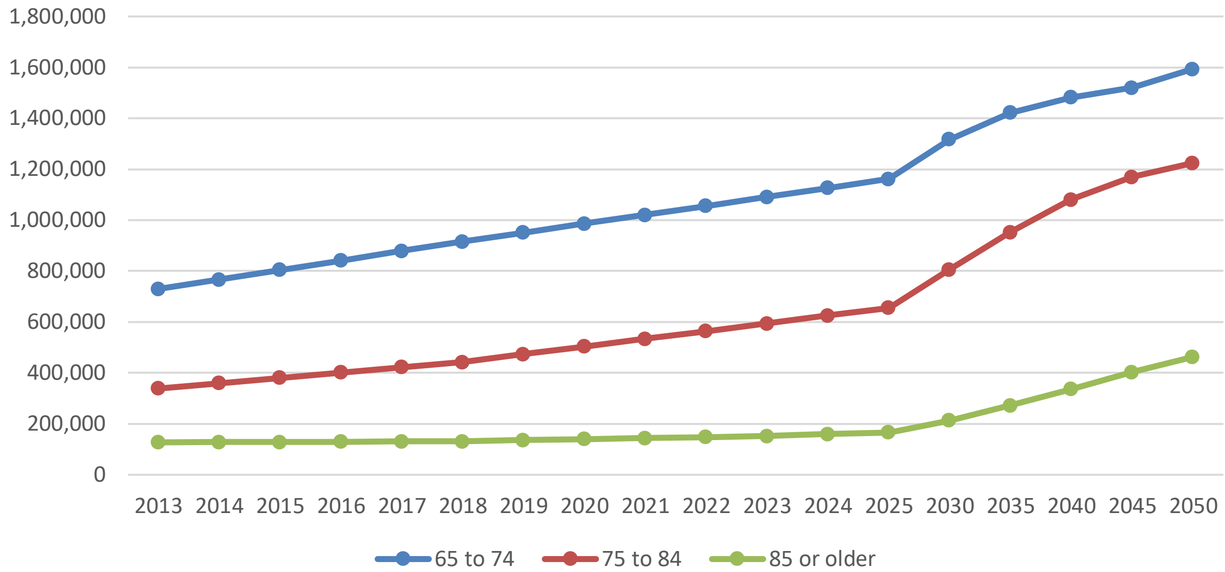
When asked what strategies could be implemented to overcome barriers to service access, providers most often responded that shuttle services, volunteer programs, and voucher programs are the most feasible to implement within their respective regions. In several regions, the aforementioned services are either already operational or will begin service within the next year. Many respondents stated that voucher and volunteer programs are cost-effective solutions and are particularly well suited to client needs. Several respondents also indicated that cost-sharing could contribute to the sustainability of various programs and strategies.

Demographic Analysis

The current and projected changes with regard to the aging of the population were analyzed utilizing demographic characteristics available for older adults in Georgia. The data presented in this section were drawn from the ACS 2016 5-Year Estimate data and the Georgia Office of Planning and Budget population projection data 2015 series. Due to data availability at the county level from the ACS files, the older adult population described in this section focuses on individuals 65 and older.

The key takeaway from the information provided with these data is that the population in Georgia is getting older. In 2016, 13% (1.3 million) of the state's population was aged 65 and older, and by 2040 that share is projected to grow to 22% (2.9 million). Due to longer life expectancies, the older adult population growth rate is different across age groups. As shown in Figure 4, while the population of individuals 65 and older makes up the largest share of the population, the rate of change is greatest for the 85 and older population. The dramatic increases seen around 2025 represent the last of the baby boom generation turning 65.

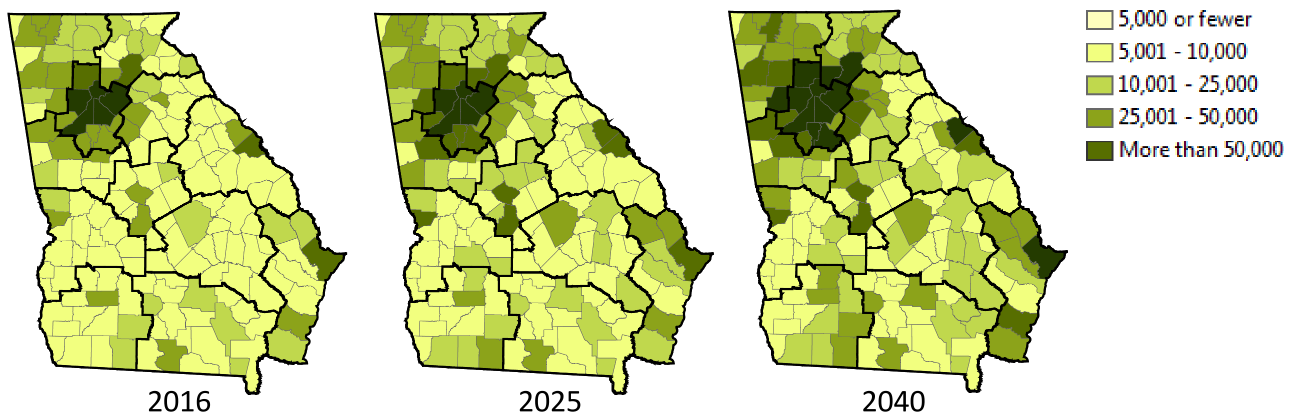
Figure 4: Georgia Population Projections by Age Group



Source: Authors' analysis of population projections from the Governor's Office of Planning and Budget, Series 2015

The information presented in Figure 5 shows the change in the absolute number of individuals over age 65 by county at three time points: 2016, 2025, and 2040. As presented in the maps, the counties with the largest number of older adults are generally concentrated in Atlanta, the suburban counties surrounding Atlanta, the northwest corridor, Georgia's coastal counties, and the counties in the Augusta area. The projected population growth between 2016 and 2040 is expected to occur largely in the counties that currently have more older adults.

Figure 5: Total Population Aged 65 and Older in 2016, 2025, and 2040



Source: Authors' analysis of population projections from the Governor's Office of Planning and Budget, Series 2015

With regard to the regional differences in population change, Table 3 presents the population 65 and older subtotaled by region across the three time points. Every region will experience growth in the older adult population, but the change will not be equally experienced across regions. For

example, the percentage change in population is projected to be the smallest in the Heart of Georgia region (2016-2025: 41%, 2025-2040: 21%), while the Atlanta region is expected to see the largest percentage change (2016-2025: 77%, 2025-2040: 61%).

Table 3: Total Population 65 and Older by Region, 2016, 2025, and 2040

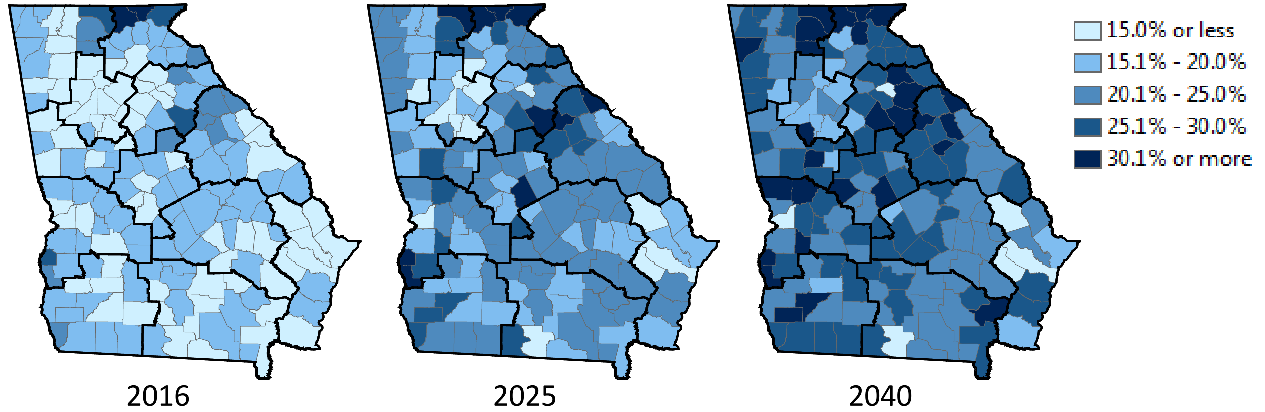
REGION	2016	2025	2040	PERCENT CHANGE 2016-2025	PERCENT CHANGE 2025-2040
Northwest Georgia	125,220	191,210	262,808	53%	37%
Georgia Mountains	102,743	152,612	234,802	49%	54%
Atlanta Region	443,748	785,032	1,265,761	77%	61%
Three Rivers	70,078	109,373	153,942	56%	41%
Northeast Georgia	76,447	121,693	184,122	59%	51%
River Valley	53,103	77,220	94,296	45%	22%
Middle Georgia	70,040	103,321	130,805	48%	27%
Central Savannah River Area	66,742	103,081	135,696	54%	32%
Heart of Georgia	45,505	64,257	77,982	41%	21%
Southwest Georgia	52,523	74,819	90,449	42%	21%
Southern Georgia	55,829	80,351	99,713	44%	24%
Coastal Georgia	83,139	121,372	168,250	46%	39%
Statewide	**1,245,116**	**1,984,341**	**2,898,626**	**59%**	**46%**

Source: Authors' analysis of population projections from the Governor's Office of Planning and Budget, Series 2015

In addition to reviewing the absolute population, Figure 6 examines the proportion of the total population over age 65 by county. In 2016 the 65 and older population made up less than 15% of the population in 66 counties, while in 2025 the number is projected to drop to 12 counties, and in

2040 to six counties. The six counties in 2040 with the lowest share of older adults are very small and rural or include large college student or military base populations.

Figure 6: Proportion of Population Aged 65 and Older, 2016, 2025, and 2040



Source: Authors' analysis of population projections from the Governor's Office of Planning and Budget, Series 2015

As shown in Table 4 below, the percentage of population 65 and older presents a different story than the absolute number. Where the Atlanta region had the largest number of older adults, the population accounts for 10% of the population in 2016, the smallest proportion of all 12 regions in the state that year. The region with the largest proportion of older adults in 2016 was the Georgia Mountains region (16%). All regions will experience significant growth in the proportion of the population that is 65 years and older, where older adults will comprise close to one-quarter of the population in most of the regions by 2040.

Table 4: Percent of Population 65 and Older by Region, 2016, 2025, and 2040

REGION	2016	2025	2040
Northwest Georgia	14%	20%	25%
Georgia Mountains	16%	19%	22%
Atlanta Region	10%	15%	21%
Three Rivers	14%	19%	23%
Northeast Georgia	13%	18%	22%
River Valley	14%	19%	22%
Middle Georgia	14%	19%	23%
Central Savannah River Area	14%	19%	23%
Heart of Georgia	15%	20%	24%
Southwest Georgia	15%	20%	24%
Southern Georgia	14%	18%	21%
Coastal Georgia	12%	16%	18%
Statewide	**13%**	**17%**	**22%**

Source: Authors' analysis of population projections from the Governor's Office of Planning and Budget, Series 2015

Estimate of Transportation Need, Number Served, and Unmet Need

To estimate the total number of individuals in Georgia who may need access to transportation services and supports, the authors utilized prevalence of driving estimates by age and sex determined by Foley, et al. (2002) and applied the estimates to the state's population. This analysis focuses on the population 70 and older due to the limitations of the data available from the dataset utilized for the study conducted by Foley et al., the Asset and Health Dynamics of the Oldest Old. Additionally, the subgroup of older adults excluded from the analyses are less likely to experience unmet need, as the majority of older adults under the age of 70 are still driving (AARP, 2011).

The findings, as presented in Table 5, estimate that there are approximately 263,582 individuals aged 70 and older who were not driving in 2016. Based on this estimate of the nondriving population, approximately 34% of individuals aged 70 and older were no longer driving. As indicated, the majority of nondrivers are female, based on findings that females were much more likely to have never driven, stopped driving, and have longer life expectancies than males (Foley, 2002). For additional information regarding the methodology of the estimate of nondrivers, see Appendix P.

Table 5: Estimate of Nondrivers in Georgia, 2016

REGION	Female Nondrivers Aged 70 and Older	Male Nondrivers Aged 70 and Older	Total Nondrivers Aged 70 and Older
Northwest Georgia	20,018	6,174	26,192
Georgia Mountains	15,987	5,499	21,486
Atlanta Region	74,678	21,062	95,740
Three Rivers	11,326	3,258	14,584
Northeast Georgia	10,547	3,125	13,672
River Valley	9,217	2,457	11,675
Middle Georgia	11,567	3,363	14,930
Central Savannah River Area	10,289	3,037	13,326
Heart of Georgia	7,418	2,241	9,660
Southwest Georgia	9,130	2,604	11,734
Southern Georgia	9,256	2,859	12,115
Coastal Georgia	14,091	4,378	18,469
Statewide	**203,524**	**60,058**	**263,582**

Source: Authors' analysis of the U.S. Census Bureau, ACS 5-Year Estimates using driving prevalence rates from Foley et al., 2002

After estimating the number of individuals who may need transportation services, it is important to consider the number of individuals who are being served by the programs currently operating. The number of individuals aged 60 and older served by existing transportation programs provided through the Georgia DCH and DHS statewide is estimated in Table 6. In total, approximately 37,877 individuals aged 60 and older were served. The programs provided clients 1,786,634 one-way trips and had $17,045,420 in total program expenditures.

Table 6: Estimate of Individuals Served, Number of Trips, and Program Expenditures by Agency in FY 18

AGENCY	Unduplicated Clients	One-Way Trips	Program Expenditures
Department of Human Services, Coordinated Transportation, Clients Aged 60 and Older	7,761	815,364	$8,271,375
Department of Human Services, Outside of Coordinated Transportation, Estimate of Clients Aged 60 and Older	3,452	157,155	$1,635,036
Department of Community Health, Medicaid Members Aged 60 and Older	26,664	814,115	$7,139,009
Total	**37,877**	**1,786,634**	**$17,045,420**

Source: Authors' analysis of administrative data provided by DHS, DCH, and the state's 12 AAAs

The authors were unable to estimate the number of older adults served by the public transportation agencies receiving funding through the GDOT due to a lack of available data. However, findings from an analysis by the AARP of data from the National Household Travel Survey suggest that a relatively small proportion of older adults' trips, approximately 2.2%, are by public transit (AARP, 2011). According to the report, individuals aged 65 and older use active transport more often than public and make approximately 8.8% of trips on foot. It is not possible to know if nondrivers in Georgia utilize alternative transportation modes such as public transit or walking at the same rate as the national estimate, but if the estimates were accurate, nearly 29,000 nondrivers may have their transportation needs met.

Table 7 presents a summary of the estimates utilized to understand the possible number of older Georgians with an unmet transportation need.

Table 7: Summary of Estimates for Transportation Need, Served Need, and Unmet Need

	Estimate of the Total Nondriver Population Individuals 70 and Older, 2016	Total DCH and DHS Program Clients Served in FY 18	Estimate of Nondriver Population Need Met by Public Transit*	Estimate of Nondriver Population Need Met by Walking**	Possible Number of Individuals with an Unmet Need
Statewide	263,582	37,877	5,799	23,195	196,711

Source: Authors' analysis of the U.S. Census Bureau, ACS 5-Year Estimates, administrative data provided by the DHS, DCH, and the state's 12 AAAs
Notes: Application of findings from the AARP analysis of the National Household Travel Survey regarding trip modes of public transit and walking. *Applies estimate that 2.2% of individuals 70 and older who do not drive have their needs met through public transit. **Applies estimate that 8.8% of individuals 70 and older who do not drive have their needs met through public transit.

In summary, an estimated 263,582 Georgians aged 70 and older may need access to services and supports to meet their transportation needs due to driving cessation. The DHS- and DCH-funded programs are serving approximately 37,877 individuals, which could be meeting the transportation need, partially or completely, for about 14% of older adults in the state. In applying national estimates of public transit and walking, an additional 28,994 individuals may have their needs met, at least in part. An undetermined portion of nondrivers may have their needs met through other modes of transportation, having services and goods delivered, or family and friends. Ultimately, some portion of the population of nondrivers have unmet needs, for which an exact number of individuals is difficult to estimate, but using the estimates provided could be nearly 200,000 Georgians aged 70 and older. An additional examination of the distribution of individuals who are likely in need of mobility support is considered in the next section.

Analysis of Geographic Density of Transportation Need

The Texas A&M Transportation Institute tested and published a methodology for identifying the geographic density of mobility need for the older adult population (Ettleman et al., 2017). The researchers named the methodology the Mobility Need Index (MoNI). The key benefits of the approach are the focus on older adults and that it combines several characteristics, drawn from publicly available ACS data, that are likely to indicate mobility need, in a composite index score. The six characteristics include age separated into three age groups, population 65 and older living in poverty, population 65 and older with a disability, and households aged 65 and older with no vehicle. The assigned weights and justifications for the characteristics included in the MoNI are provided in Table 8 below.

Table 8: MoNI Characteristics, Weights, and Weight Justifications

Characteristic	Weight	Justification for Weight Value
Aged 65–74 (young-old)	0.5	Young-old adults are the least likely segment of the aging population to have mobility challenges and are often still working, driving, and in good health.
Aged 75–84 (old)	1	Old adults in the 75–84 age segment face increased mobility challenges as transportation options, such as operating an automobile, become more limited.
Aged 85 and over (old-old)	1.5	Old-old adults have more mobility challenges and fewer options (e.g., inability to walk unassisted).
Persons living in poverty aged 65 and over	1.5	Lower-income populations have less access to services such as taxis and TNCs and are more likely to have to rely on public services for transportation.
Households with no vehicle aged 65 and over	1.5	Low vehicle access reflects populations that do not have the option to drive themselves.
Persons with a disability aged 65 and over	1.5	Individuals with disabilities have increased mobility challenges and may require access to specialized transportation options.

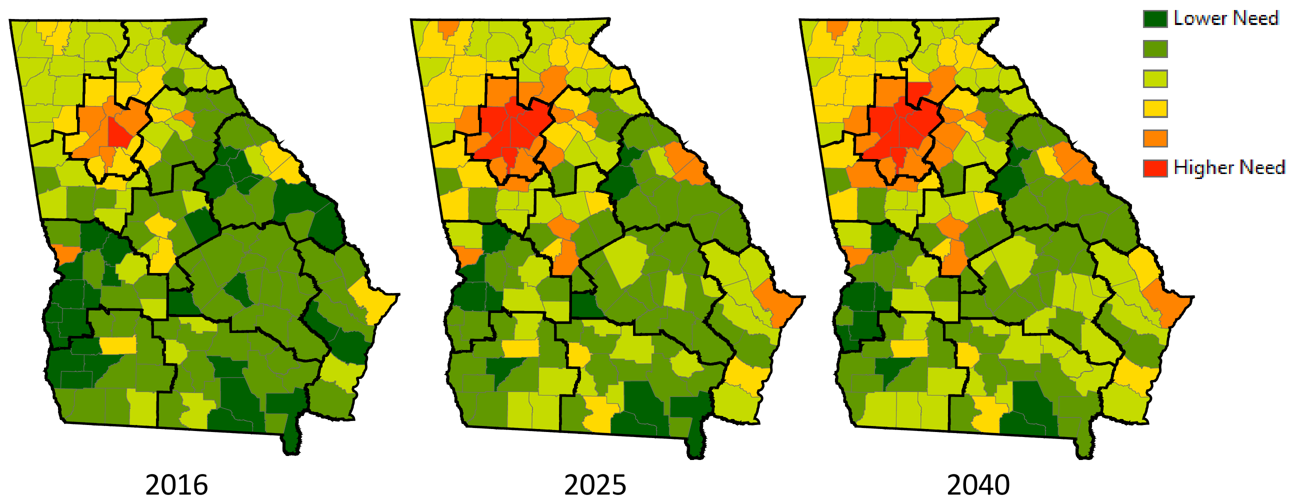
Source: Ettelman, et al., 2017

The weights applied to the characteristics are assigned to account for the relative importance of the characteristic to the increased need for mobility support. The MoNI takes into account the land area of the county in order to represent the density of individuals with greater mobility need per square mile. Due to the large variation in the population density by county in Georgia, similar to Texas, the MoNI was log transformed to produce a normal distribution of the values. This approach provides the opportunity for a greater level of variance of the counties outside of those that are more densely populated. Finally, in addition to looking at the current period (2016), the authors' maintained assumptions that the poverty rates, rate of households with no vehicle, and rate of disability would stay the same and projected the MoNI score for 2025 and 2040 utilizing the population projections. There are concerns with maintaining these assumptions, as significant changes in the economy or advances in medical technology, for example, would change the rates seen in current county statistics. However, the information is provided as a potential scenario that could be utilized to guide planning, with attention to what is also known by local planners. For additional information regarding the application of the MoNI, see Appendix N.

The results of the MoNI are displayed in Figure 7. The results of the analysis indicate that the most significant mobility need in 2016 existed in the core of the Atlanta region, in Muscogee County (Columbus), and Athens-Clarke counties. Additional areas of higher need include Bibb and

Houston counties (Macon), Catoosa and Whitfield counties (Dalton), and Chatham County (Savannah). Over time, the projected need increases in those original geographies and spreads to the suburban areas adjacent to those locations.

Figure 7: MoNI Results, 2016, 2025, and 2040



Source: Authors' analysis of population projections from the Governor's Office of Planning and Budget, Series 2015 and ACS 2016 5-Year Estimate data

The MoNI brings to the forefront the counties where the need is highest; the findings provided do not suggest that the areas on the lower end of the index do not have individuals with transportation needs. The analysis is intended to present the counties with the greatest density of need per square mile. If the rates of population growth, disability, car ownership, and poverty remain constant, it is projected over time that the need will either be constant or increase. The results suggest that there would essentially be no measurable reduction in mobility need over time due to the growth in the older adult population. There is an observable growth of need in suburban areas and much of northern Georgia. Further, the change observed shows increasing mobility need over time in many additional, more rural counties.

Analysis of Stakeholder Input Across Georgia

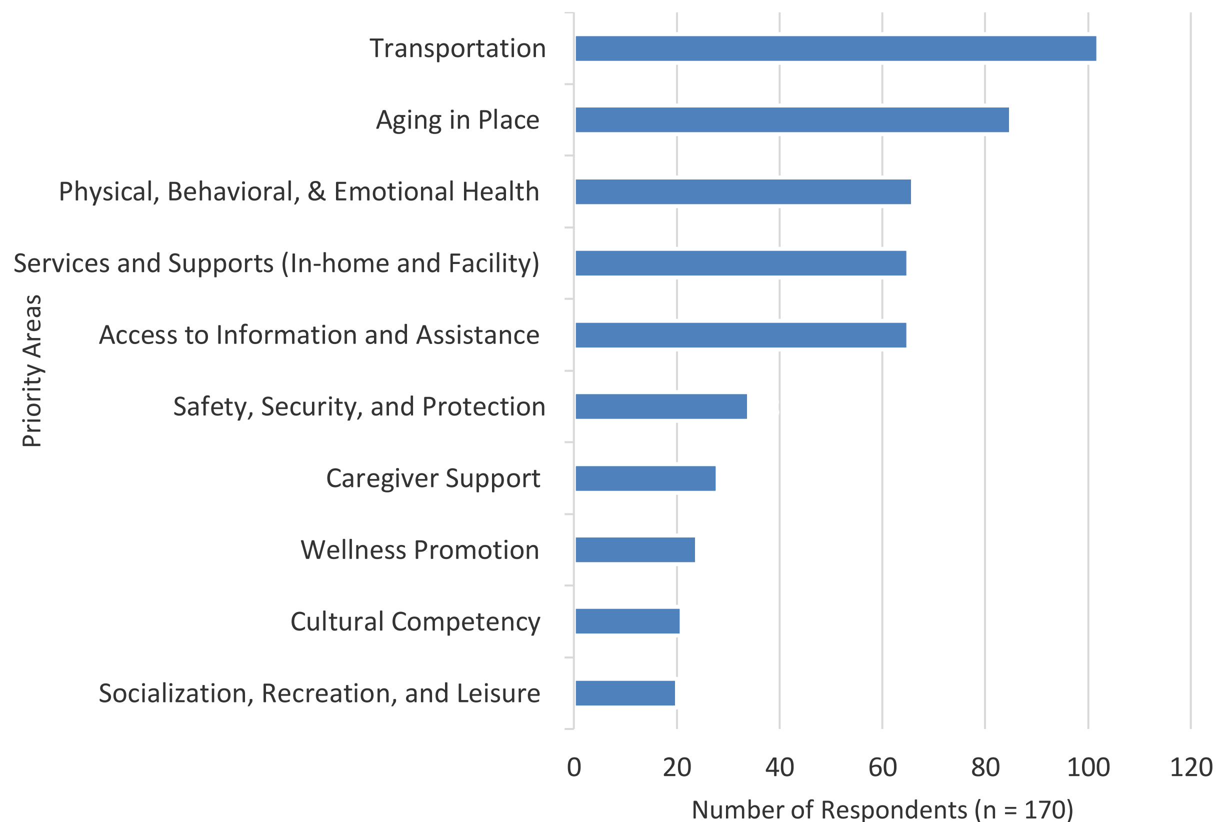
DAS contracted with the Georgia Health Policy Center at Georgia State University in 2018 to gather stakeholder input in preparation for the State Plan on Aging, a requirement to receive funding from the Administration for Community Living. The input was gathered through two modes: a web-based survey and 12 community convenings, one held in each of the DAS regions. Information collected regarding transportation through each mode is provided below. It should be noted that DAS has collected data for several years to understand the needs of older adults, and in the previous two state plan cycles transportation has been the issue respondents indicated they most needed to remain in the community, as well as continue to reside in their homes (Georgia DHS, 2011; Georgia DHS, 2015).

Survey

Stakeholders were able to complete the web-based survey between April and August 2018. The survey was promoted through the community conversations, social media, the DAS website, and other outreach completed by DAS and partner organizations. Included in the analysis that follows are 188 survey responses provided by individuals who self-identified their primary role with regard to aging and adult services as one of the following: service provider (37%), advocate (20%), unpaid caregiver/family member (14%), consumer (12%), and other (18%). The individuals who chose "other" described themselves in a variety of ways, such as AAA staff, volunteer educator, and retired citizen. Thirty-three percent of respondents were aged 60 or older, 31% were under 60 years of age, and 36% did not provide their age.

Respondents were given a list of 10 priority areas and asked to choose the top three areas the state should focus on over the next four years. As shown in Figure 8 below, the priority selected by respondents most often was transportation, which was chosen by 102 of the 170 respondents who answered this question.

Figure 8: Selection of Top 3 Priority Areas



Survey respondents were asked three follow-up questions regarding each of the priority areas selected: (1) What is working well? (2) What is not working well? and (3) What ideas or other

specifics would you like to share about this area? The respondents who selected transportation provided information regarding what is working well, including transportation to senior centers, some public transportation services within city or county boundaries, a volunteer program available in Hall county, and reduced or free fares for seniors, when available.

Survey respondents identified several areas that are not working well. Relevant to the small number of operating volunteer programs, there is difficulty recruiting and retaining volunteers. Focusing on publicly available services, respondents provided several issues, including issues related to access, service, and cost. Access issues included limited availability of services, county or city border challenges, difficulty getting to a fixed-route stop to utilize the service, and challenges gaining approval for paratransit. The service concerns were related to long wait and ride times, lack of responsiveness to phone calls when attempting to schedule rides, and a lack of benches at fixed-route stops. Finally, respondents felt that the service was not always affordable, particularly for those who have low income. In some cases the issues reported were general in nature or not necessarily describing a specific type of transportation service, and those are described next. Individuals felt that the transportation services are particularly lacking in rural parts of the state, and where available the service is often limited to morning hours during weekdays and more often on a fixed route. Respondents felt that not only should there be more services but the services should be more individualized, provide through-door service, and have well-trained drivers who are aware of the needs of older adults, including those who may have early-stage dementia. There is a reported lack of transportation providers, and one individual stated that they felt that additional monitoring of vehicles should be conducted. Finally, while ridesharing may be of interest for the opportunity it has to give a door-to-door trip, there was a concern about trusting the drivers given recent news coverage of incidents, as well as a lack of technological awareness for how to use a smartphone or an application.

Respondents provided additional information regarding transportation, which further highlights the importance of the issue and ideas for how to address the gap in services. First, respondents indicated that the lack of transportation is a very difficult challenge and one that is pivotal to get right. Transportation is a service utilized to access medical services, the grocery store, the pharmacy, and opportunities to have social outings. A respondent shared the following when asked what her greatest concerns are regarding maintaining her independence and staying in her home and community as she ages: "Transportation and remaining socially connected. There is no public transportation here and my church is approximately 15 miles away. So things like going to the movie, church, which I enjoy, going to the 'Y,' the library … and the supermarket might become difficult unless affordable and accessible transportation is in place or some other alternative." There was also the acknowledgement that there are individuals working hard to address the gaps that exist and that additional information needs to be collected regarding what works, what doesn't work, and who is not being served.

Survey respondents felt that there is a lack of awareness of the services that might be available and that further outreach should be done to ensure that learning about the resources is not haphazard. One respondent said, "If there are programs, there is little [or] no public awareness.

There is a tremendous gap of information between programs provided by the private [or] public sectors … and the aging [population] in general." Several respondents suggested increasing the resources and funding available to provide transportation. Solutions to increase capacity with additional resources included partnerships with nonprofit agencies, ridesharing, vouchers, and mass transit in Atlanta and surrounding counties. Important considerations for these options include regulating training requirements and background checks for drivers, as well as improving the capacity and support for phone-based scheduling and dispatch.

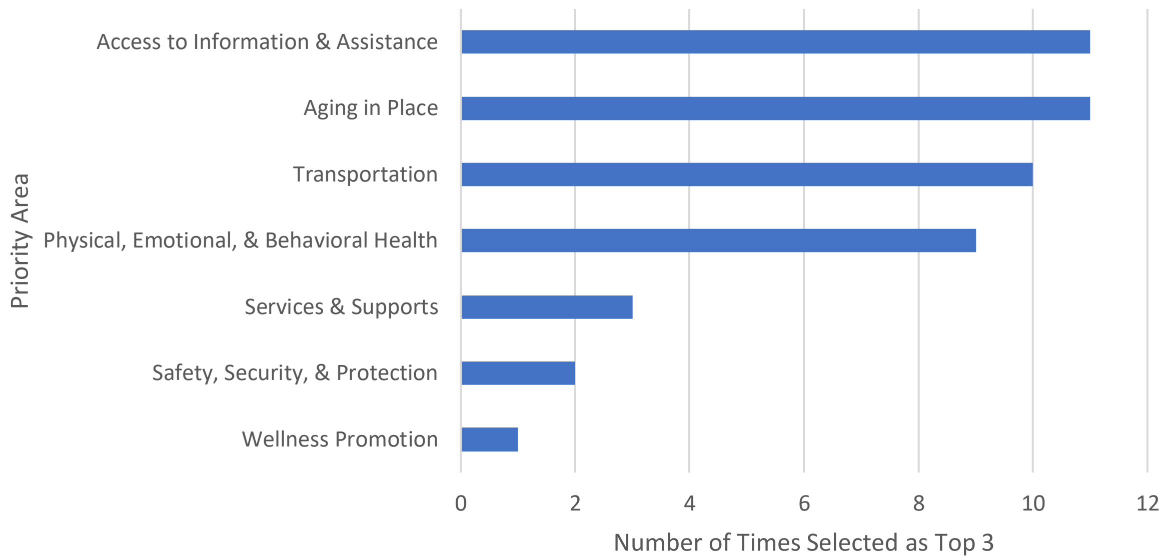
Community Conversations

Between April and August 2018, DAS held a Community Conversation hosted by the local AAA in each of the 12 DAS regions. The purpose of these sessions was to provide information to community members regarding recent DAS initiatives, for community members to provide input drawn from their experiences, and for the information shared to ultimately guide the state's upcoming four-year strategic plan for aging services.

Across the state, more than 650 individuals participated in the sessions, with an average of 55 participants per session. Of those who completed a demographic profile distributed at the end of the session, individuals were asked to indicate their primary role with regard to aging and adult services as one of the following: service provider (35%), consumer (26%), advocate (19%), unpaid caregiver/family member (6%), paid caregiver/professional (2%), and other (12%). The individuals who chose "other" described themselves in several terms, including active senior, university/education, planner, and Adult Protective Services staff. The majority (54%) of participants were 60 years of age or older, 40% were under 60 years of age, and 6% did not provide their age.

During each session, attendees participated in the identification of key priority issue areas using the same list of 10 priorities as the survey. Participants were asked to consider and prioritize their top five issue areas related to aging services: access to information and assistance; transportation; caregiver support; cultural competency; socialization, recreation, and leisure; aging in place; physical, emotional, and behavioral health; safety, security, and protection; wellness promotion; and services and supports. Participants then utilized instant polling technology to identify their top three issue areas. Figure 9 below provides a summary of the number of times each issue area was chosen. Transportation was selected as a priority area in 10 out of the 12 sessions. Two priority areas were chosen in 11 out of the 12 regions: "aging in place" and "access to information and assistance."

Figure 9: Top 3 Priority Areas Selected in Community Conversations



Notes: (1) There are more than three priority areas per session in total due to some sessions having a tie between priority areas. (2) There were three issue areas that were not chosen among the top three during the sessions: caregiver support; cultural competency; socialization, recreation, and leisure.

Once the top three priority issue areas were established, participants were asked to think about what works well, what does not work well, and ideas or recommendations they had for each priority issue area. Participants shared their perspectives with others seated at their table, while one individual at each table recorded the items discussed. An analysis of the table notes mirrors much of the information collected through the survey. When thinking about what is working well with regard to transportation, participants highlighted current services that are working well in certain geographies for particular individuals. Those highlighted include transportation to senior centers, public transit including demand-response services, Veterans Affairs services, health plan–covered transportation (e.g., Medicaid), volunteer-based programs to address gaps, and the ARC's Simply Get There program. Particular transportation policies or strategies that were highlighted included discounted rates for older adults who rode public transit, voucher programs, ensuring the built environment supports active transportation modes, and ridesharing services booked through phone-based third parties.

When the table discussion turned to what is not working well, there was significant concern expressed regarding a lack of awareness of available services, gaps in service coverage, particularly in rural areas, and county boundaries, which create barriers to accessing desired destinations. For those who had public transit available, there were many comments regarding individuals living too far from routes to get on buses, a lack of sidewalk and shelter availability, limited hours and days of service, long and unpredictable wait times, cost, and navigational challenges. For some of the services provided outside out public transit, services were often limited to particular destinations such as the senior center or a medical appointment. Individuals felt that services for shopping, pharmacy, and social visits were often not available. Some individuals stated that many older

adults continue to drive, despite physical or mental declines, due to the lack of services available. Finally, there were concerns regarding the training and sensitivity of drivers and safety of the riders, regardless of the provider of transportation services.

In addition to the polling and table conversations, participants were encouraged upon their arrival and throughout the session to complete a feedback form, which asked, "What feedback, question, or idea do you want to be sure we hear today." The feedback forms enabled participants to record ideas or questions as they arose at any point throughout the meeting and served as another means of gathering input from attendees. Many attendees took the opportunity to provide their input using the forms, often reflecting on the gaps they see in the services available, or the opportunity for the quality of the services provided to be better. Across the state, transportation was indicated as a need on feedback forms in every session except for one. One participant from the session held in Augusta summarized the need for transportation this way: "I see a HUGE need for affordable transportation for people who cannot drive due to health issues or vision. It would also help people who cannot afford cars. Current bus service does not cover many areas. Many elderly have trouble getting to bus stops, but may not meet the strict guidelines for paratransit or may not live near enough to bus stop. Transportation needs to be available evenings, weekends (including Sunday) and holidays. It [will] also improve public safety as many people who should not drive continue to do so due to lack of other affordable options. Some elders can't afford Uber and don't have smart phones."

PROMISING PRACTICES IN TRANSPORTATION SOLUTIONS SERVING OLDER ADULTS

As many of the issues detailed in this report are not unique to Georgia, the authors conducted a rapid environmental scan of promising practices in transportation solutions for older adults from around the United States. As part of this process, we also conducted targeted phone interviews with some of the people involved in these programs. The aim in this section is for Georgia to consider how organizations in other states have tackled similar issues and integrate that perspective into solutions tailored specifically for the state.

Key Findings

- Supportive relationships between state entities, regional and/or local providers, and the communities they serve are critical for creating and managing transportation supply for older adults.
- Allowing the flexibility to innovate at the local level is valuable, but it must be done in a way that allows for diffusion of promising ideas across communities and acknowledges that some innovations may not be successful.
- Coordinating multiple funding streams and maintaining collaborative partnerships are the foundations of promoting local mobility through a variety of transportation options. This is the case for serving older adults, and it is also true for serving the broader community.
- A rapid environmental scan of promising practices in transportation solutions for older adults produced information regarding organizations that have sought to tackle similar issues as those facing Georgia and may offer options for addressing unmet need for the state.

Overview of the Issues and Challenges

- Rural and suburban service delivery: Rural and suburban areas lack the provider capacity to meet demand.
    - Many nonmetropolitan providers lack the vehicles and staff to meet the demand for services.
    - Long-distance trips are cost-prohibitive.
- Rigid policies and restrictions on use of funding: Policies and restrictions limit opportunities for innovation and growth.
    - Program participation is often limited to agency clients or people who qualify for specific funding programs.
    - Trip purpose is frequently restricted.
    - Transportation is often limited in terms of days and hours service is provided.

    - Transportation service areas are often limited by administrative boundaries.
- Community support and engagement: Transportation organizations lack community support and engagement.
    - Lack of community buy-in can limit opportunities for sustainability through service utilization, planning, and funding support.
    - Collaborative partnerships: Opportunities to increase cost-effectiveness and expand services through collaboration exist but often are not pursued.
- Limited use of technology: Technologies that can enhance service delivery are often underutilized.

Insights from Interviews

A variety of formal and informal relationships between local and regional service providers and their respective state's bureaucracy exists, and the quality of these relationships plays a key role in making positive impacts on mobility for older adults. In Texas, regular convenings of partners from across the state help foster relationships and diffuse innovations in practice.

Building relationships based on trust with the communities being served is a critical foundation for meeting need through more formalized partnerships between public agencies and providers. This takes time and effort.

In regions with multiple operators in multiple jurisdictions, there can be confusion for the consumer whose needs may require travel across administrative boundaries. Community relationships and the individuals within the community are critical to success, but this also leads to wide variations in quality across a decentralized system, especially in low-density suburban and rural contexts.

Pilot programs with TNCs have seen cost-neutral increases in mobility, as measured by number of trips taken. Interviewees also cautioned that TNCs (as well as autonomous vehicles) should be viewed as a piece of a broad set of solutions across the transportation system and not as a "silver bullet" for addressing unmet need.

When an existing transit provider becomes a Managed Transportation Organization (MTO) for Medicaid-funded NEMT, they are often well-positioned to provide the most cost-effective and flexible combination of existing transit services (through their own services and those of subcontractors) and individual transport through a volunteer network.

Good data on use, costs, perceptions, and service management are critical for informing adaptations. Collecting these data from across multiple service providers presents an important, but not insurmountable, challenge.

Because many of the needs are similar or overlapping between older adults and persons with disabilities, services should be geared toward inclusiveness while still promoting independent mobility. Conceptually, this is relatively straightforward; however, it presents challenges administratively due to various sources of funding and associated requirements for specific populations.

Nobody has fully solved the issues involved with providing services for older adults, and there will always be a gap between supply and demand in terms of publicly supported services. A general recognition that this demand will continue to grow should drive solutions and innovation, and not be used as an excuse for inaction.

Programs for Further Exploration

Medicaid NEMT: Flexibility for Cost-Effectiveness

Project Amistad in West Texas serves a large, mostly rural, region of 23 counties as their MTO, with a contractual agreement and oversight by the Texas Health and Human Services Commission. Their NEMT services include providing mass transit tickets to get beneficiaries to medical appointments when that is determined to be the most cost-effective means of transportation. However, when mass transit is not available or accessible, as is often the case in rural areas of the country, they rely on a robust network of individual transportation participants to provide NEMT. These can be family members, friends, or others who use a personal car to transport beneficiaries to health care appointments, and who are then reimbursed for miles, as well as meals and lodging when appropriate. This flexibility enables beneficiaries to access health care appointments in an environment of relatively limited resources and options. Project Amistad also provides transportation to thousands of persons through various contracts and partnerships with the city and county of EI Paso, the Texas DOT, and various local agencies, expanding the portfolio of NEMT options for transportation to doctor's appointments, cancer treatments, therapy, dialysis, pharmacies, or other approved medical appointments. Out-of-town and out-of-state travel can also be arranged by Project Amistad staff with advance notice.

Project Amistad's chief of operations for transportation programs noted that offering this broad range of NEMT services is not without its challenges. They serve over 250,000 clients with an annual budget of around $9 million. As an existing transit provider in the El Paso area, they were well positioned to leverage their more traditional transit expertise in an expanded regional context once they became the MTO. Coordinating across the numerous subcontractors, while avoiding client confusion, seemed to be the main hurdle. They received good guidance from the state and requested some technical support to address identified challenges. This helped them to gain a better understanding of their enhanced oversight role and to become more efficient in capturing required information from both clients and providers. With that support from the state, they were able to streamline the amount of paperwork clients are responsible for, leading to a 50% decrease in complaints. Overall, Project Amistad's actions to diversify its NEMT services, and Texas' provision of technical assistance and policy guidance, have enabled the program to

overcome barriers to service delivery that are currently encountered in many parts of the United States.

Community Collaboration: Building Trust over Time

Ride Connection has a long history of serving older adults in the Portland, Ore., area. They are a private, nonprofit organization with diverse streams of funding that allow them to coordinate and provide transportation services to people with limited options. Over 30 years ago, TriMet, the regional transit agency, was looking at better, more cost-effective ways to serve older adults and persons with disabilities. They examined needs and services throughout their region and determined that a major barrier to more efficient options for consumers was the fact that so many social service agencies were providing transportation as a secondary service. This meant there were numerous options, but they were woefully undercoordinated. The resulting recommendation to formally coordinate services across these disparate providers and centralize some functions (like driver training) led to the creation of Ride Connection, which by 1988 was functioning as an independent nonprofit.

According to the Ride Connection CEO, trust is a major key to their success. This trust stems from a recognition in the community that TriMet does a good job with mass transit and that human services transportation is a key component of meeting individual unmet need. Having such strong support from TriMet and social service agencies is unique and critical. With this established trust comes the ability to innovate and constantly evolve, all while maintaining a strong network of volunteers, who make up two-thirds of their drivers. Other critical factors noted were having visionary leaders across partner organizations and creative staff who are willing to talk to the consumers and create new ideas to effect change.

In one example of how Ride Connection works collaboratively to innovate, they used a participatory planning process to identify existing challenges related to transportation for kidney dialysis patients and how these challenges impacted patient health. It involved the creation of an advisory committee and implementation of a public engagement effort. The project resulted in a pilot program with an NEMT method of grouping rides by neighborhood for trips to the clinic, providing flexible return trips and allowing patients to change pickup times as needed, and allowing same-day ride requests. This example illustrates two concepts their CEO noted as important: make community and user engagement a foundational part of project and program planning, and continually reinforce the high level of trust on which their business model is based. Ride Connection's commitment to community involvement and mutual support has created opportunities to increase access and sustainability and, ultimately, satisfactorily meet the transportation needs of more older adults in its service area.

Augmenting Fixed-Route Options in Suburban and Rural Areas through Local Partnerships

SMART Ride in southern Michigan provides transit services for the large region around Detroit, which includes many low-density suburban and rural areas, where the limited fixed-route system cannot realistically provide services. SMART works closely with local municipalities and counties to

augment their fixed-route options with small bus and van services to help customers remain mobile. Around 60% of their fleet of 600 vehicles is made up of these smaller buses and vans. Community partnerships play a key role in maintaining support for and expanding the services throughout the region, where local providers can use SMART-funded and maintained vehicles. However, these local partnerships vary in quality for a host of reasons and can result in a confusing patchwork of services for people traveling to and from different parts of the region. As one of the county ombudsmen noted, this reliance on local-level partnerships has benefits for fostering innovation, but it also has drawbacks for diffusing them.

In one example of success, SMART partnered with a local emergency medical services provider in two suburban townships to use off-duty ambulances for regular doctor appointments or trips to the pharmacy. This provider developed an arrangement that eventually provided access to SMART resources for a van to use for non-emergency trips. In this case, the emergency medical services director understood the public health perspective of transportation issues in his community and was willing to innovate. The program became so successful that it is now in 11 communities in the northern part of the region, with 10 vehicles and almost 30,000 rides last year. The partnerships SMART has been able to foster over time have significantly expanded access for individuals living in suburban and rural areas, and the program's approach could be modeled in other areas with limited fixed-route service options.

Shared Ride Services (TNCs): On-Demand Paratransit Opportunities

The Massachusetts Bay Transit Authority (MBTA) has an ADA program called The RIDE. Generally, anyone in the Boston area who is unable to take the bus or subway due to disability qualifies for The RIDE service. In 2016, the transit authority began a pilot to see if shifting some of these trips to TNCs (ride-shares) would be cost-effective or cost saving. Under the pilot program, customers sign up via The RIDE website, have eligibility confirmed by MBTA, and then access a coupon code through their own Uber or Lyft account that allows them to take trips for $2 (the regular price for a trip on The RIDE is $3.15). The transit authority pays the next $40, and the customer pays any additional cost beyond that. Trips are capped based on how much a given customer was using The RIDE before enrolling in the pilot: the more they used The RIDE, the more TNC trips they are eligible for. The high end of the trip cap is 40 rides per month, based on previous use. According to one of the program's administrators, the trip cap is naturally a little controversial because users inevitably want more trips than their determined cap. The pilot program has successfully increased mobility, as demonstrated by a 40% increase in number of trips taken over The RIDE alone. The per-trip cost is lower for MBTA at about $17 per trip, compared to $40 per trip for The RIDE. Though the mobility increase cancels out some of the cost savings overall, the pilot has been cost-neutral and well-received by users.

All funding for the pilot comes out of the MBTA operational budget, so there are no additional subsidies or grants. The agency moved forward under the premise that their spending on the pilot is what would otherwise be spent on The RIDE. The pilot program is restricted to ADA trips, so simply being a senior does not qualify one to participate. There needs to be a real mobility challenge that prevents a potential rider from using the train or bus regularly. The transit authority

pursued the pilot as a way to avoid the inability to do same-day trip reservations with The RIDE, which is easy to do with TNCs. This approach also provides much more direct routing, with estimated time of arrival (of vehicle) usually around seven to eight minutes versus an hour pickup window for The RIDE. Learning how to use the TNC technology is a challenge for some seniors, but not as significant of a barrier as initially expected, and Lyft offers a call-in option that addresses this challenge. Generally, the pilot has been well-received and extended to a point where it appears to be a stable part of the transit authority's services. One challenge noted by the program administrator is the issue of wheelchair-accessible vehicles: these are not a regular part of TNC fleets, so there is a lack of supply in this respect.

Taxi Services as an Alternative for Paratransit

The San Francisco Municipal Transportation Agency Paratransit service implemented an innovation to provide people who are eligible for paratransit with a non-ADA option that may suit their needs for much less cost. The San Francisco Paratransit Taxi program is not an ADA paratransit service because in some cases it does not meet the minimum requirements. However, it is similar to ADA paratransit service, and it may satisfy transportation needs of many ADA-certified riders. It enables riders to request same-day rides, rather than prescheduled ADA van rides. Eligible riders are issued a debit card with photo ID and assigned a monthly purchase allotment. For every $6 an individual pays into their debit card account, San Francisco Paratransit will add $30 to the account. This scheme is feasible because San Francisco requires all taxi companies to participate in the program, and there are over 100 taxis with wheelchair-accessible ramps, making a suitable supply of accessible vehicles available. The program has allowed for significant cost savings and enhanced accessibility for paratransit riders who are able to use the taxi program.

Demand Response: Service Across State Lines

In eastern Washington state, the Council on Aging's transportation program, COAST, supports rural mobility needs through demand-response ride service. They use both volunteer drivers with their own vehicles and paid drivers with accessible company vehicles. Additionally, the agency looks to build community resources and has done so through the creation of vehicle and insurance pools and by offering driver training. The vehicle pool enables COAST to distribute used vans to agencies that COAST cannot economically serve, while the insurance pool allows small agencies in the region to access affordable insurance coverage. The agency also trains drivers for many smaller agencies in the region. Regarding COAST's transportation services, the agency allows personal care attendants to accompany riders free of charge. Typically, residents of the service area schedule rides 48 hours in advance.

COAST also provides services to residents across state lines. The agency serves Whitman, Asotin, Garfield, and southern Spokane counties in Washington and Latah, Nez Perce, Clearwater, Idaho, and Lewis counties in Idaho. As mentioned previously, administrative boundaries, including county and state lines, act as transportation barriers for people across the country. COAST's delivery of services to older adults in multiple states and innovative strategies to extend limited resources set

it apart from many organizations in the United States and greatly increase access for residents of this large, rural area.

Transportation Voucher Programs

Voucher programs are particularly useful due to their cost-effectiveness, especially in low-density suburban and rural settings, and capacity to provide additional support for older adult riders. Additionally, voucher programs can offer more convenient and comfortable alternatives to public transit options.

Mystic Valley Elder Services, a 501(c)(3) nonprofit serving 11 counties in northern Massachusetts, offers a unique, free, passenger-controlled transportation program open to older adults and adults living with disabilities in the region. The program, called TRIP Metro North, provides the tools older adults need to make arrangements with friends, neighbors, and others interested in providing transportation support. Consumers work one-on-one with their driver to make the arrangements, and Mystic Valley provides a monthly check to reimburse for mileage.

My Rides, another voucher program, is a collaboration between the Western Placer Consolidated Transportation Services Agency, Seniors First, and the local AAA in Placer County, Calif. It aims to fill gaps in the traditional public transit system for older adults, persons with disabilities, and families of limited means with young children. Eligible residents can enlist a relative, neighbor, friend, or a pool of existing volunteer drivers to be driven to medical appointments, public assistance, and quality-of-life services.

LIMITATIONS AND OPPORTUNITIES FOR FURTHER RESEARCH

As described throughout this report, assessing transportation unmet need among older adults poses inherent challenges. The manner in which unmet need is conceptualized as it relates to older adults and transportation varies broadly, and how it is ultimately defined can significantly impact evaluation outcomes. Also, the diversity of the systems, funding streams, and players involved, and the complex ways in which they interact, complicate measurement and efforts to identify means of leveraging resources to address existing service gaps. Thus, an exact quantification of unmet need and the resources required to address it is somewhat impractical given the nature of the problem and data available. The authors applied several approaches to estimate the possible transportation unmet need among older adults, but the numbers presented should not be considered precise counts. Further research is needed to supplement these findings with regional and local knowledge of need and potential solutions, as well as account for economical, medical, and other changes that could impact older adult transportation in the future.

Regardless of the precision with which unmet need can be quantified for older adults, evidence of a large unmet need exists throughout the state, and, based on demographic projections and the current service infrastructure, this unmet need will grow immensely in the coming years if changes are not initiated. Strategies adopted to curb unmet need will need to be multifaceted and involve innovative planning and policy approaches, collaboration across agencies and sectors, and the application and dissemination of emerging technologies, among other critical components.

Planning and policy approaches that promote independence and aging in place among older adults have significant implications for transportation access and mobility broadly. AARP's Public Policy Institute (2018) published a report that includes general principles to guide planners and policymakers in the development of age-friendly communities. The principles include adopting a commitment to equity in policymaking and planning decisions; maximizing independence through convenient access to mobility options for those who do not drive; developing infrastructure that meets universal needs (e.g., design buildings, vehicles, built environments, products, services, and user interfaces that accommodate persons of all ages and ability levels); supporting livable, sustainable communities by maintaining safe, walkable streets, age-friendly housing and transportation options, and opportunities for residents of all ages to participate in community life; and encouraging data system and platform interoperability and data sharing between public and private transportation providers to inform planning and improve efficiency (AARP, 2018). Long-term, sustainable solutions that address unmet need among older adults must be initiated and maintained through planning and policymaking processes.

Cross-agency and cross-sector communication, which is interconnected with planning and policy approaches, is also essential to ensure available resources are maximized and unmet needs are addressed to the greatest extent possible. At present, transportation services for older adults are

fragmented, and differing administrative boundaries, reimbursement methodologies, and data systems among providers impede collaboration and create inefficiencies, which lead to service gaps. Enhanced communication, data sharing, and collaboration across all parties engaged in serving older adults will be critical for the system to adapt to meet the increases in demand that are likely to accompany the anticipated demographic shift.

The diffusion of new technological innovations also has the potential to dramatically impact transportation for older adults. In-vehicle technologies can extend the amount of time older adults can drive safely and are increasingly available. In a synthesis of advanced in-vehicle technologies relevant for older adults, Eby et al. (2015) reported that forward collision warning/mitigation, parking assistance (including rearview display, cross traffic warning, and semiautonomous parking assistance), navigation assistance, and automatic crash notification all present a high potential to benefit older adult drivers. Autonomous vehicles also present an opportunity for increased mobility among older adults, as they reduce the need for human involvement during driving, but their availability and likelihood of adoption among older adults remains unclear (Anderson et al., 2014). Additionally, smartphone applications hold great potential for increasing mobility and access for older adults, not only with regard to using transportation, such as through ordering TNC-delivered rides, but also in the delivery of services and goods to the home (Shirgaokar, 2018). These and other technological advances are likely to shape transportation access and mobility for older adults in the future and could mitigate some of the difficulties faced by the older adult population today.

CONCLUSION

Transportation plays a vital role in the maintenance of older adults' independence, social participation, health, and overall well-being. Many players are involved in the planning and delivery of transportation services, including federal, state, and local agencies and planning organizations; public and private transportation providers; and legislators. Although many in the state strive to deliver services tailored to the diverse needs of this population, opportunities to increase access and efficiency exist and could lead to improvements in health and quality of life among older adult residents.

Several key actions have the potential to mitigate current barriers to service delivery across the state, including improved communication regarding available services, increased coordination across agencies, and the promotion and adoption of cost-effective programs and new technologies. Of these, planning and policy initiatives that promote the development of age-friendly communities represent especially impactful long-term solutions and are needed to yield sustained positive outcomes.

Future research is needed to inform planning, policy, and service delivery in this evolving landscape. Older adults are currently among the most vulnerable to inequities in the transportation system, and efforts to address transportation disadvantage are immediately necessary, as the anticipated population shift will likely exacerbate existing disparities.

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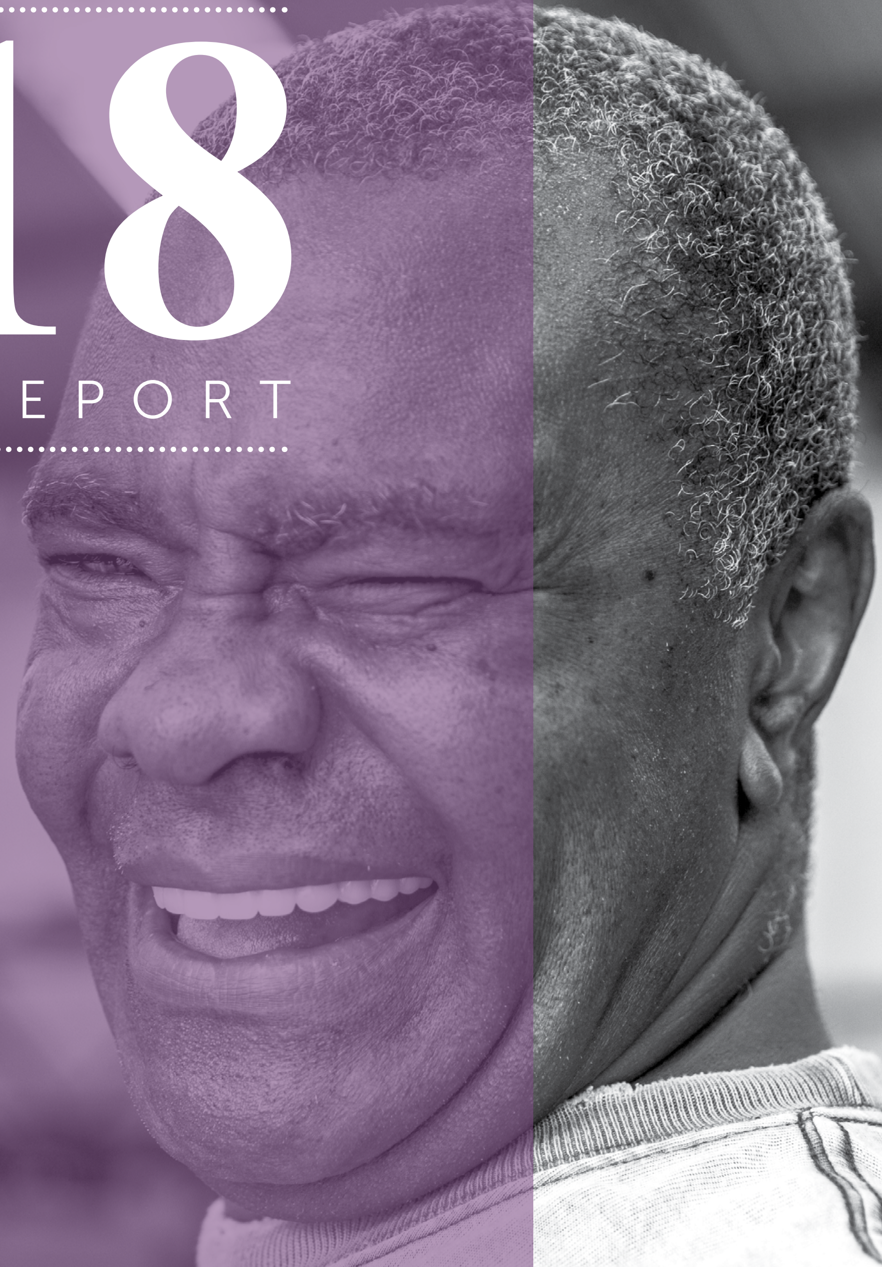
GEORGIA ALZHEIMER'S & RELATED DEMENTIAS STATE PLAN

2018

PROGRESS REPORT



GARD

collaborative

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Acknowledgments

The following 2018 report is respectfully submitted by members of the Georgia Alzheimer's and Related Dementias Advisory Council.

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At the time of publication, the remaining members of the Advisory Council had not yet been appointed. This includes:

- A social gerontologist or clinical researcher in an education or clinical setting with expertise in dementia;
- An advocate with a not-for-profit or state agency whose role is to improve services for older adults or those living with dementia;
- A caregiver, current or past, for a family member with dementia who has experience navigating health care service options.

Advisory Council members acknowledge the contributions of the many people who influenced the development of the GARD State Plan and those who continue to participate in the GARD Collaborative and were instrumental in the development of this report.

Members extend deep respect to the more than 140,000 Georgians who live with dementia, their care partners, and those who form webs of support in service organizations, workplaces, congregations and communities.

Background

HISTORY & TIMELINES

Background, History & Timeline

Today, more than 140,000 Georgians live with Alzheimer's disease, and tens of thousands more experience other forms of dementia. Like many states, Georgia answered the call set forth by the National Plan to Address Alzheimer's – by crafting a unique blueprint to address the growing challenge of dementia.

The Plan's Beginnings

During the 2013 session of the Georgia General Assembly, legislators created the Georgia Alzheimer's and Related Dementias (GARD) State Plan Task Force, a multidisciplinary group convened to improve dementia research, awareness, training, and care. Starting in June of that year, the six task force members and dozens of experts in diverse fields formed committees, conducted research, and made detailed recommendations.

The recommendations formed the core of the GARD State Plan. The document described current demographics, prevalence statistics, and existing resources; analyzed the state's capacity to meet growing needs; and presented a roadmap to create a more dementia-capable Georgia.

State Plan Establishment

In June 2014, Governor Nathan Deal signed the Georgia Alzheimer's and Related Dementias State Plan. Georgia's recommendations cover a range of topics, including research, services, policy, public safety, workforce development, and public education. And undergirding all of these areas is the importance of partnerships – creating a deeply coordinated statewide team of agencies, nonprofits, businesses, and organizations.

A Living Document

The GARD State Plan will undergo regular review to ensure that it reflects emerging priorities, shifts in resources, and evolving public- and private-sector roles. As noted in the Plan, "much of the work that needs to be done now and in future assessment and updates of the Plan will require legislation and corresponding funding to develop and implement that specific item of the Plan. The Advisory Council commits to work with partner stakeholders, state agencies, and legislators to develop and have filed appropriate legislation and corresponding appropriation requests throughout the life of this Plan."

GARD Coordinator & Work Group Structure

In June 2016, a GARD Coordinator was hired within the Department of Human Services. The GARD Coordinator provides support and technical assistance to a collection of work groups that focus on major state plan goals as outlined in the State Plan Overview section.

State plan

OVERVIEW

State Plan

Find the full GARD State Plan at
aging.georgia.gov/georgia-alzheimers-related-dementias-state-plan.

Health Care, Research and Data Collection

1. Promotion of Early and Accurate Diagnosis
2. Development and Usage of Surveillance Data
3. Public Awareness of Dementia as a Chronic Disease
4. Support for People with Dementia and their Caregivers

Workforce Development

1. Assessment of Existing Workforce Status – Size, Competency, Capacity
2. Workforce Training on Dementia and Related Resources
3. Dementia Curricula for Workforce, Students, Consumers, Advocates, and Volunteers
4. Dementia-Specific Training for Emergency Personnel and Second Responders
5. Workforce Retention Planning for Direct-Care Workers and Geriatric Health Care Providers

Service Delivery

1. Assessment of Statewide Capacity, including Urban-Rural Parity
2. Person-Centered Care Training for Professionals, Caregivers, and Volunteers
3. Adoption of Person-Centered Practices in Long-Term Care Facilities
4. Promotion of Person-Centered Facility Design, using Incentives, Training, and Regulations
5. Improvement of Consumers' Access to Key Services and Information (example: respite)
6. Provision of Tools and Guidance to Discharge Planners to Improve Care Transitions
7. Improvement of Transportation Access and Services
8. Strengthened Licensure Requirements and Quality-Care Practices for Service Providers

Public Safety

1. Dementia Training for Law Enforcement and Others that Addresses abuse, neglect and exploitation
2. Tools and Assistance to Reduce Injuries Related to Wandering

Outreach & Partnerships

1. Heightened Awareness and Coordinated Statewide Information Campaigns
2. Promotion of the "Dementia Friendly" Concept and Provision of Community Training
3. Partnerships to Maximize Resources and Access New Funding

Achievement

& PROGRESS

OVERVIEW

ACHIEVEMENT & PROGRESS HIGHLIGHTS

This section demonstrates achievements and progress toward the implementation of the GARD State Plan. The list shown is a sampling and does not encompass every activity, initiative, or project in our state. This includes work occurring through a variety of entities, including nonprofits, universities, Area Agencies on Aging, and the group collaborations. This section also covers accomplishments that are specific to GARD work groups.

Health Care, Research, & Data Collection

- Georgia Memory Net
- Alzheimer's Registry
- Behavioral Risk Factor Surveillance System (BRFSS) Data Collection

Workforce Development

- Georgia Memory Net
- Dementia Competency Guide
- Second Wind Dreams Virtual Dementia Tour CMP Grant
- Building Resources for Person-Centered Care in Nursing Homes

Service Delivery

- Second Wind Dreams Virtual Dementia Tour CMP Grant
- Decision Tree Tool
- Dealing with Dementia Training
- Assistive Technology Labs
- Benjamin Rose Institute Care Consultations
- Alzheimer's Disease Supportive Services Program (ADSSP) Grant
- Building Resources for Person-Centered Care in Nursing Homes

Public Safety

- Alzheimer's Training for Public Safety
- Prohibition against Trafficking (House Bill 803)
- At-Risk Adult Crime Tactics Courses
- Relocation Efforts for Victims of Trafficking
- Regional Multidisciplinary Teams (House Bill 635)
- Yellow Dot

Outreach & Partnerships

- Georgia Memory Net
- Dementia Friendly Initiatives
- Dementia Friendly Faith Villages Project
- Brain Strong Flyer Outreach
- ADSSP Grant
- Atlanta Regional Commission Internal Dementia Work Group

DETAILS

GEORGIA MEMORY NET

Description: Georgia Memory Net, formerly the Georgia Alzheimer's Project, seeks to improve the screening and care of Georgians with memory loss and other cognitive impairment indicative of Alzheimer's and other dementias. This project encourages consumers to seek early answers about cognitive health through the use of sustainable primary care models. In SFY2018, Georgia Memory Net established five Memory Assessment Clinics in Augusta, Atlanta, Albany, Columbus and Macon.

Project Leads: The Department of Human Services (DHS) and Emory University lead the project. Emory is partnering with Area Agencies on Aging, the Alzheimer's Association Georgia Chapter, the Rosalynn Carter Institute for Caregiving and others.

State Plan Connection: Health Care, Research & Data Collection; Workforce Development; Outreach & Partnerships

DEMENTIA FRIENDLY GEORGIA EFFORTS

The DHS Division of Aging Services (DAS) convened a strategy group in January 2018 to discuss the availability of existing dementia-friendly efforts in Georgia and ways to generate more dementia-friendly activity statewide. The Georgia Gerontology Society developed Requests for Proposals for Dementia Friendly Communities that will begin in SFY2019. The DAS has begun the process of applying for a Dementia Friends sublicense.

Description: Using the Dementia Friendly America model, the state will support communities in Georgia as they become "dementia friendly." DAS is convening a group of stakeholders around the initiative and is collaborating with the Georgia Gerontology Society on helping communities begin this work.

Project Leads: The Division of Aging Services is convening the group. The strategy group includes representation from several community organizations and entities, including but not limited to Emory Healthcare, Dementia Spotlight Foundation, Georgia Gerontology Society, Gwinnett County, DeKalb County, Atlanta Regional Commission, AARP, Georgia State University, Lewy Body Dementia Association, and people with lived experience.

State Plan Connection: Outreach & Partnerships

SECOND WIND DREAMS VIRTUAL DEMENTIA TOUR CIVIL MONEY PENALTY GRANT

Description: Through the work of Second Wind Dreams, over 95,000 long-term care workers in 171 nursing homes will experience the Virtual Dementia Tour (VDT). Participating nursing homes are located in 104 counties across Georgia. Certified trainers are working with each nursing home to provide the VDT and also conduct the Dementia Aware Competency Evaluation (DACE), which measures level of person-centered care provided by staff.

Project Leads: Second Wind Dreams

State Plan Connection: Workforce Development, Service Delivery

AT-RISK ADULT CRIME TACTICS COURSES

Description: The At-Risk Adult Crime Tactics Specialist (ACT) training course is a two-day certification offering for mandated reporters, covering abuse, neglect and exploitation of against at-risk adults. Courses are held at locations throughout the state. ACT training exposes attendees to the nexus between Alzheimer's and potential victimization. Topics covered include how to interview someone with Alzheimer's or another form of dementia, possible courtroom issues, Power of Attorney abuse, capacity for making financial decisions, and quick screenings for law enforcement to utilize when in the field.

ACT advances public safety by making key audiences aware of the complexity of Alzheimer's and other forms of dementia, by providing an open classroom setting for all disciplines to discuss challenges with at-risk adult abuse and how to overcome those challenges through collaboration with other agencies.

Project Leads: DAS' Forensic Special Initiatives Unit (FSIU) is the developer and trainer for ACT.

State Plan Connection: Public Safety

REGIONAL MULTI-DISCIPLINARY TEAMS (HB 635)

DHS collaborated with the Prosecuting Attorney's Council and the Georgia Bureau of Investigation on HB 635, which was passed during the 2018 legislative session.

Description: HB 635 gives authority to District Attorneys or their designee to establish Multi-Disciplinary Teams (MDTs) within each judicial circuit. The MDTs will assist with the coordination of and responses to investigations of abuse, neglect or exploitation of an older or disabled adult. Other key provisions in HB 635 include:

- Any individuals who made a report according to Code Section 30-5-4 can make a request to DHS to know if the report or reports made by that individual have been received, whether or not an investigation was opened, and whether the investigation is still open or has been closed, and the department will respond in writing within five business days with this information, but no other case information will be released.
- Adult Protective Services (APS) can share records with coroners and medical examiners in death cases where there has been suspected abuse or neglect.

Project Leads: DAS and the Prosecuting Attorneys Council serve as state liaisons for regional teams.

State Plan Connection: Public Safety

PROHIBITION AGAINST TRAFFICKING (HB 803)

Description: The purpose of HB 803 is to prohibit trafficking of an older or disabled adult and to provide for elements of the crime and punishment.

Project Lead: The Georgia Bureau of Investigation (GBI), Prosecuting Attorney's Council, and DAS collaborated on the development of HB 803.

State Plan Connection: Public Safety

RELOCATION EFFORTS FOR VICTIMS OF TRAFFICKING

Description: Temporary Emergency Respite Funds (TERF) provide options for at-risk adults in need of safe emergency housing in the absence of a caregiver. Examples of qualifying situations include caregiver arrest or hospitalization or where the caregiver's whereabouts are unknown. The TERF system, which is conducted in partnership with a contract agency, can be accessed 24/7 by law enforcement, Adult Protective Services, or the Department of Community Health's office of Healthcare Facility Regulation. Approximately 15 percent of at-risk adults who required the use of TERF in SFY2018 due to abuse, neglect, exploitation, or unintentional self-neglect had a form of dementia.

Project Leads: DAS

State Plan Connection: Public Safety

ALZHEIMER'S FOR PUBLIC SAFETY OFFICIALS TRAINING

Description: GBI and FSIU have conducted multiple classes of "Responding to Alzheimer's for Public Safety" for approximately 300 public safety officials. The class provides information about issues regarding Alzheimer's and other dementias to increase awareness for public safety officials who encounter adults with dementia.

Project Leads: GBI and DAS' Forensic Special Initiatives Unit

State Plan Connection: Public Safety

ATLANTA REGIONAL COMMISSION INTERNAL DEMENTIA WORK GROUP

Description: The Atlanta Regional Commission (ARC) Aging Services Division developed an internal dementia work group whose members participate in multiple GARD committees and other regional and statewide dementia activities. Members use shared information to increase awareness about dementia, related care, and best practices among clients, caregivers, professionals, providers, and communities int the Atlanta region. The work group also promotes early detection and treatment, builds workforce capacity to enhance person-centered care and service quality, seeks to reduce caregiver burden through services and education, and works to reduce stigma.

Project Leads: ARC

State Plan Connection: Outreach & Partnerships

BUILDING RESOURCES FOR PERSON-CENTERED CARE IN NURSING HOMES

Description: Georgia State University's Gerontology Institute received a $1.6 million joint grant from the Centers for Medicare and Medicaid Services and the Georgia State Survey Agency to support a three-year training and development project titled "Building Resources for Delivering Person-Centered Care in Georgia Nursing Homes."

This project builds on the momentum of the Culture Change Network of Georgia and the GARD workforce development work group. The multi-year project will be led by Jennifer Craft Morgan, Associate Professor of Gerontology, and Elisabeth O. Burgess, Director of the Gerontology Institute, in the College of Arts and Sciences at Georgia State University.

The project team will use grant funds to develop a sustainable program model aimed at improving the quality of life of Georgia nursing home residents, including those living with dementia, by providing important resources and staff development and training to the state's 374 nursing homes. The interventions are expected to increase residents' sense of autonomy, independence, empowerment and connectedness.

The project will include the following components: a three-stage needs assessment of Georgia's nursing homes; real-time web-based information and resources for Georgia's nursing homes; stakeholder engagement across the state, providing awareness education on culture change, person-centered care, and living with dementia, and an interactive competency-based online continuing education training for nursing home staff (all levels), residents and informal care partners.

For this project, Dr. Morgan and Dr. Burgess are partnering with the Culture Change Network of Georgia (CCNG). LeadingAge Georgia, led by Ginny Helms, President and CEO, will receive a subcontract to convene the CCNG and partner with other key stakeholders who will serve as advisers to the project. Project consultants are: Walter Coffey, Co-Founder CCNG and Managing Director WD International; Kim McRae, Co-Founder CCNG and President, Have a Good Life; Rose Marie Fagan, Co-Founder and Founding Executive Director, Pioneer Network; and Joan Carlson, Principal, JMC Consulting. The overall aim of this project is to create a sustainable model for improving the quality of life for nursing home residents in Georgia.

Project Leads: Georgia State University Gerontology Institute

State Plan Connection: Workforce Development; Service Delivery

ASSISTIVE TECHNOLOGY DECISION TREE TOOL

Description: The goal of the Decision Tree Tool is to help consumers and professionals identify pieces of assistive technology to purchase that will increase independence and decrease reliance on costly formal personal care assistance. The Decision Tree Tool contains dementia-specific questions developed as one of the deliverables of a federal grant titled "Alzheimer's Disease Supportive Services Program (ADSSP): Creating and Sustaining Dementia-Capable Service Systems for People with Dementia and their Family Caregivers." More work is needed to continue the development and implementation of the Decision Tree Tool.

Project Leads: Georgia Institute of Technology's Tools for Life, Georgia's Assistive Technology Act Program; Georgia Department of Human Services Division of Aging Services

State Plan Connection: Service Delivery

FAITH VILLAGE CONNECTIONS

Dementia-Friendly Faith Villages to Support African American Families

Description: Project leaders are working with African American congregations and providing them with the tools needed to support families living with dementia. Community forums and church leader workshops are held throughout the year. Dr. Fayron Epps of Georgia State University is collaborating with a design team to develop a dementia-friendly worship service and will test the effects on the well-being of families living with dementia.

Project Leads: Georgia State University, Emory University Alzheimer's Disease Research Center, SageNavigators, and other community partners; funding provided by the Alzheimer's Association

State Plan Connection: Outreach and Partnerships

CHALLENGES & BARRIERS FOR TRAINING FOR DIRECT-CARE WORKERS

Description: The GARD Service Delivery work group conducted a survey aimed at providers that identified challenges to providing dementia training for direct-care workers. The top two challenges identified were:

- Staffing costs (high training expenses plus inadequate staffing to provide coverage for those who are out for training)
- Training locations and the need to travel to training sites

In the fall of 2017, the Georgia Gerontology Society released a request for proposals to address these barriers to providing dementia training for direct-care workers. In January 2018, three grants of $2,500 were awarded to fund three projects. Please click here to access the report that covers the description, results, and lessons learned from these grants.

Project Leads: GARD Service Delivery Work Group, Georgia Gerontology Society

State Plan Connection: Service Delivery and Workforce Development

ROSALYNN CARTER INSTITUTE FOR CAREGIVING: DEALING WITH DEMENTIA

Description: Dealing with Dementia is a one-day workshop for caregivers of individuals living with dementia that provides a collection of resources, tips and educational information. Caregivers receive a guidebook with techniques that may be used to meet daily challenges experienced while providing care to their loved ones. This workshop is being offered at participating Area Agencies on Aging across the state.

Project Leads: Rosalynn Carter Institute for Caregiving

State Plan Connection: Service Delivery; Health care, Research & Data Collection

ASSISTIVE TECHNOLOGY LABS

Description: Assistive Technology labs are designed to provide individuals with dementia and their caregivers with education and hands-on experience using AT devices on display and available for loan. Eleven of the 12 Area Agencies on Aging support Assistive Technology Labs in their regions, with 15 labs total in the state.

Project Leads: Georgia Tech's Tools for Life Program

State Plan Connection: Service Delivery

BENJAMIN ROSE INSTITUTE CARE CONSULTATIONS IN AREA AGENCIES ON AGING

Description: BRI Care Consultation is an evidence-based care coaching program developed by the Benjamin Rose Institute on Aging. The program provides cost-effective assistance and support to individuals with chronic conditions and their family and friend caregivers by telephone and e-mail. BRI Care Consultation empowers clients to manage care and find simple, practical solutions to caregiving challenges, facilitates effective communication among family and health care workers, and assists clients in locating services.

Project Leads: Benjamin Rose Institute on Aging, Rosalynn Carter Institute for Caregiving, and DAS. In partnership with BRI and RCI, Georgia DHS expanded the program statewide in 2018, using funding provided through an Administration for Community Living Alzheimer's Disease Supportive Services Program (ADSSP) grant. Currently nine Area Agencies on Aging are licensed providers, and three refer clients to licensed sites.

State Plan Connection: Service Delivery

SOWEGA COUNCIL ON AGING "DOCS & DINNERS" SERIES

Description: Docs & Dinners is an educational program featuring physicians who present on various health topics. The program offers general information, presents the latest research, and allows for a Q&A session for the audience to ask questions on the topic. In November 2017, the Southwest Georgia (SOWEGA) Council on Aging offered a session on Alzheimer's and related dementias. The guest speaker, a neurologist from a local hospital, presented to more than 100 individuals. The program was so successful that SOWEGA Council on Aging is now offering it quarterly.

Project Leads: Phoebe Putney Memorial Hospital, Alzheimer's Outreach Center, Alzheimer's Association, Southwest Georgia Council on Aging

State Plan Connection: Outreach & Partnerships

MUSIC THERAPY AT MERCY CARE OF ROME

Description: Staff at Mercy Care of Rome created individualized music playlists for clients with dementia. Patients are provided headphones and can listen to their selected music throughout the day.

Project Leads: Mercy Care of Rome (Adult Day Health)

State Plan Connection: Service Delivery

Northwest GA AAA: Elder Abuse Task Force

Description: The task force provides education and awareness training for service providers, law enforcement and community organizations to prevent the financial, physical, emotional and institutional abuse of older adults.

Project Leads: North Georgia Elder Abuse Task Force

State Plan Connection: Public Safety

MAPHABIT, INC.

Description: MapHabit, Inc. is a medical technology start-up based out of Decatur, Ga. The organization developed the visual map habit system (VHMS) which uses mind-mapping software to develop personalized visual maps that help individuals who have dementia or other forms of memory impairment to structure, schedule, and visualize their day. The company's proprietary approach focuses on the brain areas that support habit behavior and remain fully intact for a substantial time after the memory parts of the brain have been affected. MapHabit boosts habit, not memory.

In June 2018, the company established the buy-in and fundamental framework for key feasibility studies across government, university and private sectors. Research partners will soon begin evaluating the VHMS to study the positive impact it has for individuals and their caregivers suffering from memory impairment

Project Leads: Atlanta VA Medical Center, Emory Alzheimer's Disease Research Center and Holbrook Communities; Research funded in part by the Georgia Research Alliance

State Plan Connection: Service Delivery

YELLOW DOT INITIATIVE

Description: The Department of Public Health (DPH) and its partners launched statewide implementation of the Yellow Dot program. Yellow Dot is designed to be a communication tool for patients and first responders in the event of a car crash or medical emergency. Users install a personalized information packet in their glove compartment, affix a Yellow Dot decal on the rear driver-side window, and store a second packet at home. The program can help officers locate family of a wandering older adult; assist first responders rescuing a patient who cannot speak, and create a consistent, uniform place to keep information that should go with a patient in emergencies. The program now runs in Savannah, Athens, Dublin, Oglethorpe County, Tucker, Dunwoody and Augusta.

Project Leads: The Georgia Department of Public Health is the implementation lead, the Governor's Office of Highway Safety and DAS provided funding, and Alliant Quality provided content development support to prepare for the program pilot.

State Plan Connection: Public Safety

Alzheimer's Disease & Related Dementias (ADRD) Registry

Description: Data from the registry is being used on a variety of projects. A team of researchers from the Department of Public Health and the Centers for Disease Control and Prevention (CDC) linked data from the Registry with data from the Georgia Violent Death Reporting System (GVDRS) to examine the risk of suicide among Georgia Medicare beneficiaries with Alzheimer's or a related dementia. Data from the Registry was also analyzed to examine the risk of accidental fall injuries among Georgia Medicare beneficiaries. The Registry is working with the Georgia Memory Net to develop messaging standards for sending data to the Registry. Five Memory Assessment Centers (MACs) will send data to the Registry once standards are finalized. The collaboration between the Registry and Georgia Memory Net will help project leads establish procedures and protocols for other health care providers to submit data to the Registry while meeting the Centers for Medicare and Medicaid Services' (CMS) Meaningful Use requirements. The Registry is in the process of receiving up-to-date Medicare claims data for 2015 and 2016 from CMS.

Project Leads: Georgia Department of Public Health

State Plan Connection: Health care, Research & Data Collection

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)

Description: The Georgia Department of Public Health includes caregiving and cognitive decline modules in the BRFSS, with caregiving questions in even-numbered years and cognitive decline in odd-numbered years. In SFY2018, project leads examined data from the Caregiving and Cognitive Impairment modules of the 2016 and 2017 GA BRFSS respectively to examine the prevalence of perceived cognitive impairment (PCI) and the burden of caregiving among GA residents. DPH will prepare an annual report that features:

- 2014 – 2016 Georgia Medicare Claims data to examine the prevalence of Alzheimer's Disease and related dementias (ADRDs) among beneficiaries, with an additional focus on those with multiple comorbidities and developmental disabilities.
- 2000 to 2016 Georgia Mortality Data to examine trends in mortality from ADRDs.

Project Leads: Georgia Department of Public Health

State Plan Connection: Health care, Research & Data Collection

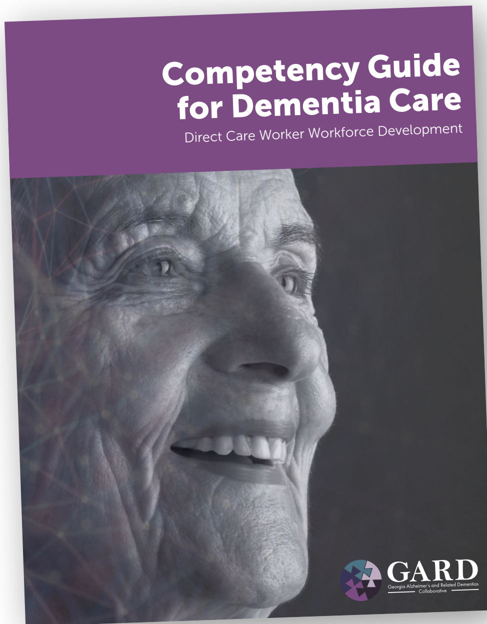
ALZHEIMER'S DISEASE SUPPORTIVE SERVICES PROGRAM (ADSSP) GRANT

Description: The Division of Aging Services completed objectives for the Alzheimer's Disease Supportive Services Program (ADSSP) expansion grant during SFY18. Activities of note include:

- The Rosalynn Carter Institute for Caregiving (RCI) completed a series of dementia-capable training webinars which are now available to DAS Access to Services staff; community partners and service provider staff, as well as family caregivers in Georgia.
- DAS, in partnership with RCI and the 12 Area Agencies on Aging, developed a statewide infrastructure to provide Benjamin Rose Institute Care Consultation a telephonic coaching program serving people with dementia and their caregivers.
- RCI staff taught 15 "Dealing with Dementia Behavior" courses for Hispanic caregivers living in rural areas of Georgia.
- Georgia Tech Research Corporation, through Tools for Life, developed an assistive technology (AT) decision tree tool for persons with dementia and their caregivers to receive appropriate AT through referrals from the Aging and Disability Resource Connection.
- DAS continued to redesign the state's approach to caregiver services and related policy to improve dementia-capable services.

Project Leads: DAS, Rosalynn Carter Institute for Caregiving

State Plan Connection: Service Delivery, Outreach & Partnerships



COMPETENCY GUIDE FOR DEMENTIA CARE

Description: "Competency Guide for Dementia Care: Direct-Care Worker Workforce Development" was designed in response to the increasing need for education and training for direct-care workers in dementia. The guide aims to help educators and employers of direct-care workers choose high-quality education as well as improve work environments. The work group authored the guide with support from the larger GARD collaborative as well as with input from care partners and persons living with dementia. The guide covers several topic areas, including person-centered care, communication, prevention and reporting of abuse, and palliative and end-of-life care. It also outlines active learning strategies for employers to consider. The guide was printed with support from the Georgia Gerontology Society.

Project Leads: GARD Workforce Development Work Group

State Plan Connection: Workforce Development

BRAIN STRONG FLYER CAMPAIGN

Description: The Outreach & Partnerships work group developed a brain health awareness flyer for older adults and their family members. The flyer encourages readers to take care of their brain health just as they take care of their heart and other aspects of health. One goal of the flyer is to increase the number of Medicare-eligible adults who take advantage of the Medicare Annual Wellness Visit, which includes a screening for cognitive impairment. The flyer was reviewed and revised by the work group and the larger GARD collaborative as well as by a sampling of Medicare beneficiaries. The work group is coordinating efforts with the Georgia Memory Net outreach campaign to promote the early screening and diagnosis of Alzheimer's and related dementias. The flyer was printed with support from the Georgia Gerontology Society.

Project Leads: GARD Outreach & Partnerships Work Group

State Plan Connection: Outreach & Partnerships

Work Group

SUMMARIES & PROGRESS

HEALTH CARE, RESEARCH & DATA COLLECTION

Chair: Vacant during SFY2018

SFY2018 Priorities & Initiatives:

- Academic Survey on Alzheimer's Disease and Dementia Content in Courses: The work group created a survey to be fielded to Georgia colleges and universities, assessing dementia-related material in the curricula. The survey will be fielded during SFY2019.
- Data Request Form: The group has formalized a form to enable other GARD work groups to request help with their research and data-related projects.

PUBLIC SAFETY

Chair: Vacant during SFY2018

SFY2018 Priorities & Initiatives:

- Capacity Subcommittee — This subcommittee is examining the issue of how capacity is assessed and determined in Georgia, particularly as it relates to guardianship cases. The primary goal is to identify validated tools which evaluators performing capacity evaluations in guardianship proceedings would be recommended to use and to create a toolkit. Although the assessment tools would primarily be used by court evaluators, providers and agencies could use the tools to assess capacity for other purposes other than filing a guardianship petition. The group has consulted with a clinician with experience working with clients living with dementia to work on this project.
- Injury Subcommittee — This subcommittee focused on the implementation of the Yellow Dot program, a Department of Public Health initiative that promotes the use of free information kits to inform first responders about users' medical conditions, emergency contacts and other lifesaving information. The committee adopted a new topic in May 2018 — the intersection of dementia and suicide. The work group is examining available data, inviting partners to the conversation, and determining how to best move forward on this topic.

WORKFORCE DEVELOPMENT

Chairs: Kathy Simpson, Alzheimer's Association and Dr. Jennifer Craft Morgan, Georgia State University

SFY2018 Priorities & Initiatives:

- Dementia Competency Guide — Developed, written and edited by the work group in order to provide guidance to service providers and educators on what content should be in dementia training and how to best support learners. The guide will be distributed at conferences, trainings, and meetings in SFY2019.
- Health Care Provider Education: The work group is developing a training that is focused on person-centered care and what the person living with dementia wants health care professionals to know. The goal is to have continuing education credit offered for this training.

SERVICE DELIVERY

Chair: Eve Anthony, Athens Community Council on Aging

SFY2018 Priorities & Initiatives:

- Service-Delivery Criteria — The work group is focused on examining how to "establish criteria which define an effective Alzheimer's/related dementias service delivery system," as recommended in the GARD State Plan. The group has been working with the Northeast Georgia Area Agency on Aging (AAA) to begin data collection. Once the data has been gathered from multiple sources, the work group will determine feasibility and cost of a statewide analysis in SFY2019.

OUTREACH & PARTNERSHIPS

Chairs: Natalie Zellner, Emory University; Ginny Helms, LeadingAge Georgia
(At the time of her chairmanship, Helms was affiliated with the Alzheimer's Association, Georgia Chapter.)

SFY2018 Priorities & Initiatives:

- Early Detection & Diagnosis — This work group is focused on education of the public and health care providers of the importance of early detection and diagnosis. The group has developed the Brain Strong flyer around this topic and the promotion of brain health. The work group is also working with the Georgia Memory Net team on an extension of this outreach effort. The Georgia Gerontology Society sponsored printing of the Brain Strong flyers and distribution is underway across the state.

POLICY

Chair: Sheila Humberstone, Stone Bridge Consulting

SFY2018 Priorities & Initiatives:

- GARD Advisory Council Authorization — This work group agreed to support Senate Bill 444 during the 2018 Legislative Session, which establishes the GARD Advisory Council.

Ammendment

RECOMMENDATIONS

This section contains recommended revisions to the GARD State Plan. These recommendations have been suggested by active GARD Collaborative participants and reviewed by the GARD Advisory Council. The GARD Collaborative and Advisory Council will review recommendations and put forward a revised State Plan to the Governor for final approval.

Overall

- Organize the goals and strategies with numbers and letters so that they are easily referred to or referenced.
- Review the plan for duplication among sections.
- Create a section for policy-related goals rather than incorporating them into other sections.
- Update goals that have been achieved or are in progress to demonstrate the current status.

Workforce Development

- Revisit language of specific offices or groups, such as "Office of Workforce Development" and opt for broad references to state agencies rather than narrow references to specific offices.
- Examine and resolve the overlap with goals in the Service Delivery section.
- Avoid words such as "require" and "develop" and replace with more general terms.

Service Delivery

- Examine Service Delivery goals for overlap with those of other work groups and identify portions that can be moved to other sections.
- Some of the goals are dense and require many steps. Consider breaking them into phases or clusters.
- The section's goals are very broad. Examine ways to narrow them.
- Many of the goals need piloting before they can be implemented. Add references to pilots where such activity may be helpful.
- Ensure that the goals incorporate the need to be culturally informed and sensitive, keeping in mind access and barriers to services.

Outreach & Partnerships

- Examine how respite programs could fit into this section, including grant opportunities for caregivers.
- Examine how rural colleges and universities could be a resource for getting information and education to families.

Public Safety

- Include more specific language regarding capacity assessment as it relates to guardianship laws
- Include information about suicide and dementia.

Health Care, Research & Data Collection

- Many goals and strategies attributed to this section of the GARD state plan do not pertain to data collection and/or analysis and would fit more appropriately in other sections. Either move strategies to other sections or revise them to make the goals more relevant to data collection and analysis.

Georgia Alzheimer's Disease and Related Dementias State Plan

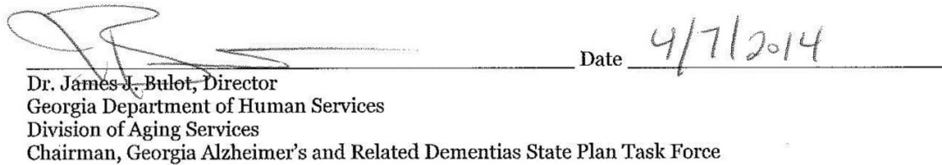
Prepared by the Georgia Alzheimer's Disease and Related Dementias State Plan Task Force

2014

Georgia Alzheimer's Disease and Related Dementias

State Plan

I, the undersigned, express support for the State Plan for Alzheimer's Disease and Related Dementias as presented to the Georgia General Assembly during the 2013-2014 Regular Session.



Date

Dr. James J. Bulot, Director
Georgia Department of Human Services
Division of Aging Services
Chairman, Georgia Alzheimer's and Related Dementias State Plan Task Force

Date

Keith Horton, Commissioner
Georgia Department of Human Services

Date

Nathan Deal, Governor
State of Georgia

Senate Bill 14

By: Senators Unterman of the 45th, Wilkinson of the 50th, Crosby of the 13th, Hill of the 4th and Orrock of the 36th

AS PASSED

A BILL TO BE ENTITLED
AN ACT

1 To amend Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to
2 indigent and elderly patients, so as to create a Georgia Alzheimer's and Related Dementias
3 State Plan Task Force; to provide for legislative intent; to provide for its members and
4 vacancies; to provide for duties and responsibilities; to provide for a chairperson; to provide
5 for a quorum for the transaction of business; to provide for a final report; to provide for
6 related matters; to provide an effective date; to provide for automatic repeal; to repeal
7 conflicting laws; and for other purposes.

8 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

9 **SECTION 1.**

10 Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to indigent and
11 elderly patients, is amended by adding a new article to read as follows:

12 "ARTICLE 9

13 31-8-300.

14 The General Assembly finds and declares that Alzheimer's disease is a looming national
15 public health crisis and impacts every state. It is important for Georgia to assess its ability
16 to provide appropriate and necessary programs and services to Georgia's citizens living
17 with Alzheimer's disease and related dementias, and determine where Georgia is, where
18 Georgia is doing well, where gaps may exist, and where the private sector, public sector,
19 nonprofit and faith-based communities' resources may be leveraged to ensure that Georgia
20 grows to be fully dementia capable. The General Assembly further finds that access to
21 quality health care for Alzheimer's and related dementias and the rising cost of such care
22 are vitally important to the citizens of Georgia. Therefore, the General Assembly has
23 determined that it is in the best interests of the state and its citizenry to address this issue.

24 31-8-301.
25 There is created the Georgia Alzheimer's and Related Dementias State Plan Task Force
26 for the purpose of studying and collecting information and data to assess the current and
27 future impact of Alzheimer's disease on Georgia's citizens; to examine the existing
28 industries, services, and resources addressing the needs of persons with Alzheimer's
29 disease, their families, and caregivers; to review the National Alzheimer's Disease Plan
30 currently under development by the federal Department of Health and Human Services;
31 and to develop a strategy to mobilize a state response to Alzheimer's and related dementias
32 as a public health crisis by creating a state plan.

33 31-8-302.
34 (a) The Georgia Alzheimer's and Related Dementias State Plan Task Force shall be
35 composed of six members and shall include the director of the Division of Aging Services
36 within the Department of Human Services, the commissioner of community health or his
37 or her designee, the state health officer or his or her designee, the chairperson of the House
38 Committee on the Health and Human Services, the chairperson of the Senate Health and
39 Human Services Committee, and the chairperson of the House Committee on Human
40 Relations and Aging.
41 (b) The director of the Division of Aging Services within the Department of Human
42 Services shall serve as the chairperson of the task force. The task force may elect other
43 officers as deemed necessary. The chairperson of the task force may designate and appoint
44 committees from among the membership of the task force as well as appoint other persons
45 to perform such functions as he or she may determine to be necessary as relevant to and
46 consistent with this article. The chairperson shall only vote to break a tie.
47 (c) The task force shall invite other advisory members to assist the committee and may
48 consider the following in making its selection: a person with Alzheimer's disease; a person
49 with Alzheimer's related dementia; such person's caregiver; a representative of the nursing
50 facility industry; a representative from the adult day care services industry; a representative
51 of the home health industry; a representative of the personal care home industry; a
52 physican; a consultant pharmacist; an Alzheimer's disease and related dementias
53 researcher; law enforcement personnel; and other stakeholders from the public, private, and
54 nonprofit sectors, voluntary health organizations, and the faith-based community.

55 31-8-303.
56 (a) The task force shall hold meetings at the call of the chairperson.
57 (b) A quorum for transacting business shall be a majority of the members of the task force.
58 (c) The members of the task force shall serve without compensation.

59 (d) The Division of Aging Services within the Department of Human Services shall
60 provide administrative support to the task force.
61 (e) Each legislative member of the task force shall receive the allowances provided for in
62 Code Section 28-1-8. Citizen members shall receive a daily expense allowance in the
63 amount specified in subsection (b) of Code Section 45-7-21 as well as the mileage or
64 transportation allowance authorized for state employees. Any members of the task force
65 who are state officials, other than legislative members, and state employees shall receive
66 no compensation for their services on the task force, but they shall be reimbursed for
67 expenses incurred by them in the performance of their duties as members of the task force
68 in the same manner as they are reimbursed for expenses in their capacities as state officials
69 or employees. The funds necessary for the reimbursement of the expenses of state
70 officials, other than legislative members, and state employees shall come from funds
71 appropriated to or otherwise available to their respective departments. All other funds
72 necessary to carry out the provisions of this article shall come from funds appropriated to
73 the House of Representatives and the Senate.

74 31-8-304.
75 (a) The purpose of the task force shall be to create a comprehensive state plan for Georgia
76 to address Alzheimer's and related dementias and shall include, at a minimum:
77 (1) Trends in state Alzheimer's and related dementias population and needs, including
78 the changing population with dementia, including, but not limited to:
79 (A) State role in long-term care, family caregiver support, and assistance to persons
80 with early stage and early onset Alzheimer's disease;
81 (B) State policy regarding persons with Alzheimer's disease and developmental
82 disabilities; and
83 (C) Ongoing periodic surveillance of persons with Alzheimer's disease for purposes
84 of having proper estimates of the number of persons in the state with Alzheimer's
85 disease, and for the development of a response to this chronic condition that has risen
86 to the level of a public health crisis;
87 (2) Existing services, resources, and capacity, including but not limited to the:
88 (A) Type, cost, and availability of dementia services;
89 (B) Dementia-specific training requirements for long-term care staff;
90 (C) Quality care measures for long-term care facilities;
91 (D) Capacity of public safety and law enforcement to respond to persons with
92 Alzheimer's disease;
93 (E) Availability of home- and community-based resources for persons with
94 Alzheimer's disease and respite care to assist families;

95 (F) Inventory of long-term care dementia care units;
96 (G) Adequacy and appropriateness of geriatric-psychiatric units for persons with
97 behavior disorders associated with Alzheimer's disease and related dementias;
98 (H) Assisted living residential options for persons with dementia;
99 (I) State support of Alzheimer's disease research through Georgia universities and other
100 resources;
101 (J) Medical education, content, and quality of course offerings and requirements for
102 dementia training provided to students in medical education programs at all levels of
103 education within both state and private programs from emergency medical technician
104 and nursing assistant programs through advanced medical specialties and medical
105 continuing education;
106 (K) Inventory of federal agencies who provide funding, services, programs, or
107 resources for individuals with Alzheimer's disease or a related dementia, caregivers,
108 medical professionals, or professional care providers; and
109 (L) Gaps in services;
110 (3) Needed state policies or responses, including but not limited to directions for the
111 provision of clear and coordinated services and support to persons and families living
112 with Alzheimer's disease and related disorders and strategies to address any identified
113 gaps in services;
114 (4) Ways in which state and local agencies, private sector, quasi-governmental, voluntary
115 health organizations, the faith community, and nonprofit organizations can collaborate
116 and work together to form a seamless network of education, support, and other needed
117 services to those living with Alzheimer's disease and related dementias and their families;
118 and
119 (5) Specific areas to addressed, including:
120 (A) Increasing awareness of Alzheimer's disease among the public;
121 (B) Encouraging increased detection and diagnosis of Alzheimer's disease;
122 (C) Improving the individual health care that those with Alzheimer's disease receive;
123 (D) Improving the quality of the health care system in serving people with Alzheimer's
124 disease;
125 (E) Expanding the capacity of the health care system to meet the growing number and
126 needs of those with Alzheimer's disease;
127 (F) Training and better equipping health care professionals and others to deal with
128 individuals with Alzheimer's disease;
129 (G) Workforce development by increasing the number of health care professionals that
130 will be necessary to treat the growing aging and Alzheimer's populations;

131 (H) Improving services provided in the home and community to delay and decrease the
132 need for institutionalized care;
133 (I) Improving access to long-term care, including assisted living, for those with
134 Alzheimer's disease;
135 (J) Assisting unpaid Alzheimer's caregivers;
136 (K) Increasing research on Alzheimer's disease;
137 (L) Promoting activities that would maintain and improve brain health;
138 (M) Creating a better system of data collection regarding Alzheimer's disease and its
139 public health burden;
140 (N) Public safety and addressing the safety related needs of those with Alzheimer's
141 disease, including in-home safety for those living at home, Mattie's Call and safety of
142 those who wander or are found wandering but who need supervision until they can be
143 reunited with their family or professional caregiver and driving safety, including
144 assessments and taking the license away when a person with dementia is no longer
145 capable of driving safely;
146 (O) Addressing legal protections for, and legal issues faced by, individuals with
147 Alzheimer's disease; and
148 (P) Improving how state government evaluates and adopts policies to help people with
149 Alzheimer's disease and their families; determination of which department of state
150 government is the most appropriate agency to house the ongoing work of the Georgia
151 Alzheimer's and Related Dementias State Plan Task Force as it convenes annually to
152 ensure track and report progress as Georgia becomes a more dementia-capable state.
153 (b) The task force shall have the following powers:
154 (1) To hold public meetings and utilize technological means, such as webcasts, to gather
155 feedback on the recommendations from persons and families affected by Alzheimer's
156 disease and related dementias and from the general public;
157 (2) To request and receive data from and review the records of appropriate agencies and
158 health care facilities to the greatest extent allowed by state and federal law;
159 (3) To accept public or private grants, devises, and bequests; and
160 (4) To enter into all contracts or agreements necessary or incidental to the performance
161 of its duties.
162 (c) Prior to the final report required in subsection (d) of this Code section, the task force
163 may advise on legislation and other recommended changes to the Governor and the General
164 Assembly.
165 (d) The task force shall issue a state plan which shall include proposed legislation, if any,
166 to the Governor and the General Assembly on or before March 31, 2014.

167 31-8-305.

168 (a) Upon the abolishment of the task force as provided by this article, there shall be created
169 the Georgia Alzheimer's and Related Dementias Advisory Council.

170 (b) The advisory council membership shall include the same membership as the original
171 task force as provided for in this article.

172 (c) The advisory council shall meet at least annually to review the progress of the state
173 plan and to make any recommendations for changes, as well as recommend any legislation
174 needed to implement the plan.

175 31-8-306.

176 The task force shall stand abolished on March 31, 2014."

177 **SECTION 2.**

178 This Act shall become effective upon its approval by the Governor or upon its becoming law
179 without such approval.

180 **SECTION 3.**

181 All laws and parts of laws in conflict with this Act are repealed.

Acknowledgments

The Georgia Alzheimer's Disease and Related Dementias State Plan Task Force wishes to thank the hundreds of individuals from across Georgia who shared their thoughts and opinions about the challenges facing them relating to Alzheimer's disease and related dementias. Their input was integral to the development of the Georgia Alzheimer's Disease and Related Dementias State Plan content and recommendations.

The State Plan Task Force thanks the elected officials, Commissioners and staff who participated in and supported the work of the State Plan Task Force. Their commitment and leadership was appreciated by all advisory panel members.

Senator Renee Unterman, Chairman, Senate Health and Human Services

Representative Sharon Cooper, Chairman, House Health and Human Services

Representative Tommy Benton, Chairman, House Human Relations and Aging

Commissioner Brenda Fitzgerald, MD, Department of Public Health

Commissioner Clyde Reese III, Esq., Department of Community Health

James J. Bulot, Ph.D., Director, Department of Human Services Division of Aging Services; Chairman, State Plan Task Force

The State Plan Task Force also thanks the staff of the Division of Aging Services and Georgia Council on Aging who helped support the work of the State Plan Task Force and provided committee support throughout the state plan process:

Mary McCarthy, Georgia Council on Aging

Sharon Hudson, Program Integrity, Division of Aging Services

Cliff Burt, Livable Communities, Division of Aging Services

Gwenyth Johnson, Livable Communities, Division of Aging Services

Jennifer Hogan, Program Integrity, Division of Aging Services

Eric Ryan, Georgia Council on Aging

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Georgia Alzheimer's Disease and Related Dementias State Plan

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Executive Summary

This is the Georgia Alzheimer's Disease and Related Dementias State Plan. Almost 30 years ago, at the request of the then-Atlanta Chapter of the of Alzheimer's Disease and Related Disorders Association, the Governor's Office and the Department of Human Resources delegated responsibility to the Office of Aging to conduct an Alzheimer's Disease Study Committee. Little was known about Alzheimer's at this time and much of the effort was devoted to understanding the nature of Alzheimer's. Early strides were made in identifying funding for respite services and expanding the Community Care Services Program, and the Office on Aging was directed to take an active role in educating the public.

In many ways, the initial study document was ahead of its time, and many of the recommendations floundered due to a lack of data (and the ability to collect and analyze data). Additionally, the public lacked a clear understanding of the extent to which Alzheimer's disease and related dementias would impact the state and nation.

This State Plan builds upon previous work done by the Division of Aging Services in developing dementia-capable systems, coupled with knowledge gleaned through the Georgia Chapter of the Alzheimer's Association, the National Alzheimer's Plan and The Healthy Brain Initiative as well as professional expertise, personal experience, and public input from across the state. It is the intent of the Georgia Alzheimer's and Related Dementias State Plan Task Force that, as the various goals are accomplished, and as new needs arise or new resources become available, the GARD Advisory Council would amend the State Plan to reflect these changes.

This plan provides:

1. Numerous recommendations to State Agencies, Offices and Departments as a starting point for transitioning Georgia into becoming a dementia-capable state. Some recommendations will be acted upon immediately and others will take time, legislation or commitments from State leadership to ensure resources are available. These should be revisited regularly to ensure that we are meeting expected outcomes.

2. A guide for Public Health to begin to develop capacity to address Alzheimer's disease and related dementias as a public health crisis. It also provides recommendations for engaging public and private-sector stakeholders to improve the state's response to community needs associated with Alzheimer's disease and related dementias.

This plan was developed to ensure that people with dementia, their families, and caregivers have ready access to reliable information, support and services and that they are delivered as effectively and efficiently as possible. Dementia is a devastating disease that causes changes in one's memory, behavior, and ability to think clearly. Statistically, dementia will eventually impact every region, every county and family in the state of Georgia. Alzheimer's is the sixth-leading cause of death in America. In Georgia in 1985, there were an estimated 40,000 people living with dementia. In the past six years alone, the number of Georgians reporting symptoms of dementia increased by 22 percent to

120,000 – this is a 427% increase from the 1985 estimates. The time is right for Georgia to adopt and implement this Alzheimer's and Related Dementias State Plan.

Dr. James Bulot, Director
DHS Division of Aging Services
Chair, Georgia Alzheimer's and Related Dementias State Plan Task Force

Introduction

More than 120,000 Georgians live with Alzheimer's disease, and the figure will leap to 160,000 by 2025.

Although Alzheimer's Disease accounts for 60-80% of dementia diagnoses, it is only one of many types of dementia. The impact on Georgians is staggering.

In 2013, Georgia joined other states in a push to address the problem comprehensively. Using the National Plan to Address Alzheimer's Disease as a model, supporters worked to create the Georgia Alzheimer's and Related Dementias State Plan Task Force. The six-person group features members of Georgia's General Assembly, Commissioners from the Departments of Public Health and Community Health and over 65 advisory panel members representing advocacy organizations, medical professions, providers and consumers.

'Between 2006 and 2012, the population at-risk for dementia grew by 22%.'

As a result of successful legislation, this multidisciplinary group of state leaders assessed Georgia's capacity to meet dementia-related needs and recommended innovative new ways to address the issue.

In addition, a diverse array of advisors who represented fields such as research, medicine, law enforcement, workforce development, and more, helped the task force analyze challenges and develop recommendations.

The resulting plan will serve as Georgia's blueprint for improving dementia prevention and treatment, community services, family support, and public awareness. As a living document, the plan will undergo regular review and reassessment to meet the evolving needs of Georgians living with dementia.

One of the goals of the creation of the State Plan is that it will work in tandem with the National Plan to ensure seamless leveraging of national and Georgia resources to address Alzheimer's as the public health crisis it has become.

At the recent G8 summit, member countries committed to the goal of identifying disease-modifying therapies for dementia by 2025 – similar to the goal in the National Plan to Address Alzheimer's Disease in the U.S.

I. Demographics

The legislative intent of the Georgia Alzheimer's and Related Dementias State Plan Task Force begins with the collection and study of data to assess the current and future impact of dementia. Per SB14, Part I of this report reviews the population trends needed by state planners. These trends include:

- Trends in the growth of the population aged 60 years and older
- Estimates for the numbers of persons with symptoms of dementia
- Estimates for the numbers of persons needing help due to these symptoms
- Estimates for the numbers of persons that need healthcare due to these symptoms

Dementia is not a normal part of the aging process. However, according to the Centers for Disease Control and Prevention (CDC), age is the best-known risk factor for Alzheimer's disease and other dementias. More than 90 percent of cases occur among persons aged 60 years and older.

Public health planning begins by counting the population with the greatest risk for dementia. In 2012, the U. S. Bureau of the Census estimated that there were 1,662,785 persons in Georgia aged 60 years and older. This is an increase of 373,376 persons in the six-year period since 2006.

The majority (70%) of this increase consists of persons aged 60 to 69 years. This is an increase of 258,468 persons. Research shows that growth of this age group is a combination of aging among Georgia residents and retirees who choose to move here.

Table 1 shows the percent growth for sub-categories of age. Other subgroups increased in number during the 2006 to 2012 period. Persons aged 80 years and older have the highest risk for developing Alzheimer's and other dementias. The numbers of persons in this age group are available on the Georgia Online Analysis and Statistical Information website. (http://oasis.state.ga.us/oasis/)

Table 1: Percent increase for each two-year period between 2006 and 2012

Adults aged 60+ years, by Age Category	% Change 2006 - 08	% Change 2008 - 010	% Change 2010 -12	% Change 2006 - 2012
Total	9.17	7.75	7.45	22.45
Aged 85+	6.42	5.80	7.12	18.12
Aged 80 - 84	3.12	2.63	4.16	9.59
Aged 75 – 79	3.21	3.30	6.00	12.02
Aged 70 – 74	5.53	6.67	9.49	20.19
Aged 65 – 69	11.34	8.94	12.23	29.14
Aged 60 – 64	14.00	10.84	4.09	26.66

Source: Georgia Online Analytical Statistical Information System; http://oasis.state.ga.us/oasis/

Counting the number of households is another approach to measure the impact of dementia. According to the 2012 American Community Survey, in Georgia there are 745,467 households with one or more persons aged 65 years and older in residence. There are 95,722 persons aged 75 and over who live alone and own their home. There are another 44,249 persons aged 75 years and over living alone and renting their residence. Both of these populations are vulnerable to the public health and safety effects of dementia.

The challenge for state planners is the size of the gap between diagnosed cases of Alzheimer's and the number of persons with undiagnosed symptoms of dementia. How large is this gap? At this point in time, we can only provide estimates. If we use a number that is too small, then healthcare, public safety and other systems will not be able to respond. The next series of tables shows estimates using different strategies.

The following section presents two strategies for counting the numbers of persons affected by Alzheimer's and other dementias.

Strategy One: Counting the numbers using data with diagnosed cases

According to the Alzheimer's Association, there are currently an estimated 120,000 persons living with a diagnosis of Alzheimer's disease in Georgia. If current trends continue, this number is expected to increase to 160,000 by the year 2025. Table 2 shows the projected numbers between 2000 and 2025.

Table 2: Number of People Aged 65+ with diagnosed Alzheimer's disease in Georgia
(Figures are rounded.)

Year	Aged 65-74	Aged 75-84	Aged 85+	Total	% change from 2000
2000	7,500	58,000	44,000	110,000	
2010	7,400	60,000	57,000	120,000	9%
2020*	10,000	68,000	64,000	140,000	27%
2025*	12,000	84,000	68,000	160,000	45%

*projected values. Source: http://www.Alz.org

Strategy Two: Using data from CDC surveys of persons with symptoms of dementia.
'These yield larger estimates and include non-dementia mental illnesses.'

Persons in the earliest stages of dementia can reliably report symptoms of confusion or memory problems. These symptoms lead to declines in the ability to focus attention and manage personal affairs and difficulties with language. Some, but not all, persons with confusion or memory problems develop Alzheimer's and other dementias.

To support the work of public health planners across the United States, the CDC is developing population estimates that can be applied to state demographic data. These estimates came from the Behavioral Risk Factor Surveillance Survey of 21 states conducted in 2011. Georgia's statistics are available in detail but were not a part of the composite reporting of other states. Participating neighboring states with similar populations included Florida, North Carolina, South Carolina, Tennessee, and West Virginia.

The following table shows estimates for the prevalence of confusion or memory problems among Georgia's 'at-risk' population aged 60 years and older. To develop the numbers shown in Table 3, we applied the CDC estimates to Georgia census data. The final two rows of Table 3 contain estimates of the potential growth between 2006 and 2012. In six years, the number reporting symptoms increased by 22 percent to 211,174. This number includes 74,333 who live alone and 73,066 who have symptoms that limit their ability to engage in self-care.

Table 3: Estimates for current Georgia Population,
Aged 60 years and older with Confusion or Memory Problems

Number living alone, reported confusion or memory problems	74,333
Number with confusion or memory problems AND disability	73,066
Estimated Number with confusion / memory problems, 2012*	211,174
Estimated percent increase in number with symptoms between 2006 - 2012	22%

Source: MMWR, May 2013

A. State Role

The mission of the Georgia Department of Human Services Division of Aging Services (DAS) is to assist older individuals, at-risk adults, persons with disabilities, their families, and caregivers to achieve safe, healthy, independent, and self-reliant lives. It should be noted that, as Alzheimer's and related dementias progress, the level of impairment rises to the level of disability.

DAS (the state agency on aging) and Georgia's Aging Services Network (Area Agencies on Aging, their providers, older adults, and advocates) are committed to developing a person-centered, statewide comprehensive and coordinated system of programs and services. The system aims to serve all eligible individuals, regardless of age or ability, by providing seamless access to long-term supports and services that are needed to remain at home and in the community for as long as possible.

'It is imperative that we develop accurate estimates to measure the impact of dementia on community caregivers and health care professionals in Georgia.'

To effectively meet this goal, DAS and Area Agencies on Aging partner with public and private organizations. DAS specifically partners with the Department of Community Health (DCH) to provide services to Medicaid beneficiaries and also to provide advocacy and guidance in long-term care policy and the development of community supports for community integration, including efforts to reduce barriers to housing and transportation. DAS aligns its strategic planning goals with the Administration for Community Living (which houses the Administration on Aging), the Office of the Governor, the Department of Health and Human Services, and the Department of Public Health.

DAS is committed to strengthening and expanding the Older Americans Act's (OAA) core programs, discretionary grants, and consumer control and choice programs. DAS is fostering an integrated and systematic approach to delivering consumer-directed long-term supports and services and community living initiatives.

Enhancing the National Family Caregiver Support Program is a key goal. DAS is working to reduce caregiver burden and stress through evidence-based Alzheimer's Disease Supportive Services Program (ADSSP) discretionary grants and collaboration with the Rosalynn Carter Institute for Caregiving at Georgia Southwestern State University.

Table 4: Number of Alzheimer's and Dementia Caregivers, Hours of Unpaid Care, Value of Caregiving, and Higher Personal Healthcare Costs Incurred by Caregivers in Georgia

Year	**Number of Caregivers** (in thousands)	**Total Hours of Unpaid Care** (in millions)	**Total Value of Unpaid Care** (in millions)	**Higher Health Costs of Caregivers** (in millions)
2010	482,000	5,490,000	$6,552	n/a
2011	488,000	5,550,000	$6,730	$222
2012	495,000	5,630,000	$6,944	$235

Source: http://www.alz.org

The state's role in planning long-term care, family caregiver support, and assistance to persons with dementia is hampered when we cannot accurately count cases. BRFSS 2011 data begins the process of filling this data gap. Using BRFSS 2011 estimates, there are:

- 112,133 persons with confusion or memory problems who need help from others in activities required for daily living.
- 74,333 persons with confusion or memory problems living alone.
- 73,066 persons with confusion or memory problems who also have disability in the activities required for daily living.

Georgia's infrastructure for long-term care, healthcare, transportation, and public safety will need to plan for these numbers. Based on these data, we can make the following statements about confusion or memory problems in Georgia:

- 89,594 persons need help but do not have access.
- 112,133 persons have not discussed the symptoms with a healthcare provider.

In Georgia, 14.3 percent – one in seven – of those aged 60 and over report that they are experiencing confusion or memory loss that is happening more often or is getting worse.

B. Cognitive Impairment

The BRFSS Cognitive Impairment Module provides demographic, geographic and socioeconomic data regarding cognitive impairment. The module asks about memory and cognitive abilities as well as the impact of any memory loss on daily living. This knowledge is vital to developing or maintaining effective policies and programs to address the needs of people living with cognitive impairment in Georgia. Age is the greatest risk factor for cognitive impairment, and as the Baby Boomer generation passes age 65, the number of people living with cognitive impairment is expected to jump dramatically. Cognitive impairment is costly. People with cognitive impairment report more than three times as many hospital stays as individuals who are hospitalized for some other condition.

Each year, the Alzheimer's Association funds research on the surveillance of persons with Alzheimer's disease in every state of the country using the BRFSS (Behavioral Risk Factor Surveillance system), a nationwide telephone survey used to track health risks throughout the country. Of the individuals who have reported experiencing confusion or memory loss, almost 80% of them have not talked to a healthcare professional about it. For those with worsening memory problems, one in four says it has interfered with household activities or chores.

BRFSS Data on Georgia from 2011 was released in May of 2012 (see Appendix II). The Caregiver Module was conducted in Georgia in 2012 – in a partnership between the DHS Division of Aging Services (which paid for the Caregiver Module to be conducted) and the Association's Georgia Chapter (which paid for the Cognitive Module to be conducted).

C. Developmental Disabilities

Little is known about people with intellectual and developmental disabilities (IDD), and there has been little effort across states to develop specific policies related to people with developmental disabilities. From existing research, it appears as if most individuals with IDD experience dementia rates similar to older adults in the general population. However, some adults with intellectual disabilities are at higher risk for dementia – adults with Down syndrome are particularly susceptible. Recent studies for adults with Down syndrome show that 10-25% of individuals ages 40-49, 20-50% of individuals, ages 50-59, and 60-75% of individuals with Down syndrome older than age 60 have Alzheimer's disease (Alvarez, 2008). As people with intellectual and developmental disabilities continue to age more successfully and live longer, the numbers with Alzheimer's disease and other dementias will continue to increase. Currently, there are no state policies regarding people with intellectual and developmental disabilities and Alzheimer's disease or other dementias.

Likewise, the exact number of persons in Georgia with Serious Mental Illness (SMI) and comorbid dementia disorder is unknown and there are no state policies regarding this growing older adult population. SMI is a diagnosis stipulated by law and defined by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) as requiring the person to have at least one (mental) disorder lasting 12 months, other than a substance use disorder, that meets DSM-IV criteria and causes "serious impairment." Serious impairment is indicated by a Global Assessment of Functioning (GAF) score of less than 60 (Epstein, Barker, Vorburger, & Murtha, 2004).

Persons with SMI are as vulnerable as the general population in acquiring a form of dementia as they age (Patterson & Jeste, 1999). For example, there is conflicting evidence regarding the rate of cognitive decline in persons with schizophrenia; however, experts speculate that schizophrenia reduces normal "cognitive reserve" which protects against dementia and lowers the threshold for clinically detected cognitive impairment (de Vries, Honer, Kemp, & McKenna, 2001). Deterioration in ability to function is also impacted by the person's opportunity throughout life to learn and participate in activities of daily living. For example, persons living in institutions do not generally

shop for their own food, cook their own meals, or manage their own finances (McCracken & Gellis, 2008). Georgia has a long history of institutionalizing persons with SMI and with the current mandate to provide persons with SMI and developmental disabilities the opportunity to live in the community. These populations warrant particular attention.

Dementia and depression are associated in older patients and often occur together. Recognizing and treating the depression can make a significant difference in terms of quality of life, caregiver stress, and institutionalization of the identified patient (Hermida & McDonald, 2011). The classic example is an elder who has a stroke and is demented secondary to the stroke. The cerebrovascular disease leading to a stroke has been shown to be associated with the development of mood symptoms. Depression is a risk factor for stroke (Krishnan et al., 2005) and approximately half of patients with post-stroke depression will meet criteria for major depression, and the other half will have minor depression (Robinson, 1998). Treating the depression can have marked benefits for the patient and the family in terms of the patient's motivation to stay in treatment and overall outcome.

The relationship between dementia and depression is well known in the medical literature. Over 50% of patients with dementing illnesses such as Alzheimer's disease may also have depressive symptoms, with 20% meeting criteria for a major depressive episode (Brown et al., 2009). Depressive symptoms may also precede cognitive decline in community elders (Sachs-Ericsson et al., 2005), and a significant number of individuals with depression and reversible cognitive deficits eventually progress to syndromic dementia (Faez-Fonseca et al., 2007). The biological markers of Alzheimer's disease are found in patients with major depression, including the genotype apolipoprotein E-e3/34 (Apo E4) (Krishnan et al., 1996) which has been linked to Alzheimer's disease.

Providing the systems of care to accurately diagnose depression and initiate appropriate treatment in patients with comorbid medical disorders is therefore important in long-term outcomes for both the family and their caregivers and may have a significant effect on the course of the illness.

II. Existing Services, Resources and Capacity

The DHS Division of Aging Services (DAS) coordinates a comprehensive array of home and community based services for older adults and adults with disabilities, including the Older American's Act Services as well as the 1915c Elderly and Disabled Waiver services programs. Since 2011, DAS, in coordination with the Alzheimer's Association, Georgia Chapter and the Rosalynn Carter Institute for Caregiving, has been providing dementia capability training to the broader Aging Services Network. Through the ACL/AoA Systems Integration Grant, DAS is creating a dementia-capable network of services through its existing providers, the law enforcement community, and Adult Protective Services. DAS, through the 12 Area Agencies on Aging, coordinates the Enhanced Services Program – a home and community based long-term care database that includes 19,000 resources for the aging community as well as 3500+ newly added statewide

resources for those individuals with developmental disabilities and brain and spinal cord injuries. In addition to the Division of Aging Services, other state agencies offering publicly funded services include the Department of Community Health, Department of Public Health and the Department of Behavioral Health and Developmental Disabilities. While all of these agencies may offer services which may benefit individuals with Alzheimer's disease or their families, no agency targets services specifically to persons with ADRD. For a listing of long term-supports and services in the community, individuals may call 866-552-4464 or visit www.georgiaservicesforseniors.org. Resources are also available on the Alzheimer's Association's website at www.alz.org or through the Association's 24/7 Helpline at 800-272-3900.

A. State Agency Resources

The legislation called for the working group to examine the array of needs of individuals diagnosed with Alzheimer's and other dementias, followed by a description of the services available to meet these needs, and the capacity of the state and current providers to meet these and future needs. The state plays a major role in the administration and provision of long-term care services for all older persons, including those with Alzheimer's, related dementias and their caregivers. Many of these roles are shared with other entities, including counties, providers, health plans, and Area Agencies on Aging. State agencies use a combination of state and federal funding to provide long-term supports and services to adults who need/require nursing home level of care. Georgia combines funds from Title III of the Older Americans Act with state appropriations and federal Medicaid funding for long-term supports and services.

Division of Aging Services (DAS): The Georgia Department of Human Services Division of Aging Services manages a statewide network of agencies, supports and services to help adults who are older or have disabilities live longer, live safely, and live well.

- Designates 12 Area Agencies on Aging under the Older Americans Act (OAA) to carry out federally mandated functions to provide information and assistance to older adults and their families, and administer federal Title III OAA and related grants for provision of nutrition, chore, transportation, caregiver support and caregiver counseling services in their planning and service area.
- Provides Information and assistance for older individuals and families as they look for options and services to meet their needs through the Aging and Disability Resource Connection.
- Administers several grant programs related to health promotion, chronic care management, falls prevention, Medicare Part D and other health insurance counseling.
- Provides administrative support to the State Long-Term Care Ombudsman, a mandated service under the OAA, which acts as a mediator for consumers and their families who are having problems with a facility or agency providing long-

term care, and provides specific information about long-term care services and programs to consumers and their families.

- Administers federally funded projects on Alzheimer's care, piloting evidence-based models for persons with Alzheimer's and their caregivers throughout the state.
- Supports the Gateway/Aging and Disability Resource Connection as the single entry point to access long-term services and supports (LTSS) statewide and assist consumers with making informed decisions on their long-term care.
- Administers the Elderly Legal Assistance Program (ELAP), Georgia's Older Americans Act Title III-B funded legal services program. It provides free legal services statewide to adults 60 and older, targeting those in the greatest need socially or economically. Attorneys provided by ELAP offer legal representation, information, and education in civil legal matters, including topics such as wills, probate and estate planning, issues related to long-term care discharge and residents' rights, advance directives for healthcare and powers-of-attorney questions, guardianship, and conservatorship issues. Information on these services can be retrieved from a variety of sources, including local AAAs (1-866-552-4464) and the Georgia Senior Legal Hotline (1-888-257-9519).
- Provides support for Powerful Tools for Caregivers (PTC), a six-week course that helps caregivers develop a wealth of self-care tools to reduce personal stress, change negative talk, communicate their needs to family members and healthcare or service providers, communicate more effectively in challenging situations, recognize the messages in their emotions, deal with difficult feelings, and make tough caregiving decisions. By 2014, Powerful Tools for Caregivers will be available in all regions of the state. The program is coordinated by Georgia's 12 Area Agencies on Aging.
- Administers the 1915c LTC Waiver**.** Currently over 30,000 adults who are older, disabled, and meet nursing home level of care receive the 1915c Medicaid LTC waiver program (CCSP and Source). HCBS waivers provide an array of LTC supportive services in a community setting with the goal of meeting the health and functional needs of low-income elders and individuals with disabilities who otherwise would be eligible for placement in a nursing home.

Department of Community Health (DCH): The Georgia Department of Community Health is one of Georgia's four health agencies serving the state's growing population of almost 10 million people. Responsible for a $12 billion budget for State Fiscal Year 2013, the department is one of the largest agencies in Georgia state government. Serving as the lead agency for Medicaid and also overseeing the State Health Benefit Plan (SHBP), Healthcare Facility Regulation and Health Information Technology in Georgia, the agency programs provide access to health care services for one in four Georgians.

- Responsible for licensing, registration and certification of hospitals, health care agencies, clinics, home care agencies, personal care homes, assisted living facilities and nursing facilities, including approval of memory care and dementia units. Georgia currently has 40,249 nursing home beds and 29,059 personal care home beds.
- Provides quality assurance and quality information for consumers related to the agencies and facilities that DCH licenses and regulates (http://www.gamap2care.info/).
- Provides quality assurance through the regular surveying of all licensed agencies, programs, and facilities and regular assessments of nursing facility residents. Operates the Office of Healthcare Facility Regulation where consumers can lodge complaints against licensed providers.

Department of Public Health (DPH): The Georgia Department of Public Health (DPH) is the lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective. DPH's main functions include: Health Promotion and Disease Prevention, Maternal and Child Health, Infectious Disease and Immunization, Environmental Health, Epidemiology, Emergency Preparedness and Response, Emergency Medical Services, Pharmacy, Nursing, Volunteer Health Care, the Office of Health Equity, Vital Records, and the State Public Health Laboratory.

- Administers Health Promotion and Disease Prevention Programs which provide population-based programs and services aimed at reducing disease risks, promoting healthy youth development, targeting unhealthy behaviors, providing access to early detection and treatment services, and improving management of chronic diseases. Alzheimer's is a chronic disease.
- Houses the Epidemiology Section which carries out a number of activities to identify diseases and describe health conditions, assess the health of Georgians, and develop recommendations to control diseases and improve overall health status in the state.
- Conducts active and passive surveillance to detect diseases and adverse health conditions.
- Recommends appropriate prevention measures, treatment, and control.

Both the Division of Aging Services and the Department of Community Health receive funding for institutional and home and community based services for people who are aged, blind or disabled; who meet nursing home level of care or for people with dementia. Each program will have varying levels of eligibility. The following lists the resources expended during the last fiscal year. Unless otherwise noted, funding is available to all eligible individuals, not just those with dementia. Please note, the list below is not meant to be all inclusive of all programs administered by each agency, just

those that are most likely to be utilized by someone with dementia requiring long-term support and services.

Program	Agency	Source	Total
State Alzheimer's Program*	DAS	State	$2,387,409
Aging and Disability Resource Connections	DAS	State	$444,000
CBS – Alzheimer's Set Aside*	DAS	State	$75,000
CBS – Respite	DAS	State	$1,042,159
Community Based Services	DAS	State	$12,257,576
Community Cares Services Program	DAS	Federal+	$154,465,271
Long Term Care Ombudsman	DAS	State	$1,054,568
Long Term Care Ombudsman	DAS	Federal+	$435,318
Title III Older Americans Act	DAS	Federal+	$30,330,297
Title III E National Family Caregiver Support Program	DAS	Federal+	$3,588,471
Social Service Block Grant	DAS	Federal+	$5,138,280
Nutrition Services Incentive Program	DAS	Federal	$3,866,515
Skilled Nursing Care in a Nursing Facility	DCH	Federal+	$1,057,232,450
Skilled Care in a State Owned Facility	DCH	Federal+	$39,070,736
Home Health Services	DCH	Federal+	$5,981,371
Source Waiver	DCH	Federal+	$277,611,612

Table does not include non-claims such as Medicare Part A, Part B and Part D expenses.
*Accessible only to people with Alzheimer's or related dementia's and their family.
+ State funds are used as match to draw down federal funds.

B. Dementia Services

Adult Day Care Services: Adult day services provide care in a congregate daytime setting, enabling family caregivers to work, run errands, or get needed respite. Older adults and people with disabilities may stay at an adult day care for a few hours or a full day while receiving meals, access to social activities, and general supervision. Some centers also provide transportation. Georgia's adult day services licensing standards, developed after the legislature approved licensing authority in 2003, are currently voluntary due to lack of funding for the licensing agency to administer the licensing process. The Division of Aging Services has standards that must be met by providers in the statewide aging network that provide day services through contracts with the Area Agencies on Aging (AAA). Georgia currently has 61 Community Care Services Program (CCSP) providers of Adult Day Health Services. CCSP is a Medicaid-funded waiver program that enables people at risk of nursing home placement to remain in the community through the use of supportive services.

Home Health Agencies (HHA): The agencies provide a full range of professional health care services in the home under the direction of the patient's physician, including, but not limited to: Skilled Nursing, Psychiatric Skilled Nursing, Physical, Occupational and Speech Therapy, Home Infusion, Medical Social Services, and Home Health Aide Services. Georgia currently has 1,282 Home Health Providers (http://www.gahha.org/displaycommon.cfm?an=1).

Long-Term Care Facilities, also called **Skilled Nursing Facilities:** provide 24-hour nursing care and personal assistance in an institutional setting. In 2013, Georgia had 369 licensed skilled nursing facilities with 40,249 beds. All Georgia nursing homes must be licensed by the state. To receive Medicare reimbursement, they must also be certified by the Centers for Medicare and Medicaid Services (CMS), or, in the case of Medicaid reimbursement, they must meet CMS certification standards even if the facility is not enrolled in Medicare.

Personal Care Homes: Personal care homes provide personal care assistance, protective oversight, social support services and 24-hour supervision for individuals with functional limitations to live as independently as possible in a community residential setting. Georgia currently has 1,913 licensed personal care homes and 10 assisted-living residences with 29,059 beds available for individuals, including private-pay and Medicaid residents.

Additionally, a wide array of home and community based services is available through the DHS Division of Aging Services and Area Agencies on Aging to persons aged 60 and older and their family caregivers. These include the following:

- **Nutrition and Wellness Programs:** These include home-delivered meals, the Senior Farmer's Market Nutrition Program, and wellness programs aimed at health promotion and disease prevention. The programs increase functional abilities, promote safety at home, help older adults avoid or delay problems caused by chronic diseases, and enhance quality of life.
- **Adult day care:** The service provides personal care for dependent elders is available in a supervised, protective congregate setting during some portion of the day. Services offered in conjunction with adult day care typically include social and recreational activities, training, and counseling.
- **In-home respite:** These services offer temporary substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers.
- **Information and assistance:** Aging and Disability Resource Centers housed in Georgia's 12 Area Agencies on Aging assist older adults and individuals with developmental, physical, or behavioral disabilities who are looking for a variety of home- and community-based services and information about long-term care options.
- **Caregiver education training programs**: Workshops for current or potential clients/caregivers, or the general public, inform participants of service availability or provide general program information. An example of these types of programs is Powerful Tools for Caregivers, a six-week educational program which has a demonstrated a positive impact on caregiver health. Powerful Tools for Caregivers is designed for a diverse group of caregivers, including rural residents,

ethnic minorities, adult children of aging parents, caregivers at differing stages in their caregiving role, families with a variety of living situations, and caregivers with a range of educational backgrounds.

- **Support groups:** Clients meet in support groups on a regular, defined basis to discuss common problems or life issues. The group can have a professional as a moderator or be run by members alone. Support groups function to provide an expansion of social resources and knowledge relevant to members' situations, relief and reassurance, and enhanced coping skills.
- **Homemaker/personal care:** This service provides assistance with activities such as preparing meals, shopping for personal items, managing money, using the telephone, or performing light housekeeping.
- **Case management:** Case managers provide assistance, either in the form of access or care coordination, in circumstances where the older person is experiencing diminished functional capacity or other characteristics which require the provision of services by a formal service provider or family caregiver. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required. Case management involves the assessment, planning, and coordination of services desired, as well as monitoring and evaluating options and services to meet the individual's unique needs. It is performed in collaboration with the consumer and/or family caregiver.
- **GeorgiaCares:** Georgia's State Health Insurance Assistance Program (SHIP) helps Medicare beneficiaries, their families, and others understand rights, benefits, and services under the Medicare program and other related health insurance options.

C. Academic and Educational Resources

University of Georgia – Athens, Institute of Gerontology (IOG) within the College of Public Health is dedicated to training the workforce. IOG offers coursework to medical and nursing students at UGA's new health science campus. The Institute also provides education through a post-degree Gerontology Certificate Program, a Masters of Public Health – Gerontology track, and a Ph.D. program in Epidemiology. In addition to preparing professionals, the IOG offers free online training for anyone in a variety of topic areas, including basic gerontology, elder law, and housing issues. To accommodate the time commitments of learners across the state, the Institute offers online college credits and executive workshop training.

Georgia Regents University Alzheimer's Disease Research Center, Augusta: Georgia Regents University promotes interdisciplinary research, manages forums, provides education, maintains a study database, and performs other functions vital to Georgia's research community. The center is funded by the National Institutes of

Health, the VA Medical Center, the Alzheimer's Association, pharmaceutical companies, and the Georgia Research Alliance. The ARC was developed to support collaborative basic and clinical research in the area of Alzheimer's disease and related neurodegenerative disorders by (1) promoting interdisciplinary approaches to answering research questions; (2) providing a venue for regular meetings of its members for the purpose of sharing members' research findings, the latest published works in the field, and supporting visits to this campus by outside experts; (3) providing course materials and lectures related to Alzheimer's disease for undergraduate, graduate, and postgraduate student instruction, and (4) supporting tow core facilities, the Neurological Disorder Database Registry, and the Animal Behavior Center.

Emory University– Atlanta, Alzheimer's Disease Research Center: Emory University's federally-supported Alzheimer's Disease Research Center (ADRC), one of 27 such centers across the country, offers a number of educational programs for community members and professionals. In almost all of its educational offerings, the ADRC partners with the Atlanta Regional Geriatric Education Center (ARGEC), a federally-supported program at Emory that has a specific Alzheimer's disease portfolio) and with the Alzheimer's Association, Georgia Chapter (AAGC). The following are programs offered by this partnership:

- **Family Caregiver Education programs**: Four types of education programs are offered regularly to family caregivers and, in some cases, persons with early stage dementia. These programs are offered at the Wesley Woods geriatric campus at Emory University. The programs include:

    - Early Memory Loss Group: This program for persons diagnosed with Mild Cognitive Impairment or early stage Alzheimer's (or other dementia) and their family care partner provides information about disease progression, communication challenges, and strategies, and encourages families to plan for the future.
    - Dealing with the management problems of dementia: This program helps family caregivers to understand and deal with the issues and choices they face as they take on and continue in the caregiver role they have assumed for a person in the active stages of dementia who continues to live in the community. The program emphasizes methods of behavior guidance, care decision-making, the use of community resources, and self-care.
    - Decision making and coping, post-institutionalization: This program for family caregivers who are about to place – or have placed – their family member in a supportive institutional environment emphasizes the maintenance of the caregiving role, the importance of on-going care decisions, partnering with institutional staff, and anticipatory preparation for end-of-life care and grieving.

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- **Community education forums.** The partnership engages in a series of programming to a variety of community groups in an effort to provide information about dementia and dementia care but also to draw those communities into collaborations that will benefit their members through focused programming and education. These forums take a number of forms:

    - o Registry for Remembrance: The Registry is an effort aimed at partnering with institutions and organizations in the Atlanta-area African American community to provide dementia-specific education to their members, to empower these organizations to develop expertise and capacity in dementia and dementia care in ways that benefit their members, and to encourage participation in research by their members. Through the Registry for Remembrance, the ADRC, ARGEC, and AAGC have, for the past two years, offered community education forums at the Carter Center and community churches and centers on dementia and brain health for people of color.
    - o Research Updates: The ADRC regularly provides community programs on the status of Alzheimer's research. These updates are also available through the ADRC newsletter and website.
    - o Savvy Caregiver mini-seminars: The ADRC provides "short courses" in Savvy caregiving to organizations and community groups. These mini-programs are available to provider groups and also to employee assistance programs.

- **Memory screening events:** The ADRC regularly provides screening events. These are designed to examine the concerns of those who feel they may have memory problems. The results of the screening are not definitively diagnostic, but can identify the need for further testing and assessment. These screening events are held both at the Wesley Woods geriatric center at Emory and at collaborating community organizations.
- **Symposia for community health professionals:** Recognizing professionals' need for continuing education about dementia and new diagnostic, management, and treatment options, the ADRC-ARGEC-AAGC partnership is an available resource. The partnership offers scheduled seminars and workshops for professionals, but it also stands ready to collaborate with professional groups to design and deliver programs to their members.
- **Savvy Caregiver Train-the-Trainer programs:** In an effort to disseminate this evidence-based caregiver psychoeducation program, the ADRC is offering day-long workshops to organizations willing to offer the Savvy Caregiver to their constituents. This six-hour workshop provides continuing education credits to

participants who will learn how to conduct this program in their home organizations. Materials for the implementation of the program are provided.

- **Memory Clinics:** The Emory ADRC and associated Cognitive Neurology program offer specialty clinics to evaluate memory loss, mild cognitive impairment, Alzheimer's disease, and other forms of dementia. About 2500 patients receive comprehensive evaluations and/or longitudinal care annually. The clinics are located in the Emory Clinic at Wesley Woods and at Grady Memorial Hospital, and they are staffed by subspecialty trained neurologists, neuropsychologists, and advanced practice nurses. Emory ADRC clinicians work closely with the Fuqua Center for Late-Life Depression/ Emory Division of Geriatric Psychiatry clinicians in caring for persons with dementia with severe behavioral disturbances.
- **ADRC Newsletter:** Published 2-3 times a year, this newsletter, available via email, regularly provides updates on research advances in the field. It also provides opportunities to participate in research and articles focused on family caregiving and caregiver well-being.

Georgia Southwestern State University – Americus, Rosalyn Carter Institute for Caregiving (RCI), The Rosalynn Carter Institute for Caregiving establishes local, state, and national partnerships committed to building quality, long-term, home and community-based services. RCI focuses on providing caregivers with effective supports to promote caregiver health, skills and resilience. RCI focuses on helping caregivers coping with chronic illness and disability across the lifespan. RCI's overall goal is to support caregivers – both family and professional- through efforts of advocacy, education, research, and service.

- **Advocacy:** Reinforce the need for caregivers and the need to give support to those that give care at local, state, national, and international levels; Advocate for the use of evidence-based research to address the strain and burdens associated with family, volunteer and professional caregiving.
- **Education:** Develops caregiving curricula for multiple levels of educational need; Provides scholarship opportunities for both individuals in the caregiving field and family caregivers interested in obtaining skill knowledge for their caregiving situation; Provides training and certification in selected evidence-based caregiver programs
- **Research**: Provides technical assistance related to translational research targeting evidence-based caregiver programs; Contributes to the caregiving field through collaborative partnerships that invest in and support caregiving research
- **Service:** Provides caregiver support to individuals through education and advocacy through local, state, and national partnerships.

Georgia State University – Atlanta, Gerontology Institute: The Gerontology Institute is engaged in the study of aging and charged with the responsibility of developing and coordinating research, instruction, and service in gerontology throughout the university. Institute faculty and staff work cooperatively with many agencies and programs that serve older people in the Atlanta metropolitan area, providing consultation and sharing information and resources. Gerontology Institute faculty members conduct groundbreaking research designed to address the challenges of our aging society. Much of their work is focused on four inter-related areas: (1) Housing and Formal Long-term Care; (2) Social Relationships, Families, and Caregiving; (3) Diversity and Aging; and (4) Health and Aging.

Atlanta Regional Geriatric Education Center: The federally funded Atlanta Regional Geriatric Education Center (ARGEC) focuses principally on the education of health care providers in a variety of topics related to the care of older persons. The ARGEC has a special focus on enhancing providers' abilities to care for persons with dementing disorders, such as Alzheimer's disease. The ARGEC, by itself or in collaboration with the ADRC, can provide tailored training programs to groups of health care providers on a variety of dementia care topics.

As noted in the ARGEC's most recent report, special dementia-related training topics include: Recognizing the signs and symptoms of AD or other dementias/cognitive impairment; Non-Pharmacological Interventions for Patients with Dementia; Assessing, managing, and treating caregiver burden and depression; Long-term services and supports in the community; Referring patients and their families to appropriate support services in the community; Referring patients and their families to appropriate and cutting-edge research programs ranging from Healthy Brain and AD studies to research projects focusing on stress among caregivers of persons with dementia; Assisting AD patients and their families on accessing long-term services and support; Training on the unique needs of medically underserved and special populations, including racial and ethnic minorities and individuals with intellectual disabilities; and the impact of AD and cognitive impairment on mobility and driving to include dangers and public health information regarding older drivers, impact on individuals health, and effects of loss of executive function on driving among AD patients.

D. Advocacy Organizations and Services

The Alzheimer's Association, Georgia Chapter: The Alzheimer's Association, Georgia Chapter is a voluntary health organization which offers a wide range of services designed to meet the unique needs of families caring for people with Alzheimer's disease and related dementias. These include: helpline information and referral; care consultation; community support groups; Caring Connection, a telephone support group; Caregiver Time Out, a respite reimbursement program; family education; professional education; MedicAlert + Safe Return; resource library and information about clinical trials. The goals of the Georgia Chapter remain consistent with those of the national office: advancing research, enhancing care and support, raising public awareness and building capacity (http://www.alz.org/georgia/index.asp) .

- **24/7 Helpline:** The Alzheimer’s Association provides free reliable information, referrals, and support in multiple languages for caregivers and persons with Alzheimer’s disease. In addition, the standard packet provided to callers includes a 24/7 Helpline Card, a Georgia Chapter brochure, and fact sheets on Alzheimer's and other dementias, stages of Alzheimer's disease, Medic Alert + Safe Return, and the Alzheimer’s Association. The Association includes additional printed information based upon needs and requests, as well as referrals to resources such as in home care, nursing homes, assisted living facilities, grief counseling, homemaker assistance services, and more. Specialists respond to the caller’s need with a minimum of three referrals to each community resource requested. Other information is tailored to the individual caller's needs. ASK Kits are also offered to those calling the Helpline who may need more information. A basic ASK Kit includes fact sheets on: adult day centers, bathing, brain health, dressing, driving, eating, feelings, grief, mourning, and guilt, hallucinations, holidays, hospitalization, incontinence, taking medication safely, safety, sexuality, telling others about an Alzheimer's diagnosis, vacationing, and visiting. (1-800-272-3900)
- **Care Consultation:** The Alzheimer’s Association provides telephone or in-person care consultation for those individuals needing more than information and referral. Care consultants are masters-level social workers or masters-level counselors.
- **Early Stage Programs:** The Association provides early stage support groups for both the care partner and the individual with dementia, social activities, Arts for Alzheimer’s, and opportunities to volunteer in the Chapter office, in the Chapter’s advocacy program and Walks.
- **Message Board:** The Alzheimer’s Association offers message boards that connect people from all across the country who share their experiences and find support and friendship with others living with Alzheimer’s disease.
- **MedicAlert + Alzheimer’s Association Safe Return:** This is a 24-hour nationwide emergency response service for individuals with Alzheimer’s disease or related dementias who wander or who have a medical emergency. To receive these services, a one-time enrollment fee of $55 is required plus a $7 shipping and handling fee. The annual renewal fee for these services is $35. The program also includes training for police-fire/EMS/911 operators on how to recognize and assist individuals with dementia who may wander, and how to initiate a Mattie’s Call (a community-wide alert used when a person with dementia is missing).
- **Alzheimer’s Association CareSource:** This is an online suite of resources that will help caregivers coordinate assistance from family and friends, locate senior housing, review customized care recommendations, and enhance caregiving skills.

- **A Time to Talk:** The Alzheimer's Association, Georgia Chapter, provides A Time to Talk, a statewide program that provides telephone calls to participants who can benefit from receiving emotional support, coping strategies, or just a listening ear.
- **Advocacy Training:** The Alzheimer's Association provides free advocacy training to individuals living with dementia, as well as to their family caregivers, friends, and any Georgia citizen who wants to help change public policy regarding services for individuals with dementia. The Alzheimer's Association operates year-round advocacy programs that address needs at the city, county, state, and federal agency level and on the international level.
- **HealthCare Interactive:** The Alzheimer's Association and HealthCare Interactive provide online Alzheimer's training for family members; staff at nursing homes, assisted living facilities, hospice, home organizations, adult day programs, governmental and social service agencies; and police, fire, and other first responders.
- **Caregiver Time Out Program:** The Alzheimer's Association, Georgia Chapter, manages a caregiver time-out program that is also available to families of individuals with Parkinson's Disease and dementia

American Parkinson Disease Association, Georgia Chapter: The Georgia Chapter works in close cooperation with the Information & Referral Center to provide educational programs featuring topics that relate to Parkinson's disease and to the caregivers. The organization's target audience is people diagnosed with Parkinson's disease and their caregivers, and its goal is also to serve the medical community and the community at large by raising awareness of the disease and the treatments and support available. The Georgia Chapter works in close cooperation with the Information & Referral Center to provide educational programs featuring topics that relate to Parkinson's disease and to the caregivers. The Georgia Chapter initiates, funds and implements other outreach programs as requested by members and the target audience (http://www.apdageorgia.org/).The primary purposes of the Georgia Chapter are:

- To raise awareness about Parkinson's disease
- To raise funds for Parkinson's disease research
- To plan and execute educational programs with the local Information and Referral Center
- To plan and execute Chapter outreach programs for the Parkinson's community

Second Wind Dreams: Second Wind Dreams, a Georgia-based nonprofit, offers a virtual dementia tour to increase awareness of dementia's effects on individuals. The mission of Second Wind Dreams® (SWD) is to change the perception of aging through the fulfillment of dreams and the offering of innovative educational opportunities to caregivers and communities. The Virtual Dementia Tour is a scientifically proven method designed to increase sensitivity toward those with dementia. The Second Wind

Dreams® program is delivered **primarily** through volunteer efforts. It is available to individuals and communities. (http://www.secondwind.org)

Fuqua Center for Late-Life Depression / Emory University: The Fuqua Center for Late-Life Depression, an initiative of the Division of Geriatric Psychiatry at Emory University, is committed to improving the community's understanding and recognition of mental illnesses in older adults and improving access to geriatric psychiatric service including care for persons with co-occurring psychiatric and dementing illnesses and persons with behavioral disturbances related to dementia. The Fuqua Center provides community education programs, professional training and clinical services in Atlanta, throughout the state of Georgia and nationally.

See appendix XV for a listing of national Dementia Specific Organizations

E. Dementia Specific Training Requirements for Long-Term Care Staff

Assisted living guidelines indicate that training must be provided that meets the medical and social needs and characteristics of the resident population, including special needs of residents with dementia. Also, training must be provided that is specific to assigned job duties such as responding appropriately to dementia-related behaviors (Rules of Department of Community Health Rules for Assisted Living Communities Interpretive Guidelines, see Appendix III). Staff providing hands-on personal services in the memory care unit, must be trained specifically to care for residents with dementia (Rules of Department of Community Health Rules and Regulations for Assisted Living Communities, see Appendix VI).

Personal care homes in Georgia are licensed by the Department of Community Health (DCH) Healthcare Facility Regulation Division (HFRD). Within the first 60 days of employment, personal care homes are required to train staff in specialized memory care units or homes on various aspects of dementia including:

- The nature of Alzheimer's disease and other dementias
- Common behavior problems and appropriate behavior management techniques
- Communication skills that facilitate better resident-staff relations
- Positive therapeutic interventions and activities
- The role of family in caregiving for residents with dementia
- The support needed for family members of residents with Alzheimer's or other forms of dementia
- Environmental modifications that can be implemented to avoid problematic behaviors and create a more therapeutic environment
- The development of comprehensive and individual service plans
- How to update or provide relevant information for implementing those service plans consistently across all shifts
- New developments in diagnosis and therapy

- Recognizing physical or cognitive changes in residents, and
- Maintaining the safety of residents with Alzheimer's or other forms of dementia.

Staff training also includes guidance on how to manage residents who may elope from the home, including what actions are to be taken if a resident wanders away (elopes). (Rules of the Department of Community Health Rules and Regulations for Personal Care Homes, see Appendix V).

Staff of nursing facilities are required to receive in-service training toward understanding emotional problems and social needs of residents (Rules of the Department of Community Health Nursing Homes, see Appendix VI). Additionally, Certified Nurse Assistants (CNAs) are required by statute in the Code of Federal regulations to receive training for supporting residents with Alzheimer's or other dementia conditions.

The Code of Federal Regulations for nursing aide training (42CFR483.152) mandates these requirements for caring for cognitively impaired residents:

Care of cognitively impaired residents:

(i) Techniques for addressing the unique needs and behaviors of individual with dementia (Alzheimer's and others);

(ii) Communicating with cognitively impaired residents;

(iii) Understanding the behavior of cognitively impaired residents;

(iv) Appropriate responses to the behavior of cognitively impaired residents; and

(v) Methods of reducing the effects of cognitive impairments.

See Appendix VII for the complete Code of Federal Regulations 42CFR483.152 for nursing aides.

The Alzheimer's Association, in collaboration with HealthCare Research Inc., provides Alzheimer's training for family members, as well as staff at nursing homes, assisted living facilities, hospice, home organizations, adult day programs, governmental and social service agencies, and police, fire, and other first responders (http://www.hcinteractive.com/CARES; http://www.ghca.info/index.php?option=com_eventbooking&task=view_event&event_id=109).

F. Quality Care Measures for Long Term Care Facilities

Alliant/GMCF – QIO: Alliant GMCF, the Medicare Quality Improvement Organization for Georgia, convenes providers, practitioners and patients to build and share knowledge, spread best practices and achieve rapid, wide-scale improvements in

patient care, increases in population health, and decreases in healthcare costs for all Americans.

Nursing Homes: The Centers for Medicare and Medicaid Services (CMS) identifies the quality measures required for nursing homes. They include the following:

Short-Stay Quality Measures

- Percent of Residents who Self-Report Moderate to Severe Pain (Short Stay)
- Percent of Residents with Pressure Ulcers that are New or Worsened (Short Stay)
- Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay)
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Short Stay)
- Percent of Short-Stay Residents Who Newly Received an Antipsychotic Medication

Long-Stay Quality Measures

- Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
- Percent of Residents who Self-Report Moderate to Severe Pain (Long Stay)
- Percent of High-Risk Residents with Pressure Ulcers (Long Stay)
- Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long Stay)
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long Stay)
- Percent of Residents with a Urinary Tract Infection (Long Stay)
- Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder (Long Stay)
- Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay)
- Percent of Residents Who Were Physically Restrained (Long Stay)
- Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)
- Percent of Residents Who Lose Too Much Weight (Long Stay)
- Percent of Residents Who Have Depressive Symptoms (Long Stay)
- Percent of Long-Stay Residents Who Received An Antipsychotic Medication

These quality measures can also be found, using the following link:http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html.

Although none of these quality-care measures are specifically targeted at persons with Alzheimer's disease, according to the Alzheimer's Association, Georgia Chapter, some of these measures indirectly relate to persons with Alzheimer's disease. Some Alzheimer's patients eventually lose the ability to swallow. This can result in the patient losing weight and even becoming bedbound. This causes a heightened risk of excessive weight loss and pressure ulcers. Because of the behavioral expressions associated with Alzheimer's disease, if a person with Alzheimer's disease becomes agitated, this has potential to cause them to be restrained, fall, or be prescribed antipsychotic medication.

National Partnership to Improve Dementia Care in Nursing Homes: Georgia participates in this federal initiative, developed by the Centers for Medicare & Medicaid Services (CMS), to reduce unnecessary antipsychotic drug use in nursing homes. The Partnership's goal is "to optimize the quality of life and function of residents in America's nursing homes by improving approaches to meeting the health, psychosocial and behavioral health needs of all residents, especially those with dementia." (CMS, S&C Memo: 13-35-NH). (See Appendix 12.)

CMS Quality Indicator Survey (QIS) Stage 1 Interview Tools: Georgia uses interview tools developed by CMS to review the care of and services provided to nursing home residents with dementia. (See Appendix 12.)

Assisted Living Facilities & Personal Care Homes: Assisted living facilities and personal care home have specific requirements for memory care services and/or specialized memory care units or homes (see Appendix III & VI). The requirements include criteria that enhance the quality and safety of the home for persons with Alzheimer's disease and other dementias.

G. Capacity of Public Safety & Law Enforcement to Respond to People with Dementia

In 2011, the Forensic Special Investigations Unit (FSIU), located within the DHS Division of Aging Services and composed of individuals with backgrounds in Medicare fraud, criminal justice, and law enforcement, developed a course curriculum in collaboration with other state agencies representing the criminal justice system. The course is entitled At-Risk Adult Crime Tactics (ACT) Specialist Certification Course. ACT is co-sponsored by the Prosecuting Attorneys' Council of Georgia (PACGA) and is approved by Georgia Peace Officer Standards and Training Council (P.O.S.T.). The focus of ACT was, and remains, to equip primary and secondary responders with knowledge and skills to address the needs of at-risk adult crime victims in Georgia as part of a multi-disciplinary team, thus advancing public safety. Frequently, victims of these crimes have Alzheimer's or another dementia; therefore a basic understanding of Alzheimer's is part of the curriculum. At-risk adults include adults age 65 and older and adults age 18 and older with a disability.

FSIU offers ACT classes to primary and secondary responders including law enforcement, prosecutors, judges, social, protective and regulatory professionals,

financial institutions, fire, medical examiners, coroners, healthcare, EMS, victim advocates and other professionals working with at-risk adults. The training currently provides two-days/16 hours of curriculum. Providing multi-disciplinary training should increase collaboration among various agencies with diverse legal authority and priorities in order to address crimes against at-risk adults.

ACT covers at-risk adult abuse, neglect, and exploitation as it relates to Georgia law, describes the types of abuse (physical, sexual, emotional, neglect, and exploitation), explains the role of Georgia social service agencies (Adult Protective Services, Healthcare Facility Regulation, Long-term Care Ombudsman Program, and Department of Behavioral Health and Developmental Disability), explains Alzheimer's and the basics of investigating, e.g. evidence, red flags, and tips for interviewing at-risk adults.

To date, FSIU has conducted 32 ACT classes in all 12 DHS service regions in 24 counties. Currently, over 1100 professionals across the state have been certified as ACT Specialists. Of the 1100 certified ACT Specialists, 488 (48%) are law enforcement. Although classes have been held in only 24 counties, at least one local law enforcement officer has been trained in each of 76 counties and 40 GBI agents have been trained.

In addition to ACT, FSIU has also developed two P.O.S.T. certified courses specific to law enforcement and 9-1-1 personnel. The courses, Abuse, Neglect, and Exploitation of At-Risk Adults and At-Risk Adult Crime for 9-1-1 Personnel, are designed to give law enforcement officers and public safety communication center call-takers and dispatchers the basic skills needed when responding to crimes involving at-risk adults.

- **Forensic Special Investigations Unit:** This unit identifies and addresses system gaps and develops process improvements to protect Georgia's at-risk adults from abuse, neglect and exploitation. It provides training, outreach technical assistance, and case consultation to agencies, including, but not limited to, law enforcement, fire departments, emergency response, medical examiners, judges, adult protective services.

- **Adult Protective Services (APS):**The Georgia Department of Human Services (DHS), Division of Aging Services, Adult Protective Services (APS) investigates all reports of abuse, neglect, and/or exploitation of older persons (65+) or adults (18+) with a disability who do not reside in long-term care facilities pursuant to the Disabled Adults and Elder Persons Protection Act, O.C.G.A. §§ 30-5-1, et seq. For persons living in the community, Georgia law requires mandatory reporting of suspected abuse, neglect or exploitation by certain professionals who are mandated reporters. Failure for a mandated reporter to report abuse, neglect and/or exploitation of a disabled adult or elder person is punishable by a criminal misdemeanor. This statewide team investigates reports of abuse, neglect, and exploitation. They also work to prevent recurrence through the provision of protective services intervention.

The Alzheimer's Association, Georgia Chapter also provides training to law enforcement officers through the Georgia Peace Officer Standards and Training Council. The curriculum helps officers enhance their ability to identify and assist persons with Alzheimer's disease. Topics offered to law enforcement and emergency services agencies include MedicAlert& Safe Return training, how to activate Mattie's Call, and resources the Association has available to assist them in safely returning the person home. The Association also partners with public safety agencies to provide training for families to help ensure that elopement does not occur.

H. Inventory of Long-Term Care Units

Enhanced Services Program (ESP) is Georgia's most comprehensive database of long-term support services for aging and disability populations. Over 25,000 resources are in ESP, and DAS standards require that each of the 12 ADRCs have a full-time equivalent staff person to serve as the Resource Specialist so that new resources are continuously identified and added to the database and other records are kept current. All Gateway Counselors use ESP in providing information and assistance.

Nursing Home Information from the ESP Database

- Total number of nursing homes in ESP: 363
- Number of nursing homes listed on DCH website: 372
- Nursing home providers who have self-reported they can serve persons with dementia: 355*

Dementia Care:	Number:
Case by Case	217
All Stages	175
Early Stage	80
Early to Moderate	76
Moderate to Later	67
Later Stage	68
Separate Unit	38
Secured Unit	60
Separate/Secured Unit	56

*Information is self-reported by providers who may select multiple service options.

See Appendix VIII for additional information regarding this subject.

I. Community Residential Options for Persons with Dementia

Assisted living communities (ALC) exist as a subset of personal care homes. The following information, obtained from the ESP database, will relate to personal care homes in general, not specifically ALCs.

Personal Care Home Information from the ESP Database

Total number of Personal Care Homes in ESP: 1,104
Number of Personal Care Homes listed on DCH website: 1817
Personal Care Home providers who have self-reported they can serve persons with dementia*

Personal Care Homes Reporting Dementia Care (Total Resident Capacity of 6 or More)

Dementia Care Available	Number of Facilities (from total of 549)
Case by Case	413
Early Stage	211
Moderate Stage	116
Later Stage	38

Personal Care Homes Reporting Dementia Care (Total Resident Capacity of 7-11)

Dementia Care Available	Number of Facilities (from total of 60)
Case by Case	48
Early Stage	39
Moderate Stage	20
Later Stage	9

Personal Care Homes Reporting Dementia Care (Total Resident Capacity of 12-24)

Dementia Care Available	Number of Facilities (from total of 235)
Case by Case	190
Early Stage	124
Moderate Stage	59
Later Stage	27

Personal Care Homes Reporting Dementia Care (Total Resident Capacity of 25+)

Dementia Care Available	Number of Facilities (from total of 237)
Case by Case	151
Early Stage	166
Moderate Stage	129
Later Stage	96

* Numbers may be duplicated by providers if they have indicated they serve persons at all levels of dementia. Other information on dementia care may be clarified in the comments section of individual records.
** Capacity may not be listed in all records

J. ADRD Research through Georgia Universities and Other Resources

National Institute on Aging (NIA): The NIA funds the Emory Alzheimer's Disease Research Center (ADRC) at Emory University in Atlanta, GA. The goal of this AD center is to improve diagnosis, care, and prevention of Alzheimer's disease.

National Institute of Health (NIH)/VA Medical Center/Alzheimer's Association/Georgia Research Alliance/Several pharmaceutical companies: The listed organizations are responsible for the funding provided to the Alzheimer's Research Center (ARC) at Georgia Regents University in Augusta. The ARC was developed to support collaborative basic and clinical research in the area of Alzheimer's disease and related neurodegenerative disorders by (1) promoting interdisciplinary approaches to answering research questions; (2) providing a venue for regular meetings of its members for the purpose of sharing members' research findings, the latest published works in the field, and supporting visits to this campus by outside experts; (3) providing course materials and lectures related to Alzheimer's disease for undergraduate, graduate, and postgraduate student instruction, and (4) supporting tow core facilities, the Neurological Disorder Database Registry, and the Animal Behavior Center.

Georgia REACH Project: The Rosalynn Carter Institute (RCI) selected 11 rural counties in Georgia to implement a caregiver intervention program which is designed to reduce negative outcomes associated with caregiving for a family member with Alzheimer's disease. A pre- and post-assessment of the intervention is given to evaluate the effectiveness of the program in reducing negative outcomes related to caregiving of a family member with Alzheimer's disease. Results indicated statistically significant decreases in caregiver depression and burden, as well as improved caregiver health. Caregivers report that working one-on-one with the interventionist led to a better understanding of the disease and consequently reduced their frustrations with the care recipient (Easom, Alston, & Coleman, 2013). The cost of the Georgia REACH Project is $7/day over the six-month implementation period. Because this was conducted in a rural **area**, travel costs for interventionists were high; in an urban area, the cost may be less.

Georgia REACH-Coastal Project: RCI selected the Coastal Georgia Area Agency on Aging (AAA) to replicate this evidence-based caregiver intervention program (Georgia REACH) which is designed to reduce negative outcomes associated with caregiving for a family member with Alzheimer's disease -- outcomes such as depression and poor health. Preliminary data analysis reveals large effects in the reduction of caregiver stress and caregiver depression, even with a relatively small sample size. The program has been successfully embedded within the agency and has proven to be an effective addition to the menu of services offered to their constituents.

Georgia Care Consultation Project: RCI collaborated with three Georgia AAAs to replicate an evidence-based telephone care consultation intervention program for Alzheimer's disease and related disorders (ADRD) patients and caregivers. Over a 12-month time period, participants converse with a Care Consultant. Information

regarding health problems, support services, and other available resources are provided through the Care Consultation project. Preliminary data analysis reveals a decrease in unmet needs, improved self-rated health, and a decrease in reported hospital and emergency room visits. Results from the use of this intervention in prior studies indicate improved care, reduced hospital admissions, delayed nursing home placement, fewer emergency department visits, decreased symptoms of caregiver depression, reduced caregiver stress and burnout, reduced relationship strain, decreased embarrassment and isolation, and improved access to information. Due to the success of the implementation in their central office, the Atlanta Regional Commission AAA has expanded the program into two additional offices within their region. The Rosalynn Carter Institute for Caregiving and the Atlanta Regional Commission will examine this expansion to develop a model for further dissemination through other AAAs. (See Appendix IX). The cost of the Care Consultation is $1.03/day over the 12 month period.

ROAD Program (Reaching Out to Assess Dementia): RCI uses the Rowland Universal Dementia Assessment Scale (RUDAS) as a tool to screen for memory loss. This tool was developed and validated in the southwest of Sydney by a team at the Liverpool Hospital. Memory screening is conducted in the home, and if the test indicates a potential memory issue, clients receive a confidential copy of their questionnaire to take with them to their doctor. For additional information on RUDAS, see Appendix X.

Emory Alzheimer's Disease Research Center (ADRC): This center at Emory University, funded by the National Institute on Aging, operates to improve the diagnosis, care, and prevention of Alzheimer's disease.

K. Inventory of Federal Agencies that Provide Services or Resources for People with ADRD

Administration for Community Living (ACL): DAS and the Rosalynn Carter Institute for Caregiving (RCI) have received multiple demonstration grants from the ACL to develop new protocols and interventions to better serve persons with Alzheimer's disease (AD) and their caregivers. These grants include the following:

- Caregiver Assessment: From 2007-2010, ACL funded the Tailored Caregiver Assessment and Referral® (TCARE®) protocol in three Georgia AAAs. TCARE® protocol is an evidence-based program designed to enable care managers to more effectively support family caregivers by efficiently targeting services to their needs and strengths (Montgomery, Kwak, Kosloski, & Valuch, 2011). TCARE® guides care managers through an assessment and care planning process that helps them examine the care context and identify the sources and types of stress that a caregiver is experiencing. Research studies on TCARE from four states including Georgia indicate a statistically significant reduction in caregiver burden and intention to place in a nursing home. For more information on TCARE®, see Appendix XI.

- Early Stage Alzheimer's Disease**:** DAS, in collaboration with the Alzheimer's Association and participating AAAs, designed new protocols and interventions for persons with early stage Alzheimer's disease. Innovations included driving assessments, tools to determine financial capacity, and a clinical counseling protocol. (*See Alzheimer's Disease and Support Services, Georgia Division of Aging Services Final Report for additional information)*.

- The Eldercare Locator helps find help on a variety of subjects and can be filtered by topic area or geographic location. http://www.eldercare.gov

The U.S. Department of Veterans Affairs can help caregivers of veterans find nearby assistance via their zip code locator or their Caregiver Support Line http://www.caregiver.va.gov/help_landing.asp

NIH's Alzheimer's Disease Education and Referral Center can be contacted five days a week via phone at 1-800-438-4380 or via email at adear@nia.nih.gov.http://www.nia.nih.gov/alzheimers

National Institute on Aging (NIA): The NIA funds the Emory Alzheimer's Disease Research Center (ADRC) at Emory University in Atlanta, GA. The goal of this AD center is to improve diagnosis, care, and prevention of Alzheimer's disease.

III. ◆ Recommendations ◆

The recommendations are a result of collaboration, research and deliberation by the Georgia Alzheimer's and Related Dementias State Plan Task Force. The Task Force consisted of Senator Renee Unterman --Chair of the Senate Health and Human Services Committee, Representative Tommy Benton,-- Chair of the House Human Services and Aging Committee, Representative Sharon Cooper — Chair of the House Health and Human Services Committee, Clyde Reese — Commissioner of the Department of Community Health, Dr. Brenda Fitzgerald — Commissioner of the Department of Public Health, and Dr. James Bulot — Director of the Department of Human Services Division of Aging Services who also served as Chair of the Task Force. The Task Force was assisted by an Advisory Council provided for in Senate Bill 14, and convened by the Chair to help with the task of doing the work of the Task Force.

The Advisory Council was composed of persons living with Alzheimer's and a related dementia, caregivers, representatives of the nursing facility industry, representatives from adult day programs, representatives from home health industry, representatives of the personal care home industry, physicians, a consultant pharmacist, Alzheimer's researchers, law enforcement personnel, and other stakeholders from the public, private, and non-profit sectors, voluntary health organizations and the faith-based community.

The work of the Task Force reflects the concerns and priorities conveyed to the Task Force through seven Task Force meetings, one listening session conducted by the Task Force, numerous listening sessions by the Alzheimer's Association, Georgia Chapter

conducted both prior to the passage of Senate Bill 14, and during the tenure of the Task Force. Public input through a survey was conducted by the Division of Aging Services through its website and through the Alzheimer's Association, Georgia Chapter's classes, speaking engagements, Town Halls, and its website.

Sections:

- Healthcare, Research, and Data Collection
- Workforce Development
- Service Delivery
- Public Safety
- Outreach and Partnerships
- Resources

A. Healthcare, Research and Data Collection

GOAL: Ensure the early and accurate diagnosis of dementia. Early diagnosis improves accuracy and treatment effectiveness while also enabling individuals to plan for care needs and financial considerations in advance.

STRATEGIES TO ACHIEVE THIS GOAL:

- De-stigmatize dementia and encourage individuals to explore concerns about memory problems with their physicians.
- Identify and promote culturally appropriate strategies designed to increase public awareness about dementia.
- Educate physicians and other healthcare providers about the importance of early, accurate diagnosis and provide appropriate tools and training.
- Recognize cognition as a "vital sign" and assess all Medicare patients during the Annual Wellness Visit under Medicare.
- Promote the NIA-designated Emory University Alzheimer's Disease Research Centers as the key referral source for community physicians to support diagnosis and management of complex cases.

GOAL: Use surveillance data to enhance awareness and action in public health programming and state planning. Surveillance is the ongoing analysis and interpretation of health data. Incorporating cognitive impairment and caregiver surveillance data into all State agency work, particularly state planning for public health, aging services and community health, will aid in the development of research, policy, and regional service plans for individuals with ADRD.

STRATEGIES TO ACHIEVE THIS GOAL:

- Develop a plan to have the diagnosis of dementia routinely recorded in medical records.
- Develop a plan for high-risk populations such as persons with mental illness and developmental disabilities to be screened for dementia and, when diagnosed, to have the diagnosis is routinely recorded in medical records.
- Implement a State Alzheimer's Disease and Related Disorders Registry to be housed in the Department of Public health.
- In alternating years, utilize the Behavioral Risk Factor Surveillance System's (BRFSS) Cognitive Impairment and Caregiver Modules
- Link BRFSS data with health related outcome and/or quality measures.
- Provide surveillance data to state agencies, regional commissions and other planning agencies to encourage communities and agencies to adequately plan on ADRD growth.
- Add comorbidities to the death certificate to better enable tracking of dementia incidence.

GOAL: Recognize Alzheimer's as a chronic disease, and develop a public awareness and education campaign that will promote a healthy lifestyle which may reduce the risk of Alzheimer's and related dementias as well as promote early, accurate diagnosis.

STRATEGIES TO ACHIEVE THIS GOAL:

- Provide public health awareness, education and resource information through the Georgia Department of Public Health and other agencies, with website information and media releases.
- Pursue public, private, corporate and philanthropic funding for broad-based statewide educational campaigns.
- Promote positive images of people living with dementia and their caregivers to combat stigma
- Partner with secondary and post-secondary educational institutions to infuse ADRD throughout health-related curricula.
- Identify and promote strategies designed to increase awareness about dementia, reduce conflicting messages, decrease stigma, and promote early diagnosis.
- Coordinate efforts to disseminate evidenced-based messages about risk reduction for preserving cognitive health.
- Ensure that local Aging and Disability Resource Centers as well as Area Agencies on Aging are aware of and promote existing training and informational materials available to family caregivers, especially those located in rural areas.

- Integrate Alzheimer's and related dementias awareness training into existing heart, stroke, and diabetes education programs as the risk factors are interconnected – via managing the numbers (blood pressure, pulse, cholesterol, and blood sugar) Integrate into the training that what is good for the heart is good for the brain.
- Adopt the 16 action items from *The Healthy Brain Initiative Road Map* that are relevant to immediate implementation to assist states in becoming dementia-capable.

GOAL: Improve the care and health outcomes of people with Alzheimer's disease and related dementia and their families. Families currently provide the majority of care for people with dementia. Ensuring that both the person with dementia and the caregiver are adequately supported is essential to ensure adequate resources are in place statewide to meet the growing needs.

STRATEGIES TO ACHIEVE THIS GOAL:

- Develop protocols and a corresponding training module to help ensure professionals recognize the role of care partners in the care coordination of persons with dementia.
- Increase awareness among healthcare professionals about care partner health and its importance in maintaining the health and safety of the person with dementia.
- Develop and implement quality standards for dementia care in state-funded services such as Medicaid State Plan services, HCBS waivers, personal care, and nursing homes.
- Require that all State contracts providing services to older adults, including those with developmental disabilities and/or mental illness and comorbid dementia, include quality measures specific to dementia-capable care.
- Review HCBS Waivers and modify as necessary to provide person-centered care to people with dementia as well as to expand caregiver support services to family members providing care to people with dementia.
- Evaluate the cost and feasibility of developing state and/or federally funded caregiver support programs for caregivers who do not currently qualify for Medicaid services.
- Provide care coordination to people with dementia and their caregivers upon diagnosis to improve access to information on options and resources
- Establish Quality Care measures with system benchmarks for facility- and community-based care for persons with Alzheimer's disease and other dementias.
- Identify and promote wide use of evidence-based practices through the development of an Evidence-Based Practice Guide specific to Alzheimer's care.

B. Workforce Development

GOAL: Determine the size, competency, and capacity of the existing workforce. The Georgia Alzheimer's and Related Dementias Advisory Council shall request and analyze workforce data to make recommendations to the Office of Workforce Development, the Departments of Public Health and Community Health, the Department of Behavioral Health and Developmental Disabilities, the Division of Aging Services, and the legislature regarding workforce policies to attract and train qualified individuals.

STRATEGIES TO ACHIEVE THIS GOAL:

- The Chair of the GARD Advisory Council shall convene a Healthcare Workforce Work group which shall:
  - Survey professionals, utilizing information on licensed professionals from the Secretary of State's office, the Georgia Board for Physician Workforce, and other entities as necessary.
  - Coordinate with the Georgia Alliance of Direct Support Professionals (or another direct-care worker association) to assist in assessing the size of the direct-care workforce.
  - Collaborate with professional associations related to the non-licensed professional workforce to determine the prevalence of this workforce in Georgia (i.e. the American Geriatric Society).
  - Explore and initiate recruitment plans for the direct-care and healthcare provider workforce focused on geriatric care.
- Determine the geographic distribution of the workforce, focusing on rural and urban and other aspects of distribution.
- Determine the demographics of this workforce, looking at age, sex, national origin/ethnicity, languages spoken, and other relevant demographics.
- Project the future supply of the workforce and estimate future shortages or surpluses.

GOAL: Develop a dementia-capable, culturally competent workforce. In becoming a dementia capable state, the existing and future long-term services and supports workforce, as well as individuals across the health care continuum, would benefit from education and training in Alzheimer's disease and related disorders. As Georgia continues to develop a no-wrong-door entry into long-term supports and services, agencies must ensure that the staff are competent in dementia-care skills and knowledgeable about the resources and services necessary to help support people with Alzheimer's disease and related disorders.

STRATEGIES TO ACHIEVE THIS GOAL:

- Encourage state agencies to develop hiring strategies to ensure they have the appropriate expertise in cognitive health and impairment related to research and best practices.
- Develop and implement an evidence-based training curriculum and implementation strategies for targeted audiences (e.g., Department of Behavioral Health and Developmental Disabilities, Office of the State Inspector General, Georgia Bureau of Investigation)
- Require training for all state staff associated with any of the Medicaid and Non-Medicaid home and community based waivers, as well as training for primary and secondary contract staff who have a primary role of interacting with older adults, their family or caregivers.
- Support voluntary certification, licensure, and degree programs that encourage working with older adults and persons with Alzheimer's disease and related dementias.
- Infuse a basic level of information on older adults, aging and dementia in all health-related fields that require licensing and certification.
- Partner with licensing boards to cultivate continuing education on aging and chronic disease topics including Alzheimer's disease and related dementias for health and allied healthcare providers.
- In partnership with the State Plan Task Force member agencies and academic institutions, create an open-source web-based basic training curriculum for entities and individuals desiring to provide dementia-capable services (skilled nursing, adult day health, home care, hospital, personal care home). Create electronic system of verifying and tracking basic certification.
- Create and/or support continuing education efforts that improve healthcare providers' ability to recognize early signs of dementia.
- Dementia care management competencies must be developed and taught in medical schools, academic health centers and allied health professional education and also extended to the full range of helping professions, include those working in the aging services network.

GOAL: Develop a direct-care workforce education and training curriculum. Develop and implement a career and training model for Georgia's direct-care workforce. Use the input of a broad-based partner team which should include representatives from, but not be limited to: aging and adult services; healthcare facility regulation; community/technical colleges; career, technical and agricultural education in high schools; disability advocates; consumer direction groups; aging advocates; provider associations (e.g., home and hospice care, assisted living, affordable and public housing, healthcare facilities); Department of Labor; universities, the Alzheimer's Association, faith-based groups, and consumers.

STRATEGIES TO ACHIEVE THIS GOAL:

- Develop 30-60 hour competency-based, dementia-specific core training or standardized training across the direct-care workforce, regardless of setting
- Provide an introduction to direct-care work and "on-ramping" for new entrants, unemployed workers and individuals receiving unemployment or other state assistance. The use of resources embedded into community colleges can leverage State or Workforce Investment Act funds or unemployment-related dollars. Provide tuition waivers for low-income new entrants.
- Develop sustainable delivery systems, including community/technical colleges and high school allied health career/technical programs.
- Collaborate with the Office of Workforce Development to identify resources potentially available to provide support for vulnerable workers through the provision of services such as case management, career counseling and/or educational planning services, and partnerships with Head Start or other support services for transportation and childcare.
- Recognize agencies and/or organizations which work toward enhancing the wages of the direct-care work force, the professionalization of direct-care workers; effective coaching; the promotion of direct-care workers' vital role in interdisciplinary teams; and the effective engagement of direct-care workers in care transitions and health IT.
- Develop residencies or fellowships for the training of geriatric psychiatrists, geriatricians, and other geriatric specialists.
- Develop a specific track on dementia and dementia-related diseases for medical students and residents.
- Evaluate the feasibility of a "Bucks for Brains" program to recruit and train geriatric psychiatrists, geriatricians, and other geriatric specialists.
- Universities and colleges throughout Georgia, including public entities governed by the Board of Regents and the Technical College System of Georgia, should evaluate existing social, health and allied health curriculums to ensure adequate basic information is provided on an aging population and Alzheimer's disease and related dementias.

GOAL: Encourage dementia-specific training for ER, first responders, and Protective Services. Encourage dementia-specific training as part of yearly in-service training for emergency personnel (e.g., firefighters, emergency medical technicians, behavioral health crisis and access telephone line and mobile assessment personnel, and police officers) as well as support personnel, including Public Guardianship and Adult Protective Services.

STRATEGIES TO ACHIEVE THIS GOAL:

- Work with affiliated statewide associations on the development of dementia-specific training for emergency room staff, including nurses, physicians and related professionals such as radiologists.
- Increase training for state Adult Protective Services workers on Alzheimer's disease and related dementias.
- Partner with the Georgia Hospital Association and the Medical Association of Georgia to develop protocols for emergency care of persons with dementia.
- Develop emergency-room specific protocols on appropriate treatment of those with dementia – including behavior management strategies.
- Ensure that these emergency providers understand the role and partnership of the care partner in the emergency care of the person with dementia.

GOAL: Develop a workforce retention group. In collaboration with the Office of Workforce Development, convene a Geriatric Workforce Retention Group to explore and initiate retention plans for the direct-care and healthcare provider workforce focused on geriatric care.

STRATEGIES TO ACHIEVE THIS GOAL:

- Potential members for the primary group and sub-groups include:
  - Care Facilities: representatives of nursing homes and assisted living facilities
  - Direct Care Workers: representatives of nurses, certified nursing assistants, and home care organization staff members
  - Medical Professions: physicians, medical assistants, allied health providers
  - Government: the Department of Labor, the Governor's Office of Workforce Development, the DHS Division of Aging Services, Area Agencies on Aging, Centers for Medicare and Medicaid Services, etc.
  - Patients and Caregivers: patient advocates, family caregivers, and community-based or faith-based organizations
  - Recruiters: Staffing agencies and others that recruit workers.
- Evaluate opportunities for advanced training in geriatrics, dementia, behavioral health, and related topics.
- Evaluate the feasibility of private/public payers' provision of enhanced reimbursement for practitioners (direct and professional) who have advanced training in relevant subject matter.
- Examine the current work environment (respect of other employees and supervisors, hours, patient load, pay, benefits, and safety measures).

- Develop strategies to improve care and communication among workers, patients, and family caregivers.

C. Service Delivery

GOAL: Assess statewide capacity on a regional basis. Evaluate access and capacity in regions throughout the state, especially in regard to issues of proximity and parity in urban versus rural areas. Develop a person-centered system that provides dependable, high-quality, and affordable services for individuals with Alzheimer's and related dementias throughout the entire state of Georgia.

STRATEGIES TO ACHIEVE THIS GOAL:

- Establish criteria which define an effective Alzheimer's/related dementias service delivery system, using other state plans as models, and compile a comprehensive statewide catalogue and assessment of Georgia's current service delivery which measures the current system against the proposed established criteria. Funding is necessary to conduct the assessment.
- Make specific recommendations to address gaps in service delivery based on findings.
- Assign/procure dedicated staff persons or consultants to develop and conduct the assessment.
- Analyze the assessment of gaps in service.
- Identify potential recommendations from other states' plans for consideration (including recommendations that could be implemented prior to completion of the assessment). Resources needed include technical and financial resources to analyze the assessment and implement recommendations. Note that recommendations cannot be made until baseline criteria are established and an assessment of current service delivery system is completed.
- Identify best practices for the care of persons with serious mental illness (SMI) and developmental disabilities and comorbid dementia.
- Raise awareness that individuals with younger-onset Alzheimer's need services targeted to their specific needs.
- Recognize self-determination. Distinguish between younger-onset and early-stage Alzheimer's and recognize that early-stage individuals still have much that they can contribute and control in their lives and should be allowed to be as independent as possible until the disease robs them of their ability to do so.

GOAL: Train professionals, caregivers, and volunteers in person-centered care. Provide training to family caregivers, proxy caregivers, nursing home staff, assisted living staff, and others who interact with individuals who have dementia. Train those who provide care for people with dementia to use person-centered practices to interact

with them in ways that honor and support their individual personhood, recognizing that each person has his or her own preferences, needs, interests, personality, and history.

STRATEGIES TO ACHIEVE THIS GOAL:

- Work with professional licensing and certification entities to require dementia-specific training* in relevant licensing, certification, and continuing education initiatives for health care providers, including, but not limited to, nurses, certified nursing assistants, physicians not specializing in geriatrics, emergency room staff, emergency medical technicians, rehabilitation therapists, dentists, clergy and chaplains, etc.

  ** Dementia-specific training should include the diagnostic process, progression of the disease, communication skills, understanding and guiding behaviors, (non-pharmacological management interventions and medication management), the importance of understanding person-centered care as it pertains to nutrition and dining information, activities, and daily life skills. This model will also include the effective communication with and understanding of the stress of the family caregiver.*

- Train facility staff to view behavioral "problems" as *behavioral expressions* that are a way for a person with dementia to communicate. Train care providers to identify the root cause of behavioral expression and then address the cause through an individualized approach focusing on the strengths and preferences of the individual, one that may incorporate social interaction, music, pets, solitude, spiritual practices, beneficial touch such as massage, and awareness of lighting and noise.

  Reference:
  Dementia Initiative "Dementia Care: The Quality Chasm" (2013), Kitwood, 1997

- For the family caregiver, offer accessible training* to include an understanding of the disease, its progression, and how it affects thinking and behavior; strategies for effective communication and behavior guidance; information about available resources and services; treatment; strategies for self-care; and the management of caregiver stress.

  **Accessible Training should take advantage of a variety of available delivery mechanisms such as free or low-cost online e-learning modules and local group training available through the Alzheimer's Association,*

the Emory Alzheimer's Disease Research Center, Area Agencies on Aging, health departments, and the Rosalyn Carter Institute for Caregiving. Training includes specific programs such as Savvy Caregiver and Powerful Tools for Caregivers classes.

- For volunteers working in settings that involve interaction with people with dementia, appropriate training* should be readily available and promoted. These volunteers could include those involved with Meals on Wheels, day centers, senior centers, faith-based programs, long-term care facilities, or hospitals.

  **Appropriate training should include an understanding of the disease, its progression and how it affects thinking and behavior; strategies for effective communication and behavior guidance; the recognition of caregiver stress; and alterations in behavior that may require expert attention. A model volunteer training curriculum may be developed by the Alzheimer's Association.*

GOAL: Research and adopt person-centered best practices in facility type and scale. Provide person-centered service at home and in small home-like facilities that are integrated into the community.

STRATEGIES TO ACHIEVE THIS GOAL:

- Allow for state dollars to fund long-term care options other than skilled nursing homes.
- Create incentives for providing services to those with dementia that increase access and improve quality, according to national best practices. Use innovative "aging in place" homes/housing such as naturally occurring retirement communities (NORC), villages, and livable communities.
- Develop and make small-scale adult day programs more accessible by offering them through existing service providers.
- Fund a pilot to demonstrate expanded person-centered evidence-based best practices in long-term care and community-based facilities caring for individuals with dementia, specifically focused on creating small units (6 -10 residents) based on The Netherlands model.
- Explore the development of a model program for residents with severe dementia, such as De Hodeweyk, an innovative dementia-care village in the Netherlands.
- Utilize approaches used by the disability community in their approach to person-first / person-centered care.

GOAL: Promote the use of person-centered facility design. Use incentives, training, and regulations to ensure that environments that serve individuals with dementia will incorporate the best evidence-based practices and design features.

STRATEGIES TO ACHIEVE THIS GOAL:

- Develop regulations, grants, waiver protocols or other financial incentives to invite the development of new approaches to facility design. Such approaches should reflect evidence-based practices which support person-centered care and show promise for improving the quality of life.
- Create policy within facilities that serve people with dementia to enforce best practice in design, color, texture, lighting, air change ratio, and sound, thereby promoting the safety, security, and management of persons with dementia.
- Educate architects and engineers about the impact of architecture and engineering, reflected through design, color, texture, lighting, air change ratio, and sound, on the safety, security, and management of persons with dementia. Educate these professionals through pre-service and in-service training.

GOAL: Improve consumers' access to needed services and information. Address information and key services such as respite. Facilitate the use of technology.

STRATEGIES TO ACHIEVE THIS GOAL:

- Determine what resources are available and what barriers exist to accessing the resources.
- Develop a service delivery directory, electronic or otherwise. Enhance the existing directory available through the Georgia Association of Area Agencies on Aging. Allocate funding for the creation and ongoing management and maintenance of this database.
- Provide funding and implement innovative models to increase caregivers' access to respite that is provided through in-home respite providers, adult day services organizations, volunteer-based respite programs, and other sources. Respite relieves the caregivers of care duties for a specified period of time and may include support services such as home-delivered meals.
- Use assistive technology to provide services and training in care and safety to help both persons with dementia and their caregivers.

    - Research current and upcoming technology options being utilzed for dementia.
    - Create a Resource Guide for Adaptive Technology. The guide should be avilable electronically.
    - Provide increased access to safety monitoring and support for caregivers.

GOAL: Improve care transitions of persons with dementia by providing guidance and tools for discharge planners.

STRATEGIES TO ACHIEVE THIS GOAL:

- Assure that an appropriate discharge plan is developed for each patient being discharged from a hospital, skilled nursing facility or emergency room. The plan should be made in collaboration with the individual and family, the physician, and the provider.
- Assure that all discharge planners in hospitals, skilled nursing facilities, and emergency rooms have access to region-specific resources, including websites and written literature.
- Ensure that discharge planners provide families with access to resource information before discharge occurs. Information should include the number for the regional Aging and Disability Resource Connection (ADRC) and the Alzheimer's Association, Georgia Chapter to assist with long-term care planning.
- Support care transitioning programs that help patients move from one healthcare setting to another.
- Identify means (payor sources, administrative policies) for obtaining neuropsychological, psychiatric, and occupational therapy evaluations needed to plan adequately for an individual's transition from an institution (hospital, skilled nursing facility) to the community.
- Conduct an evidence-based review of transitions of care models for people with Alzheimer's disease, and then pilot.

GOAL: Examine and respond to transportation challenges. Lack of transportation leads to social isolation and the underutilization of available services.

STRATEGIES TO ACHIEVE THIS GOAL:

- Identify agencies and organizations currently working on statewide, regional, and local transportation "best practice" plans for transportation throughout the state.
- Explore additional funding options for accessible and affordable transportation services that are dementia-capable, and improve the integration and coordination of public and social service transportation.
- Partner with the Georgia Department of Transportation to develop a plan that encompasses travel training, door-through-door services, and assisted transportation, all of which serve to foster the independence of persons with early-stage Alzheimer's and other forms of dementia.

- Explore public and private sources of funding for such supplemental transportation efforts.
- Offer incentives and training to local nonprofit providers to launch volunteer transportation programs in their communities. Give priority to providers that are familiar with this population, such as senior centers, faith-based respite programs, and adult day programs.

GOAL: Ensure that providers offer high-quality services to persons with dementia. Maintain effective practices for licensure and quality care measurement.

STRATEGIES TO ACHIEVE THIS GOAL:

- Fund, implement and enforce adult day services licensure in order to ensure the quality of providers. Legislation must be passed to secure funding for enforcement of licensure.
- Establish and enforce quality care measures related to personalized practices (person-centered care) for facility- and community-based care for persons with Alzheimer's disease and other dementias.

D. Public Safety

GOAL: Ensure the safety of persons with dementia who are at risk of abuse, neglect, and/or exploitation. Provide tools and training to law enforcement and partnering community professionals and provide resources to address emergency needs.

STRATEGIES TO ACHIEVE THIS GOAL:

- Develop a website for law enforcement and first responders which contains training modules related to dementia.
- Develop specialized regional multi-disciplinary teams to 1) respond to and investigate crimes against at-risk adults, including those with dementia, and 2) relocate victims when needed.
- Create an at-risk adult subject matter expert in each Georgia Bureau of Investigation region to focus on combating crime and providing technical assistance to local law enforcement.
- Create a network of housing options, personal support services and other needed services for at-risk adults in need of safe emergency housing due to dangerous situations, such as the absence of a caregiver, wandering, or exposure to potential abuse, neglect, and/or exploitation. The system should have an infrastructure to facilitate access to resources 24/7.
- Provide state-approved forms such as the Georgia Advance Directive for Healthcare, Physician Orders for Life Sustaining Treatment (POLST), and other

documents at no cost to the consumer via public libraries, resource centers, and easily accessible websites.
- Evaluate state laws, specifically with respect to powers of attorney and Guardianship, and make recommendations which will decrease fraud, abuse, neglect, and self-neglect of persons with Alzheimer's disease and other dementias.
- Collaborate with the 12 Area Agencies on Aging, the Governor's Office of Consumer Protection, the Georgia Bureau of Investigation, the Medicaid Fraud Control Unit, the United States Department of Health and Human Services, the United States Office of the Inspector General, and the Division of Aging Services, Adult Protective Services and Senior Medicare Patrol project to educate consumers and financial professionals regarding risks, prevention, and mitigation of abuse and fraud specific to consumers with dementia.
- Partner with Adult Protective Services (APS), law enforcement, the banking and financial industry, and the court system to recognize ongoing or potential financial abuse of people with dementia, protect those at risk, and curb ongoing exploitation.
- Create a 24/7 emergency access line to APS so that law enforcement and other key community safety net agencies/organizations can reach them during the evening, weekends, and holidays.

GOAL: Reduce rates of injury among persons with dementia. Increase the usage of voluntary alert systems, technical assistance, tools, and regulations to prevent and avoid injury due to wandering public emergencies, auto accidents, and other occurrences that put persons with dementia at risk.

STRATEGIES TO ACHIEVE THIS GOAL:

- Encourage law enforcement to use Mattie's Call when a person with dementia is reported missing. The public alert system is currently voluntary and is not used to its full potential.
- Engage partners to develop guidance for local emergency management agencies. Guidance should help to ensure that the needs of individuals with dementia will be met during evacuation, transportation, and sheltering during a disaster.
- Implement an educational program for medical providers to increase the use of the STEADI screening tool - Stopping Elderly Accidents, Deaths, and Injuries in medical practices. This evidence-based practice developed by the Centers for Disease Control reduces falls, driving injuries, and other accidents experienced by persons with dementia and other at-risk individuals.
- Through the Department of Public Health, engage partners to 1) determine the public safety impact of implementing gradual restrictions in driving privileges

based on demonstrated driving ability and 2) determine infrastructure needed to implement the practice.

- Increase awareness of driving assessment programs in Georgia – to both physicians and families.
- Because visual acuity is not an appropriate measure of the driving ability of a person with Alzheimer's or a related dementia, it is recommended that the Short Blessed Test * and the Rapid Paced Walk Test * be administered by the Department of Driver Services as a first screening of drivers who are diagnosed with Alzheimer's or a related dementia.

    - The **Short Blessed Test** is a paper test from which the tester asks the driver questions. If the individual scores 6 or more on the Short Blessed Test, he or she should be referred for a full evaluation. A copy of the test can be found in the Appendix.

    - The **Rapid Paced Walk** is a timed 20-foot walk in which the participant walks 10 feet and returns as fast as possible without falling. A return walk of seven seconds or more is an indicator of greater crash risk and should prompt a referral for a full driver evaluation.

- Promote programs that (a) ensure home safety through falls prevention programs, home safety assessments, and home monitoring devices; (b) help people with dementia and their families prepare for care and services in the event of a disaster or emergency; and (c) develop employer- supported dementia caregiver training and other employer-supported programs.
- Increase safety in the community by improving the visibility and utilization of locator devices and programs such as the MedicAlert + Alzheimer's Association Safe Return program.
- Educate caregivers on the importance of home modifications to prevent injury. *(Recommendation also noted in Outreach and Partnerships section.)*

E. Outreach and Partnership

GOAL: Raise public awareness about dementia. Encourage persons presenting with symptoms or whose family indicate potential cognitive impairment to seek diagnosis and treatment from a healthcare professional in to plan ahead for needed resources and care. Increase availability of information for people with dementia their families, caregivers and professionals. Leverage the various national association and state campaigns and related materials to allow greater access to trusted public information.

STRATEGIES TO ACHIEVE THIS GOAL:

- Identify and implement culturally appropriate strategies designed to increase public awareness about dementia. Use materials developed by AARP, Area Agencies on Aging, the Alzheimer's Association, the Centers for Disease Control, the Georgia DHS Division of Aging Services, the Rosalynn Carter Institute and other organizations.
- Develop a marketing and media plan with a message that helps reduce stigma and fear related to dementia. Include the developmental disability community in the target population. Determine branding and implement the plan statewide.
- Promote advance care planning and advance financial planning to care partners, families, and individuals with dementia in the early stages before function declines. This population includes those with younger-onset Alzheimer's and developmental disabilities.
- Create an electronic clearinghouse of information, forms and resources for public consumption related to ADRD and provide appropriate linkages between all of the state health agencies to ensure citizens have access to the most up-to-date information.
- Work with national organizations, state chapters and other outreach partners to identify and disseminate culturally appropriate information through statewide promotional campaigns.
- Develop a dementia-capable website and portal to allow family members and those with early onset dementia to navigate and make healthcare decisions related to all services and care.
- Provide public health awareness, education and resource information through the Georgia Department of Public Health with website information and media releases.
- Educate caregivers on the importance of home modifications to prevent injury. *(Recommendation also noted in Public Safety section.)*

GOAL: Educate the public and organizations to become more "dementia-friendly." Increase the knowledge and sensitivity levels of those in the surrounding community through training programs, resources, and volunteer-based initiatives.

STRATEGIES TO ACHIEVE THIS GOAL:

- Provide training modeled after the "Dementia Friends" program in Japan and the United Kingdom. Over four million people have been trained to be dementia friendly in Japan. Using a one-hour education program on dementia similar to

Red Cross training on first aid and CPR, organizers prepare individuals, organizations, and businesses to be dementia friendly.

- Explore and create ways to make culturally sensitive, evidenced-based information and education available through existing and new programs. Incorporate education into wellness and employee assistance programs and through partnerships with organizations such as the Society for Human Resource Management.
- Develop a strategic plan that supports faith- and community-based organizations in their efforts to provide early detection, education and resources for individuals and families experiencing symptoms of memory loss and dementia. Make training programs available for all faith- and community-based organizations. Work through health ministries to identify persons in need of an assessment and to support those with dementia and their caregivers. (Note: Only physicians can make a diagnosis. "Detection" tools often available at health fairs and other events are accompanied by the caveat that the test is not definitive. If a reason for possible concern is detected, individuals are strongly encouraged to see a physician who specializes in the diagnosis of Alzheimer's and related dementias.)
- Train the community on person-centered concepts and practices in planning and service delivery.

GOAL: Expand Georgia's capacity to address the needs of persons with dementia through strategic partnerships and resource sharing, the leveraging of existing funding, and accessing new sources. Potential funding sources include VA benefits, Medicaid waivers, long-term care insurance, and other options.

STRATEGIES TO ACHIEVE THIS GOAL:

- Promote appropriate public and private partnerships and determine strategies to increase awareness, promote early detection and diagnosis, decrease fear and stigma, refer individuals to assistance organizations, promote brain health, leverage resources, provide education, and promote research. (Private and public partners may include, but are not limited to, major employers, the healthcare industry, chambers of commerce, state and federal government, organizations, agencies, business associations, educational institutions and non-traditional partners.)
- Develop an ongoing repository of culturally sensitive resources for use by partners. Engage organizations as repositories that are currently serving in this capacity (such as the Rosalynn Carter Institute).
- Explore funding from diverse sources to support carrying out the State Plan. Invite partners to contribute funding to support the State Plan. Seek funding through foundations and corporations.

- Create funding mechanisms to support family caregivers to keep their family member with dementia at home longer by providing reimbursement for personal care services, specialized medical supplies, and respite, for example.
- Leverage enhanced funding available through the Balancing Incentive Program to increase access to home and community based services.

Resources

While the Georgia Alzheimer's and Related Dementia State Plan Task Force provided many recommendations which would require little to no additional funding, the issues of funding must be addressed. The State Plan Task Force recognizes that there will never be enough public resources to meet the needs of the growing population of people with dementia. One of the key goals of the Plan is to provide hope that, through implementation of the Plan, resources can incrementally be made available to meet the need through leveraging of federal/national, state, public, private, and faith-based collaborative, cooperatively designated resources. Benchmarking this data with the surveillance data is essential to ensure that the legislature, policy makers, state agencies and the public are informed regarding where resources are being directed.

GOAL: Establish dedicated Alzheimer's and related dementia private funding. The Division of Aging Services is one of the few state agencies that receive a high level of public support. Each year, for every $1 received in state and or federal funding, the Aging Services Network generates an additional $2 in local contributions to expand services. Additionally, each year, through the Georgia Fund for Children and Elderly alone, the Division of Aging Services receives over $150,000 in public contributions which is used to expand services for older adults. Earmarking and dedicating funds for Alzheimer's and dementia-related activities will provide needed resources across Georgia to meet the growing demand.

STRATEGIES TO ACHIEVE THIS GOAL:

- Revise existing "tax check-off" legislation allowing the public to earmark specific, tax deductible funds to be targeted to for dementia-specific purposes (ie: research, expansion of services, advocacy, education, etc.).
- Evaluate the feasibility of a statewide healthcare tax that would be utilized to expand Medicaid services for people with dementia to provide for long-term care supports and services; the fund would be split between home and community based services and long-term care services, particularly novel, innovative services for people with ARD.

GOAL: Monitor State and Federal Fund expenditures for long-term supports and services for people with dementia - including Medicaid, Older Americans Act and State Funds. The GARD Advisory Council shall evaluate the use of state and federal funds and make findings available to the Governor, the Legislature, the Department of Community Health, the Department of Public Health, and the Division of Aging

Services. The GARD Advisory Council shall evaluate the availability and proportion of funds and make budget requests to the Governor based upon surveillance data and past expenditures.

STRATEGIES TO ACHIEVE THIS GOAL:

- The Department of Community Health and the Division of Aging Services shall submit, upon request, to the GARD Advisory Council an accounting of the funding spent on long-term care and community based care services for people with dementia by fund source and the number of people served.
- The Department of Community Health should explore various methodologies to expand home and community based waivers for people with dementia.
- The Department of Community Health should consider nursing home reimbursement and personal care home reimbursement for facilities which provide for person-centered dementia-specific services.
- The Department of Community Health should explore the expansion of provider fees for community based programs in order to draw down more federal funding.
- The Department of Community Health should facilitate the use of civil monetary penalties for improving quality care for nursing home residents with dementia.

Regarding all Goals and Strategies, it should be recognized that much of the work that needs to be done now and in future assessment and updates of the Plan will require legislation and corresponding funding to develop and implement that specific item of the Plan. The Advisory Council commits to work with partner stakeholders, state agencies, and legislators to develop and have filed appropriate legislation and corresponding appropriations requests throughout the life of this Plan.

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Appendix I: Demographic Analysis Tables

Table: Demographic analysis.
Population aged 60 years and older 'At-risk' for Alzheimer's and related Dementias, Georgia 2012.

Population aged 60 and older, GA	2006	2008	2010	2012
Total	1,289,409	1,419,658	1,538,984	1,662,785
Aged 85+	101,108	108,040	114,696	123,483
Aged 80 - 84	121,869	125,789	129,191	134,797
Aged 75 - 79	171,109	176,787	182,816	194,484
Aged 70 - 74	222,213	235,231	252,029	278,443
Aged 65 - 69	289,474	326,491	358,555	408,494
Aged 60 - 64	383,636	447,320	501,697	523,084

Estimate for Current Georgia Population with Confusion or Memory Problems	
Estimated increase in percent of adults reporting Confusion and / or memory problems, 2006 to 2012	22%
Estimated Number with Confusion / Memory problems, 2012*	211,174
Sub-populations of Confusion / Memory Problem, 2012	
Number living alone, reported confusion or memory problems	74,333
Number with confusion or memory problems AND Disability	73,066
Number of persons with confusion or memory problems Needing help from someone	112,133
Number of persons with confusion or memory problems Receiving help	22,539
Estimated current impact of confusion and memory problems in Georgia, 2012	
Unmet need for help	89,594
Number 'Not discussed with healthcare provider'	170,417

Total Population Growth, Adults aged 60+ years by Age Category	% Change 2006 - 08	% Change 2008 - 010	% Change 2010 -12
Total	9.17%	7.75%	7.45%
Aged 85+	6.42%	5.80%	7.12%
Aged 80 – 84	3.12%	2.63%	4.16%
Aged 75 – 79	3.21%	3.30%	6.00%
Aged 70 – 74	5.53%	6.67%	9.49%
Aged 65 – 69	11.34%	8.94%	12.23%
Aged 60 – 64	14%	10.84%	4.09%

***Estimates in summary statistics based on Morbidity and Mortality Weekly Report, May 10, 2013.** 'Self-reported increased Confusion or Memory Loss and Associated Functional Difficulties among adults >=60 years, 21 States, 2011" Vol. 62 / No. 18. Corresponding author: Angela J. Deokar, ajdeokar@cdc.gov. 770-488-5327. **Source: Georgia OASIS, 1/2/2014. Created 1/2/2014 for GARD Task.**

Appendix II: Behavioral Risk Factor Surveillance System

BRFSS Data, Georgia 2011

What is already known about confusion and memory loss?

Declines in cognitive function vary from person to person and may include changes in attention, memory, learning, executive function, and language that negatively affect quality of life, personal relationships and capacity for making informed decisions about health care and other issues (Wagster, et. al, 2012).

Memory problems are typically one of the first warning signs of cognitive loss, and Mild Cognitive Impairment (MCI) may occur when memory problems are greater than normal for a person's age but not as severe as those experienced in Alzheimer's disease (NIH, 2013). Some, but not all, people with MCI develop Alzheimer's disease (the most common cause of dementia), and some may even recover from MCI if treatable causes such as medication side effects or temporary depression are detected and treated (NIH, 2013).

In 2011, 22 states added 10 questions on cognitive impairment to their Behavioral Risk Factor Surveillance System (BRFSS) survey. These data were analyzed for respondents aged 60 and older in the 22 states.

What has been learned about this topic in Georgia?

- 14.3% of Georgia adults aged 60 or older self-reported confusion or memory loss that is happening more often or getting worse over the past 12 months[2] (values ranged from 6.4% to 20.0% across the 22 states)

Among Georgia adults aged 60 or older with confusion or memory loss:

- 25.1% reported confusion or memory loss that always, usually, or sometimes interfered with their ability to work or engage in social activities (range: 13.2% - 39.7%)
- 25.1% reported confusion or memory loss that always, usually, or sometimes caused them to give up household chores (range: 14.3% - 38.3%)
- 7.9% reported that they always or usually received help from a family member or friend because of their confusion or memory loss (range: 2.8% - 14.7%)
- 37.7% live alone, with no other adults or children in the household (range: 28.2% - 48.8%)
- 21.9% discussed their confusion or memory loss with a health care provider (range: 11.2% - 32.0%)

Characteristics of Older Adults who Self-Reported Confusion or Memory Loss, Georgia BRFSS 2011	Weighted %	95% C.I.
All adults aged 60+	14.3	12.4 - 16.5
Age (years)		
60-64	12.2	9.3 - 16.0
65-74	12.9	10.5 - 15.9
75-84	19.9	14.7 - 26.3
85 and older	13.4	8.1 - 21.3
Gender*		
Male	14.7	11.3 - 18.8
Female	14.0	11.9 - 16.4
Education		
Less than high school	20.4	15.7 - 26.2
High school	14.7	11.6 - 18.5
Some college	11.1	8.5 - 14.5
College graduate	7.6	5.6 - 10.2
Disability Status		
Disabled	21.4	18.3 - 24.8
Not disabled	8.9	6.6 - 12.0
Veteran Status*		
Veteran	15.7	11.9 - 20.4
Non-veteran	13.9	11.7 - 16.5

The denominator in every case is >50

P > 0.05; not statistically significant

Why is this important?

This report provides a baseline estimate of the extent of self-reported confusion or memory loss among non-institutionalized adults aged 60 or older who may require services and support now or in the future. These findings underscore the need for increased awareness about changes in memory and confusion that may warrant discussions with health care and service providers so that linkages can be made to accurate information and needed services.

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[1] Sample size for Georgia is 2,471 adults aged 60 and older.

[2] Results are specific for this question and do not correspond to a specific diagnosis. Data are weighted and refer to the civilian, non- institutionalized population. Source: CDC, BRFSS, 2011.

Appendix III:Rules of the Dept. of Community Health for Assisted Living Communities Int. Guidelines; includes mandated rules for assisted living communities related to memory care services and specialized memory care units

(11) Medical, nursing (other than developing and updating care plans, training, medication administration and skills competency determinations) health services required on a periodic basis, or for short-term illness, must not be provided as services of the assisted living community. When such services are required, they shall be purchased by the resident or the resident's representative or legal surrogate, if any, from appropriately licensed providers which are managed independently and not owned or operated by the assisted living community. The assisted living community may assist in arrangement for such services, but not in the provision of those services.	
Authority O.C.G.A. §§. 31-2-7, 31-2-8, 31-7-1, *et seq*. and 43-26-12.	
111-8-63-.18 Requirements for Memory Care Services.	
(1) An assisted living community which serves residents with cognitive deficits which place the residents at risk of eloping, i.e. engaging in unsafe wandering activities outside the assisted living community must do the following:	
(a) Develop, train and enforce policies and procedures for staff to deal with residents who may wander away from the assisted living community including what actions, are to be taken if a resident wanders away (elopes) from the assisted living community.	Mattie's Call Law must be followed. See O.C.G. A. §38-3-110 et seq.
(b) Utilize appropriate effective safety devices, which do not impede the residents' rights to mobility and activity choice or violate fire safety standards, to protect the residents who are at risk of eloping from the premises.	Such devices could include alarms that sound when an exterior door is opened and alert the staff to a resident's leaving the building.
1. If the safety devices include magnetic locks used on exit doors, as approved by the fire marshal having jurisdiction over the assisted living community, then the locking device shall be electronic and release whenever the following occurs: activation of the fire alarm or sprinkler system, power failure to the assisted living community or by-pass for routine use by the public and staff for service using a key button/key pad located at the exit or continuous pressure for thirty (30) seconds or less.	Before installing new locks, check with the fire safety jurisdiction having authority for the community to ensure that the device meets local requirements and that there is always a safe method of exiting through the door in the event of a power failure, etc.

2. If the safety devices include the use of keypads to lock and unlock exits, then directions for their operations shall be posted on the outside of the door to allow individuals' access to the unit. However, if the unit is a whole assisted living community, then directions for the operation of the locks need not be posted on the outside of the door. The units must not have entrance and exit doors that are closed with non-electronic keyed locks nor shall a door with a keyed lock be placed between a resident and the exit.	
(2) An assisted living community serving residents who are at risk of eloping from the premises must retain on file at the assisted living community current pictures of any such residents.	At a minimum, a community must have a current picture of any resident who is at risk of eloping, e.g. has advancing dementia and gets confused about location and may wander outside the community. The picture may be taken at the time of admission but must be periodically updated if the resident's physical appearance changes greatly. A copy of the photo should be provided to law enforcement authorities if Mattie's Call is initiated. It is a good idea to maintain current pictures of all residents particularly where medications are being administered to ensure that the right medication is being administered to the right resident by PRN staff, etc.
Authority O.C.G.A. §§ 31-2-7,31-2-8, 31-7-1 *et seq*.	
111-8-63-.19 Additional Requirements for Specialized Memory Care Units	
(1) In addition to all other requirements contained in this Chapter, where an assisted living community holds itself out as providing additional or specialized care to persons with probable diagnoses of Alzheimer's Disease or other dementia or charges rates in excess of that charged other residents because of cognitive deficits which may place the residents at risk of eloping, the assisted living community must meet the following requirements:	The purpose of this rule is to assist potential residents and families in understanding what services are provided, by whom, when and at what cost.
(a) Written Description. The assisted living community must include in its licensed residential care profile an accurate written description of the special care unit that includes the following:	

1. a statement of philosophy and mission;	
2. how the services and activities of the special care unit are different from those	
3. staffing including job titles of staff who work in the unit, staff training and continuing education requirements;	Potential residents and families need to know who is staffing the unit. Does the community provide a nurse, and if so, for how many hours a week? Is a nurse on call?
4. admission procedures, including screening criteria;	
5. assessment and service planning protocol, including criteria to be used that would trigger a reassessment of the resident's status before the customary quarterly review;	The protocol should explain the kinds of changes in condition that would trigger a re-evaluation, e.g. loss of ability to ambulate.
6. staffing patterns, including the ratio of direct care staff to resident for a 24-hour cycle, and a description of how the staffing pattern differs from that of the rest of the program;	
7. a description of the physical environment including safety and security features;	
8. a description of activities, including frequency and type, and how the activities	
9. the program's fee or fee structure for all services provided by the unit or assisted living community;	Residents and their families need to be given clear information on all fees that might be charged.
10. the discharge criteria and procedures;	
11. the procedures that will be utilized for handling emergency situations; and	
12. the involvement of the unit with families and family support programs.	
(b) Physical Design, Environment, and Safety. The memory care unit or special care unit must be designed to accommodate residents with severe dementia or Alzheimer's Disease in an assisted living community-like environment which includes the following:	
1. multipurpose room(s) for dining, group and individual activities which are appropriately furnished to accommodate the activities taking place;	
2. secured outdoor spaces and walkways which are wheel chair accessible and allow residents to ambulate safely but prevent undetected egress;	

3. high visual contrast between floors and walls and doorways and walls in resident use areas—except for fire exits, door and access ways which may be designed to minimize contrast to conceal areas where the residents should not enter;	
4. adequate and even lighting which minimizes glare and shadows;	
5. the free movement of the resident, as the resident chooses, between the common space and the resident's own personal space in a bedroom that accommodates no more than two (2) residents;	
6. individually identified entrances to residents' rooms to assist residents in readily identifying their own personal spaces;	
7. an effective automated device or system to alert staff to individuals entering or leaving the unit in an unauthorized manner. An assisted living community need not use an automated alert for an exit door when the particular exit is always staffed by a receptionist or other staff member who views and maintains a log of individuals entering and leaving the assisted living community. If the exit door is not always staffed, then the assisted living community must activate an automated alert when the door is not attended;	
8. communication system(s) which permit staff in the unit to communicate with other staff outside the unit and with emergency services personnel as needed; and	The unit must have a functioning communication system to allow staff in the unit to summon help from others outside the unit. The system should include an internal intercom or alarm system to alert other staff and a telephone to contact emergency medical services.
9. a unit providing specialized memory care services which undergoes major renovation or is first constructed after December 9, 2009, must be designed and constructed in compliance with applicable state and local building and fire codes relevant to the specialized unit and the assisted living community.	
(c) Staffing and Initial Staff Orientation. The assisted living community must ensure that the contained unit is staffed with sufficient specially trained staff to meet the unique needs of the residents in the unit.	

1. At a minimum, the assisted living community must employ certified medication aides in the unit to administer certain medications.	Residents who are properly placed in a specialized memory care unit require the administration of medications by certified medication aides, at a minimum.
2. At least one staff member who is awake and supervising the unit at all times and sufficient numbers of trained staff on duty at all times to meet the needs of the residents.	
3. Staff who, prior to caring for residents independently, have successfully completed an orientation program that includes at least the following components in addition to the general training required in Rule 111-8-63-.09:	
(i) the assisted living community's philosophy related to the care of residents with dementia in the unit;	
(ii) the assisted living community's policies and procedures related to care in the unit and the staff's particular responsibilities including wandering and egress control; and	
(iii) an introduction to common behavior problems characteristic of residents residing in the unit and recommended behavior management techniques.	
(d) Initial Staff Training. Within the first six months of employment, staff assigned to the unit shall receive training in the following topics:	
1. the nature of Alzheimer's Disease and other dementias, including the definition of dementia, and knowledge of dementia-specific care needs;	
2. common behavior problems and recommended behavior management techniques;	
3. communication skills that facilitate better resident-staff relations;	
4. positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills;	
5. the role of the family in caring for residents with dementia, as well as the support needed by the family of these residents;	
6. environmental modifications that can avoid problematic behavior and create a more therapeutic environment;	
7. development of comprehensive and individual service plans and how to update or provide relevant information for updating and implementing them consistently across all shifts, including establishing baseline care needs;	

8. new developments in dementia care that impact the approach to caring for the residents in the special unit;	
9. skills for recognizing physical or cognitive changes in the resident that warrant seeking medical attention; and	
10. skills for maintaining the safety of residents with dementia.	
(e) Special Admission Requirements for Unit Placement. Residents must have a physician's report of physical examination completed within 30 days prior to admission to the community or unit on forms made available by Department. The physical examination must clearly reflect that the resident has a diagnosis of probable Alzheimer's Disease or other dementia and has symptoms which demonstrate a need for placement in the specialized unit. However, the unit may also care for a resident who does not have a probable diagnosis of Alzheimer's Disease or other dementia, but desires to live in this unit and waives his or her right to live in a less restrictive environment. In addition, the physical examination report must establish that the potential resident of the unit does not require 24-hour skilled nursing care.	Departmental Physical Examination form is required. A resident who requires 24-hour skilled nursing care for management of their medical needs must not be admitted to the Memory Care Unit.
(f) Post-Admission Assessment. If the resident is admitted directly into the specialized memory care unit, the unit must obtain an assessment of each resident's care needs to include the following components: resident's family supports, level of activities of daily living functioning, physical care needs and level of behavior impairment.	
(g) Individual Written Care Plan and Reviews. The resident's written care plan will be developed or updated by staff with at least one member of the specialized memory care staff providing direct care participating. Input from each shift of direct care staff that provides care to the resident will be requested. All team members participating shall sign the written care plan and the plan will be shared with the direct care staff providing care to the resident and serve as a guide for the delivery of care to the resident. The written care plan must be reviewed at least quarterly and modified as changes in the resident's needs occur.	Quarterly reviews of care plans are required for residents in a specialized memory care unit.
(h) Therapeutic Activities. The unit shall provide activities appropriate to the needs of the individual residents and adapt the activities, as necessary, to encourage participation of the residents in the following at least weekly with at least some therapeutic activities occurring daily:	
1. gross motor activities; e.g. exercise, dancing, gardening, cooking, etc;	

2. self-care activities; e.g. dressing, personal hygiene/grooming;	
3. social activities; e.g. games, music;	
4. sensory enhancement activities, e.g. distinguishing pictures and picture books,	
5. outdoor activities; e.g. walking outdoors and field trips.	
(2) No licensed assisted living community is permitted to hold itself out as providing specialized care for residents with probable Alzheimer's disease or other dementia or charge a differential rate for care of residents with cognitive deficits that place the residents at risk of engaging in unsafe wandering activities (eloping) unless it meets the additional requirements specified in Rule 111-8-63-.19(1) and its subparagraphs (a) Through (h) above.	
Authority: O.C.G.A. §§ 31-2-7, 31-2-8, 31-7-1 et seq. *et seq.* and 43-26-32.	

Appendix IV: Rules and Regs of the Dept. of Community Health for Assisted Living Communities; includes mandated rules for assisted living communities related to memory care services and specialized memory care units

111-8-63-.18 Requirements for Memory Care Services

(1) An assisted living community which serves residents with cognitive deficits which place the residents at risk of eloping, i.e. engaging in unsafe wandering activities outside the assisted living community must do the following:

(a) Develop, train and enforce policies and procedures for staff to deal with residents who may wander away from the assisted living community including what actions, are to be taken if a resident wanders away (elopes) from the assisted living community.

(b) Utilize appropriate effective safety devices, which do not impede the residents' rights to mobility and activity choice or violate fire safety standards, to protect the residents who are at risk of eloping from the premises.

1. If the safety devices include magnetic locks used on exit doors, as approved by the fire marshal having jurisdiction over the assisted living community, then the locking device shall be electronic and release whenever the following occurs: activation of the fire alarm or sprinkler system, power failure to the assisted living community or by-pass for routine use by the public and staff for service using a key button/key pad located at the exit or continuous pressure for thirty (30) seconds or less.

2. If the safety devices include the use of keypads to lock and unlock exits, then directions for their operations shall be posted on the outside of the door to allow individuals' access to the unit. However, if the unit is a whole assisted living community, then directions for the operation of the locks need not be posted on the outside of the door. The units must not have entrance and exit doors that are closed with non-electronic keyed locks nor shall a door with a keyed lock be placed between a resident and the exit.

(2) An assisted living community serving residents who are at risk of eloping from the premises must retain on file at the assisted living community current pictures of any such residents.

Authority: O.C.G.A. §§ 31-2-7, 31-2-8, 31-7-1 *et seq*.

111-8-63-.19 Additional Requirements for Specialized Memory Care Units

(1) In addition to all other requirements contained in this Chapter, where an assisted living community holds itself out as providing additional or specialized care to persons with probable diagnoses of Alzheimer's Disease or other dementia or charges rates in excess of that charged other residents because of cognitive deficits which may place the residents at risk of eloping, the assisted living community must meet the following requirements:

(a) Written Description. The assisted living community must include in its licensed residential care profile an accurate written description of the special care unit that includes the following:

1. a statement of philosophy and mission;

2. how the services and activities of the special care unit are different from those provided in the rest of the assisted living community;

3. staffing including job titles of staff who work in the unit, staff training and continuing education require

4. admission procedures, including screening criteria;

5. assessment and service planning protocol, including criteria to be used that would trigger a reassessment of the resident's status before the customary quarterly review;

6. staffing patterns, including the ratio of direct care staff to resident for a 24-hour cycle, and a description of how the staffing pattern differs from that of the rest of the program;

7. a description of the physical environment including safety and security features;

8. a description of activities, including frequency and type, and how the activities meet the needs of residents with dementia,

9. the program's fee or fee structure for all services provided by the unit or assisted living community;

10. the discharge criteria and procedures;

11. the procedures that will be utilized for handling emergency situations; and

12. the involvement of the unit with families and family support programs.

(b) Physical Design, Environment, and Safety. The memory care unit or special care unit must be designed to accommodate residents with severe dementia or Alzheimer's Disease in an assisted living community-like environment which includes the following:

1. multipurpose room(s) for dining, group and individual activities which are appropriately furnished to accommodate the activities taking place;

2. secured outdoor spaces and walkways which are wheel chair accessible and allow residents to ambulate safely but prevent undetected egress;

3. high visual contrast between floors and walls and doorways and walls in resident use areas—except for fire exits, door and access ways which may be designed to minimize contrast to conceal areas where the residents should not enter;

4. adequate and even lighting which minimizes glare and shadows

5. the free movement of the resident, as the resident chooses, between the common space and the resident's own personal space in a bedroom that accommodates no more than two (2) residents;

6. individually identified entrances to residents' rooms to assist residents in readily identifying their own personal spaces;

7. an effective automated device or system to alert staff to individuals entering or leaving the unit in an unauthorized manner. An assisted living community need not use an automated alert for an exit door when the particular exit is always staffed by a receptionist or other staff member who views and maintains a log of individuals entering and leaving the assisted living community. If the exit door is not always staffed, then the assisted living community must activate an automated alert when the door is not attended;

8. communication system(s) which permit staff in the unit to communicate with other staff outside the unit and with emergency services personnel as needed; and

9. a unit providing specialized memory care services which

undergoes major renovation or is first constructed after December 9, 2009, must be designed and constructed in compliance with applicable state and local building and fire codes relevant to the specialized unit and the assisted living community.

(c) Staffing and Initial Staff Orientation. The assisted living community must ensure that the contained unit is staffed with sufficient specially trained staff to meet the unique needs of the residents in the unit.

1. At a minimum, the assisted living community must employ certified medication aides in the unit to administer certain medications.

2. At least one staff member who is awake and supervising the unit at all times and sufficient numbers of trained staff on duty at all times to meet the needs of the residents.

3. Staff who, prior to caring for residents independently, have successfully completed an orientation program that includes at least the following components in addition to the general training required in Rule 111-8-63-.09:

(i) the assisted living community's philosophy related to the care of residents with dementia in the unit;

(ii) the assisted living community's policies and procedures related to care in the unit and the staff's particular responsibilities including wandering and egress control; and

(iii) an introduction to common behavior problems characteristic of residents residing in the unit and recommended behavior management techniques.

(d) Initial Staff Training. Within the first six months of employment, staff assigned to the unit shall receive training in the following topics:

1. the nature of Alzheimer's Disease and other dementias, including the definition of dementia, and knowledge of dementia-specific care needs;

2. common behavior problems and recommended behavior management techniques;

3. communication skills that facilitate better resident-staff relations;

4. positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills;

5. the role of the family in caring for residents with dementia, as well as the support needed by the family of these residents;

6. environmental modifications that can avoid problematic behavior and create a more therapeutic environment;

7. development of comprehensive and individual service plans and how to update or provide relevant information for updating and implementing them consistently across all shifts, including establishing baseline care needs;

8. new developments in dementia care that impact the approach to caring for the residents in the special unit;

9. skills for recognizing physical or cognitive changes in the resident that warrant seeking medical attention; and

10. skills for maintaining the safety of residents with dementia.

(e) Special Admission Requirements for Unit Placement. Residents must have a physician's report of physical examination completed within 30 days prior to admission to the community or unit on forms made available by Department. The physical examination must clearly reflect that the resident has a diagnosis of probable Alzheimer's Disease or other dementia and has symptoms which demonstrate a need for placement in the specialized unit. However, the unit may also care for a resident who does not have a probable diagnosis of Alzheimer's Disease or other dementia, but desires to live in this unit and waives his or her right to live in a less restrictive environment. In addition, the physical examination report must establish that the potential resident of the unit does not require 24-hour skilled nursing care.

(f) Post-Admission Assessment. If the resident is admitted directly into the specialized memory care unit, the unit must obtain an assessment of each resident's care needs to include the following components: resident's family supports, level of activities of daily living functioning, physical care needs and level of behavior impairment.

(g) Individual Written Care Plan and Reviews. The resident's written care plan will be developed or updated by staff with at least one member of the specialized memory care staff providing direct care participating. Input from each shift of direct care staff that provides care to the resident will be requested. All team members participating shall sign the written care plan and the plan will be shared with the direct care staff providing care to the resident and serve as a guide for the delivery of care to the resident. The written care plan must be reviewed at least quarterly and modified as changes in the resident's needs occur.

(h) Therapeutic Activities. The unit shall provide activities appropriate to the needs of the individual residents and adapt the activities, as necessary, to encourage participation of the residents in the following at least weekly with at least some therapeutic activities occurring daily:

1. gross motor activities; e.g. exercise, dancing, gardening, cooking, etc;

2. self-care activities; e.g. dressing, personal hygiene/grooming;

3. social activities; e.g. games, music;

4. sensory enhancement activities, e.g. distinguishing pictures and picture books, reminiscing and scent and tactile stimulation; and

5. outdoor activities; e.g. walking outdoors and field trips.

(2) No licensed assisted living community is permitted to hold itself out as providing specialized care for residents with probable Alzheimer's disease or other dementia or charge a differential rate for care of residents with cognitive deficits that place the residents at risk of engaging in unsafe wandering activities (eloping) unless it meets the additional requirements specified in Rule 111-8-63-.19(1) and its subparagraphs (a) through (h) above.

Authority: O.C.G.A. §§ 31-2-7, 31-2-8, 31-7-1 et seq. *et seq.* and 43-26-3

Appendix V: Rules of the Dept. of Community Health Rules and Regs for Personal Care Homes; includes mandated rules for personal care homes related to memory care services and specialized memory care units or homes

111-8-62-.18 Requirements for Memory Care Services

(1) A home which serves residents with cognitive deficits which place the residents at risk of eloping, i.e. engaging in unsafe wandering activities outside the home must do the following:

(a) Develop, train and enforce policies and procedures for staff to deal with residents who may elope from the home including what actions, as specified in rule 111-8-62-.30 are to be taken if a resident wanders away (elopes) from the home.

(b) Utilize appropriate effective safety devices, which do not impede the residents' rights to mobility and activity choice or violate fire safety standards, to protect the residents who are at risk of eloping from the premises.

1. If the safety devices include locks used on exit doors, as approved by the fire marshal having jurisdiction over the home, then the locking device shall be electronic and release whenever the following occurs: activation of the fire alarm or sprinkler system, power failure to the home or by-pass for routine use by the public and staff for service using a key button/key pad located at the exit or continuous pressure for thirty (30) seconds or less.

2. If the safety devices include the use of keypads to lock and unlock exits, then directions for operation must be posted on the outside of the door to allow individuals' access to the unit. However, if the unit is a whole home, then directions for the operation of the locks need not be posted on the outside of the door. The units must not have entrance and exit doors that are closed with non-electronic keyed locks nor shall a door with a keyed lock be placed between a resident and the exit.

(2) A home serving residents who are at risk of eloping from the premises must retain on file at the home current pictures of residents who are at risk of eloping.

Authority: O.C.G.A. §§ 31-2-7, 31-7-1, 31-7-2.1 and 31-7-12.

111-8-62-.19 Additional Requirements for Specialized Memory Care Units or Homes

(1) A home must meet the additional requirements contained in rule 111-8-62-.19 where the home serves persons with probable diagnoses of Alzheimer's Disease or other dementia and does any of the following

(a) Provides additional or specialized care in locked units to such residents.

(b) Holds itself out as providing additional or specialized care to such residents.

(c) Charges rates in excess of that charged other residents because of the cognitive deficits of such residents which may place them at risk of eloping.

(2) Written Description. The home must develop an accurate written description of the special care unit that includes the following:

(a) A statement of philosophy and mission.

(b) How the services of the special care unit are different from services provided in the rest of the personal care home.

(c) Staffing, including job titles of staff who work in the unit, staff training and continuing education requirements.

(d) Admission procedures, including screening criteria.

(e) Assessment and service planning protocol, including criteria to be used that would trigger a reassessment of the resident's status before the customary quarterly review.

(f) Staffing patterns, maintained within the unit, including the ratio of direct care staff to resident for a 24-hour cycle.

(g) A description of the physical environment including safety and security features.

(h) A description of activities, including frequency and type, how the activities meet the needs of residents with dementia.

(i) The program's fee or fee structure for all services provided by the unit or home.

(j) Discharge criteria and procedures;

(k) The procedures that will be utilized for handling emergency situations.

(l) The involvement of the unit with families and family support programs

(3) Disclosure of Description. A personal care home with an Alzheimer's/dementia special care unit must disclose the written description of the special care unit to:

(a) Any person upon request.

(b) The family or resident's representative before admission of the resident to the Memory Care Unit or program.

(4) **Physical Design, Environment, and Safety.** The memory care unit or special care unit must be designed to accommodate residents with severe dementia or Alzheimer's Disease in a home-like environment which includes the following:

(a) Multipurpose room(s) for dining, group and individual activities which are appropriately furnished to accommodate the activities taking place.

(b) Secured outdoor spaces and walkways which are wheel chair accessible and allow residents to ambulate safely but prevent undetected egress.

(c) High visual contrasts between floors and walls and doorways and walls in resident use areas except for fire exits, door and access ways which may be designed to minimize contrast to conceal areas where the residents should not enter.

(d) Adequate and even lighting which minimizes glare and shadows.

(e) The free movement of the resident, as the resident chooses, between the common space and the resident's own personal space in a bedroom that accommodates no more than four residents.

(f) Individually identified entrances to residents' rooms to assist residents in readily identifying their own personal spaces.

(g) An effective automated device or system to alert staff to individuals entering or leaving the building in an unauthorized manner. A home need not use an automated alert for an exit door when the particular exit is always staffed by a receptionist or other staff member who views and maintains a log of individuals entering and leaving the home. If the exit door is not always staffed, then the home must have a system that activates an automated alert when the door is not attended;

(h) A communication system(s) which permit staff in the unit to communicate with other staff outside the unit with emergency services personnel as needed; and

(i) A unit or home which undergoes major renovation or is first constructed after December 9, 2009 must be designed and constructed in compliance with applicable state and local building and fire codes relevant to the specialized unit and the home.

(5) **Staffing and Initial Staff Orientation.** The home must ensure that the contained unit is staffed at all times with sufficient specially trained staff to meet the unique needs of the residents in the unit, including the following:

(a) Medications for residents living in the memory care unit must be provided to the residents by either or both of the following:

1. A licensed registered nurse or a licensed practical nurse who is working under the supervision of a licensed physician or registered nurse.

2. A proxy caregiver employed by the home in compliance with the Rules and Regulations for Proxy Caregivers, Chapter 111-8-100.

(b) At least one awake staff member who is supervising the unit at all times and sufficient numbers of trained staff on duty at all times within the unit to meet the needs of the residents.

(c) Staff who, prior to caring for residents independently, have successfully completed an orientation program that includes at least the following components in addition to the general training required in Rule 111-8-62-.09:

1. The home's philosophy related to the care of residents with dementia in the unit.

2. The home's policies and procedures related to care in the unit and the staff's particular responsibilities including wandering and egress control.

3. An introduction to common behavior problems characteristic of residents residing in the unit and appropriate behavior management techniques.

(6) Initial Staff Training. Within the first six months of employment, staff assigned to the unit must receive training in the following topics:

(a) The nature of Alzheimer's disease and other dementias, including the definition of dementia, the need for careful diagnosis and knowledge of the stages of Alzheimer's disease

(b) Common behavior problems and appropriate behavior management techniques.

(c) Communication skills that facilitate better resident-staff relations.

(d) Positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills.

(e) The role of the family in caring for residents with dementia, as well as the support needed by the family of these residents.

(f) Environmental modifications that can avoid problematic behavior and create a more therapeutic environment.

(g) Development of comprehensive and individual service plans and how to update or provide relevant information for updating and implementing them consistently across all shifts, including establishing a baseline and concrete treatment goals and outcomes.

(h) New developments in diagnosis and therapy that impact the approach

to caring for the residents in the special unit.

(i) Recognizing physical or cognitive changes in the resident that warrant seeking medical attention.

(k) Maintaining the safety of residents with dementia.

(7)Special Admission Requirements for Unit Placement. Residents must have a Report of Physical Examination completed by a licensed physician, nurse practitioner or physician's assistant within 30 days prior to admission to the home or unit on forms provided by Department. The physical examination must clearly reflect that the resident has a diagnosis of probable Alzheimer's disease or other dementia and has symptoms which demonstrate a need for placement in the specialized unit. However, the unit may also care for a resident who does not have a probable diagnosis of Alzheimer's disease or other dementia, but desires to live in the unit as a companion to a resident with a probable diagnosis of Alzheimer's Disease or other dementia with which the resident has a close personal relationship. In addition, the physical examination report must establish that each potential resident of the unit does not require 24-hour skilled nursing care.

(8) Post-Admission Assessment. The home must assess each resident's care needs to include the following components: resident's family supports, level of activities of daily living functioning, physical care needs and level of behavior impairment. Individual Service Plans: The post-admission assessment must be used to develop the resident's individual service plan within 14 days of admission. The service plan must be developed by a team with at least provides care to the resident. All team members participating must sign the service plan and the service plan must be shared with the direct care staff providing care to the resident and serve as a guide for the delivery of services to the resident. The service plan must include the following:

A description of the resident's care and social needs and the services to be provided, including frequency to address care and social needs.

(a) Residents expressed preferences regarding care, activities and interests.
(b) Specific behaviors to be addressed with interventions to be used.
(c) Names of staff primarily responsible for implementing the service plan.
(d) Evidence of family involvement in the development of the plan when appropriate.
(e) Evidence of the service plan being updated at least quarterly or more frequently if the needs of resident change substantially.

Therapeutic Activities. The unit must provide therapeutic activities appropriate to the needs of the individual residents and adapt the activities, as necessary, to encourage the participation of the residents. The following kinds of therapeutic activities must be provided at least weekly with a least some therapeutic activities occurring daily:

(f) Gross motor activities; e.g. exercise, dancing, gardening, cooking, other outdoor activities
(g) Self-care activities; e.g. dressing, personal hygiene/grooming

(h) Social activities; e.g. games, music, crafts

(i) Sensory enhancement activities, e.g. distinguishing pictures and picture books, reminiscing and scent and tactile stimulation.

(9) No licensed personal care home may provide or hold itself out as providing specialized care for residents with probable Alzheimer's disease or other dementia or charge a differential rate for care of residents with cognitive deficits that place the residents at risk of engaging in unsafe wandering activities (eloping) unless it meets the additional requirements specified in Rule 111-8-62-.19.

Authority: O.C.G.A. §§31-2-7, 31-7-1, 31-7-2, 31-7-2.1, 31-7-12, 31-8-180 et seq. and 43-26-32.

Appendix VI: Rules of the Department of Community Health Nursing Homes; includes mandated rules for nursing homes related to social service needs of all patients

111-8-56-.07 Social Service

(1) Each home shall provide services to assist all patients in dealing with social and related problems through one or more case-workers on the staff of the facility or through arrangements with an appropriate outside agency.

(2) Social service information concerning each patient shall be obtained and kept. This information shall cover social and emotional factors related to the patient's condition and information concerning his home situation, financial resources and relationships with other people.

(3) All nursing personnel and employees having contact with patients shall receive social service orientation and in- service training toward understanding emotional problems and social needs of patients.

(4) One person in each home shall be designated as being responsible for the social services aspects of care in the home.

Authority: O.C.G.A. §§ 31-2-4 et seq. and 31-7-1 et seq.

Appendix VII: Code Of Federal Regulations 42CR483.152 For Nursing Aides; Includes Regulations For Nursing Aides Related To Caring For Dementia Patients

§ 483.152 Requirements for approval of a nurse aide training and competency evaluation program.

(a) For a nurse aide training and competency evaluation program to be approved by the State, it must, at a minimum—

(1) Consist of no less than 75 clock hours of training;

(2) Include at least the subjects specified in paragraph (b) of this section;

(3) Include at least 16 hours of supervised practical training. *Supervised practical training* means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse;

(4) Ensure that—

(i) Students do not perform any services for which they have not trained and been found proficient by the instructor; and

(ii) Students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse;

(5) Meet the following requirements for instructors who train nurse aides;

(i) The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long term care facility services;

(ii) Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides;

(iii) In a facility-based program, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility who is prohibited from performing the actual training; and

(iv) Other personnel from the health professions may supplement the instructor, including, but not limited to, registered nurses, licensed practical/vocational nurses, pharmacists, dietitians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physical and occupational therapists, activities specialists, speech/language/hearing therapists, and resident rights experts. Supplemental personnel must have at least 1 year of experience in their fields;

(6) Contain competency evaluation procedures specified in § 483.154.

(b) The curriculum of the nurse aide training program must include—

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

(i) Communication and interpersonal skills;

(ii) Infection control;

(iii) Safety/emergency procedures, including the Heimlich maneuver;

(iv) Promoting residents' independence; and

(v) Respecting residents' rights.

(2) Basic nursing skills;

(i) Taking and recording vital signs;

(ii) Measuring and recording height and weight;

(iii) Caring for the residents' environment;

(iv) Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor; and

(v) Caring for residents when death is imminent.

(3) Personal care skills, including, but not limited to—

(i) Bathing;

(ii) Grooming, including mouth care;

(iii) Dressing;

(iv) Toileting;

(v) Assisting with eating and hydration;

(vi) Proper feeding techniques;

(vii) Skin care; and

(viii) Transfers, positioning, and turning.

(4) Mental health and social service needs:

(i) Modifying aide's behavior in response to residents' behavior;

(ii) Awareness of developmental tasks associated with the aging process;

(iii) How to respond to resident behavior;

(iv) Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity; and

(v) Using the resident's family as a source of emotional support.

(5) Care of cognitively impaired residents:

(i) Techniques for addressing the unique needs and behaviors of individual with dementia (Alzheimer's and others);

(ii) Communicating with cognitively impaired residents;

(iii) Understanding the behavior of cognitively impaired residents;

(iv) Appropriate responses to the behavior of cognitively impaired residents; and

(v) Methods of reducing the effects of cognitive impairments.

(6) Basic restorative services:

(i) Training the resident in self care according to the resident's abilities;

(ii) Use of assistive devices in transferring, ambulation, eating, and dressing;

(iii) Maintenance of range of motion;

(iv) Proper turning and positioning in bed and chair;

(v) Bowel and bladder training; and

(vi) Care and use of prosthetic and orthotic devices.

(7) Residents' Rights.

(i) Providing privacy and maintenance of confidentiality;

(ii) Promoting the residents' right to make personal choices to accommodate their needs;

(iii) Giving assistance in resolving grievances and disputes;

(iv) Providing needed assistance in getting to and participating in resident and family groups and other activities;

(v) Maintaining care and security of residents' personal possessions;

(vi) Promoting the resident's right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff;

(vii) Avoiding the need for restraints in accordance with current professional standards.

Appendix VIII: Inventory Of Long-Term Dementia Care Units; An Inventory Of All Licensed Nursing Homes In GA With The Ability To Care For Dementia Patients

NURSING HOME DEMENTIA ALL STAGES

Name	Address	City	Zip Code
A G Rhodes Health and Rehab - Wesley Woods	1819 Clifton Road, N.E.	Atlanta, GA	30329
Abbeville Healthcare and Rehab	206 Main Street East	Abbeville, GA	31001
Altamaha HealthCare Center	1311 West Cherry Street	Jesup, GA	31545
Amara Healthcare and Rehabilitation	2021 Scott Road	Augusta, GA	30906
Anderson Mill Health and Rehabilitation Center	2130 Anderson Mill Road	Austell, GA	30106
Appling Nursing and Rehabilitation Pavilion	163 E Tollison Street	Baxley, GA	31513
Arrowhead Healthcare Center	239 Arrowhead Boulevard	Jonesboro, GA	30236
Autumn Breeze Health Care Center	1480 Sandtown Road, SW	Marietta, GA	30008
Avalon Health and Rehabilitation	120 Spring Street	Newnan, GA	30263
Azalea Health and Rehabilitation	300 Cedar Street	Metter, GA	30439
Baptist Village, Inc	2650 Carswell Avenue	Waycross, GA	31502
BayView Nursing Home	12884 Cleveland Street	Nahunta, GA	31553
Bell Minor Nursing Home	2200 Old Hamilton Place NE	Gainesville, GA	30507
Bethany Nursing Center of Millen	466 South Gray Street	Millen, GA	30442
Bethany Nursing Center of Vidalia	1305 East North Street	Vidalia, GA	30474
Bolingreen Health and Rehabilitation Center	529 Bolingreen Drive	Macon, GA	31210
Brandon Wilde Pavilion	4275 Owens Road	Evans, GA	30809
Brentwood Health and Rehabilitation	115 Brentwood Drive	Waynesboro, GA	30830
Brian Center of Canton	150 Hospital Circle	Canton, GA	30114
Brightmoor Health Care, Inc.	3235 Newnan Road	Griffin, GA	30224
Bryan County Health & Rehabilitation Center	127 Carter Street	Richmond Hill, GA	31324
Budd Terrace at Wesley Woods	1833 Clifton Road, N.E.	Atlanta, GA	30329
Calhoun Health Care Center Inc	1387 U S Highway 41 North	Calhoun, GA	30701
Calhoun Nursing Home	265 Turner Street	Edison, GA	39846

Name	Address	City	Zip Code
Camellia Gardens of Life Care Nursing Home	804 South Broad Street	Thomasville, GA	31792
Carrollton Manor, Incorporated	2455 Oak Grove Church Road	Carrollton, GA	30117
Cartersville Heights Care and Rehabilitation Center	78 Opal Street	Cartersville, GA	30120
Cedar Springs Health and Rehab	148 Cason Road	Cedartown, GA	30125
Cedar Valley Nursing and Rehabilitation	225 South Philpot Street	Cedartown, GA	30125
Chaplinwood Nursing Home	325 Allen Memorial Drive	Milledgeville, GA	31061
Chatsworth Health Care Center	102 Hospital Drive	Chatsworth, GA	30705
Chatuge Regional Nursing Home	386 Bel Aire Drive	Hiawassee, GA	30546
CHC Woodstock Nursing and Rehabilitation	105 Arnold Mill Road	Woodstock, GA	30188
Coastal Manor	128 Coastal Manor Drive SE	Ludowici, GA	31316
Cobb Health Care Center	2430 Paoli Road	Comer, GA	30629
Cordele Health & Rehabilitation	1106 North 4th Street	Cordele, GA	31015
Countryside Health Center	233 Carrollton Street	Buchanan, GA	30113
Crestview Health and Rehabilitation Center	2800 Springdale Road SW	Atlanta, GA	30315
Crossview Care Center	402 East Bay Street	Pineview, GA	31071
Cumming Nursing Center and Manor	2775 Castleberry Road	Cumming, GA	30041
Dade Health and Rehab	1234 Highway 301	Trenton, GA	30752
Dawson Health and Rehabilitation	1159 Georgia Avenue SE	Dawson, GA	39842
Delmar Gardens of Smyrna	404 King Spings Village Park	Smyrna, GA	30082
Douglasville Nursing and Rehabilitation Center, LLC	4028 Highway 5	Douglasville, GA	30135
Dublinair Health Care & Rehabilitation Center	300 Industrial Blvd	Dublin, GA	31021
Early Memorial Nursing Home	11740 Columbia Street	Blakely, GA	39823
East Lake Arbor	304 Fifth Avenue	Decatur, GA	30030
Eastman Healthcare and Rehab	556 Chester Hwy	Eastman, GA	31023
Eatonton Health & Rehab Center	125 Sparta Highway, 16 East	Eatonton, GA	31024
Elberta Health Care	419 Elberta Road	Warner Robins, GA	31093
Emanuel County Nursing Home - Emanuel Medical Center	117 Kite Road	Swainsboro, GA	30401

Name	Address	City	Zip Code
Evergreen Health and Rehab	139 Moran Lake Road	Rome, GA	30161
Fairburn Healthcare Center	178 West Campbellton Street	Fairburn, GA	30213
Fifth Avenue Health Care Center	505 North 5th Avenue	Rome, GA	30165
Florence Hand Home	200 Medical Drive	LaGrange, GA	30240
Fort Valley Health and Rehab	604 Bluebird Boulevard	Fort Valley, GA	31030
Fountainview Center for Alzheimers Disease	2631 North Druid Hills Road	Atlanta, GA	30329
Friendship Health and Rehab	161 Friendship Road	Cleveland, GA	30528
Gateway Health and Rehabilitation	3201 Westmoreland Road	Cleveland, GA	30528
Genesis Healthcare at Folkston Park	36261 Okefenokee Drive	Folkston, GA	31537
Gilmer Nursing Home	1362 South Main Street	Ellijay, GA	30540
Glenn-Mor Nursing Home	10629 US Highway 19	Thomasville, GA	31792
Glenwood Healthcare	303 North 5th Street	Glenwood, GA	30428
Gold City Convalescent Center	222 Moores Drive	Dahlonega, GA	30533
Golden Living Center - Jesup	1090 West Orange Street	Jesup, GA	31545
Golden Living Center - Thomaston	310 Avenue F	Thomaston, GA	30286
Golden Living Center Augusta	1600 Anthony Road	Augusta, GA	30904
Goodwill Healthcare and Rehab LLC	4373 Houston Avenue	Macon, GA	31206
Gordon Health and Rehabilitation	1280 Mauldin Road	Calhoun, GA	30701
Grace Healthcare of Tucker	2165 Idlewood Road	Tucker, GA	30084
Gracemore Nursing & Rehabilitation	2708 Lee Street	Brunswick, GA	31520
Green Acres Health and Rehabilitation	313 Allen Memorial Drive, S	Milledgeville, GA	31061
Habersham Home	541 Hwy 441 North	Demorest, GA	30535
Haralson Nursing and Rehab Center	315 Field Street	Bremen, GA	30110
Hart Care Center	261 Fairview Avenue	Hartwell, GA	30643
Hartwell Health Care	94 Cade Street	Hartwell, GA	30643
Hazlehurst Court Care & Rehabilitation Center	180 Burketts Ferry Road	Hazlehurst, GA	31539
Heardmont Health Care Inc	1043 Longstreet Road	Elberton, GA	30635
Heart of Georgia Nursing Home	815 Legion Drive	Eastman, GA	31023

Name	Address	City	Zip Code
Heritage Healthcare at Shepherd Hills	800 Patterson Road	LaFayette, GA	30728
Heritage Healthcare at Sunrise	2709 South Main Street	Moultrie, GA	31768
Heritage Healthcare of Fort Oglethorpe	1067 Battlefield Parkway	Fort Oglethorpe, GA	30742
Heritage Healthcare of Franklin	360 South River Road	Franklin, GA	30217
Heritage Healthcare of Jasper	1350 East Church Street	Jasper, GA	30143
Heritage Healthcare of LaFayette	205 Road Runner Boulevard	LaFayette, GA	30728
Heritage Healthcare of Lilburn	788 Indian Trail Road	Lilburn, GA	30047
Heritage Healthcare of Macon	2255 Anthony Road	Macon, GA	31204
Heritage Healthcare of Toccoa	633 Falls Road	Toccoa, GA	30577
Heritage Healthcare of West Atlanta	2645 Whiting Street N.W.	Atlanta, GA	30318
Heritage Inn Health and Rehabilitation Center	307 Jones Mill Road	Statesboro, GA	30458
Jeffersonville Nursing Home and Rehabilitation Center	113 Spring Valley Drive	Jeffersonville, GA	31044
Jesup Health and Rehab	3100 Savannah Hwy	Jesup, GA	31545
Kindred Transitional Care and Rehab - Marietta	26 Tower Road	Marietta, GA	30060
Lanier Village Estates - WillowBrooke Court	4000 Village View Drive	Gainesville, GA	30506
Life Care Center of Gwinnett	3850 Safehaven Drive	Lawrenceville, GA	30044
Life Care Center of Lawrenceville	210 Collins Industrial Way	Lawrenceville, GA	30043
Lumber City Nursing & Rehabilitation Center	93 GA Hwy 19	Lumber City, GA	31549
Magnolia Manor - St. Simons	2255 Frederica Road	St. Simons Island, GA	31522
Magnolia Manor - West	2000 Warm Springs Road	Columbus, GA	31904
Magnolia Manor Methodist Nursing Center	2001 South Lee Street	Americus, GA	31709
Maple Ridge Health Care Center	22 Maple Ridge Drive SE	Cartersville, GA	30121
McRae Manor Nursing Home, Inc.	160 South 1st Avenue	McRae, GA	31055
Meadowbrook Nursing Home	4608 Lawrenceville Highway	Tucker, GA	30084
Medical Management Health & Rehab Center	1509 Cedar Avenue	Macon, GA	31204

Name	Address	City	Zip Code
Miller Nursing Home	206 Grace Street	Colquitt, GA	39837
Molena Health & Rehab	185 Hill Street	Molena, GA	30258
Mountain View Health Care	547 Warwoman Road	Clayton, GA	30525
Muscogee Manor and Rehab Center	7150 Manor Road	Columbus, GA	31907
New Horizons Limestone	2020 Beverly Road NE	Gainesville, GA	30501
New London Health Center	2020 McGee Road	Snellville, GA	30078
NHC Healthcare - Rossville	1425 McFarland Avenue	Rossville, GA	30741
NHC of Fort Oglethorpe	2403 Battlefield Parkway	Fort Oglethorpe, GA	30742
Northeast Atlanta Health and Rehab	1500 South Johnson Ferry R	Atlanta, GA	30319
Nursecare of Buckhead	2920 Pharr Court South, N.W	Atlanta, GA	30305
Oaks Health Center at The Marshes of Skidaway	95 Skidaway Island Park Road	Savannah, GA	31411
Oakview Health and Rehabilitation	960 Highland Avenue	Summerville, GA	30747
Orchard Health and Rehabilitation	1321 Pulaski School Road	Pulaski, GA	30451
Palmyra Nursing Home	1904 Palmyra Road	Albany, GA	31701
Parkside at Hutcheson	110 Park City Road	Rossville, GA	30741
Peachbelt Health & Rehab Center	801 Elberta Road	Warner Robins, GA	31093
Pinewood Manor	277 Commerce Street	Hawkinsville, GA	31036
Pinewood Nursing Center	433 North McGrift Street	Whigham, GA	39897
Pleasant View Nursing Center	475 Washington Street	Metter, GA	30439
Presbyterian Village	2000 East-West Connector	Austell, GA	30106
Ridgewood Manor Health and Rehabilitation	1110 Burleyson Drive	Dalton, GA	30720
Roberta Health and Rehab	420 Myrtle Drive	Roberta, GA	31078
Rockdale Healthcare Center	1510 Renaissance Drive NE	Conyers, GA	30012
Rockmart Nursing and Rehabilitation Center	528 Hunter Street	Rockmart, GA	30153
Rosemont Of Stone Mountain	5160 Spring View Avenue	Stone Mountain, GA	30083
Rosewood Nursing Center	2795 Finney Circle	Macon, GA	31217
Ross Memorial Health Care Center	1780 Old Highway 41 N.W.	Kennesaw, GA	30152
Roswell Nursing and Rehabilitation Center	1109 Green Street	Roswell, GA	30075
Sadie G. Mays Health and Rehabilitation Center	1821 Anderson Avenue, N.W	Atlanta, GA	30314
Savannah Beach Nursing and Rehabilitation Center	90 Van Horne Street	Tybee Island, GA	31328

Name	Address	City	Zip Code
Shady Acres Health and Rehabilitation	1310 West Gordon Street	Douglas, GA	31533
Shamrock Nursing & Rehabilitation Center	1634 Telfair Street	Dublin, GA	31021
Smith Medical Nursing Care Center	501 East McCarty Street	Sandersville, GA	31082
Southern Traditions	144 Depot Street	Buchanan, GA	30113
Southland Care Center	606 Simmons Street	Dublin, GA	31021
Sparta Health Care Center	11744 Highway 22	Sparta, GA	31087
Spring Harbor at Green Island	100 Spring Harbor Drive	Columbus, GA	31904
Summerhill Senior Community	500 Stanley Street	Perry, GA	31069
Summerhill Senior Community- Veranda West	500 Stanley Street	Perry, GA	31069
Summit Health and Rehab	2 Three Mile Road	Rome, GA	30165
Sylvester Health Care	104 Monk Street	Sylvester, GA	31791
Tattnall Healthcare Center	142 Memorial Drive	Reidsville, GA	30453
The Oaks at Limestone	2560 Flintridge Road	Gainesville, GA	30501
The Oaks at Scenic View	205 Peach Orchard Road	Baldwin, GA	30511
The Oaks of Carrollton	921 Old Newnan Road	Carrollton, GA	30117
The Retreat	Jasper Memorial Hospital	Monticello, GA	31064
Thomson Health and Rehabilitation Center	511 Mount Pleasant Road	Thomson, GA	30824
Townsend Park Health and Rehabilitation	196 North Dixie Avenue	Cartersville, GA	30120
Treutlen County Health and Rehabilitation	2249 College Street North	Soperton, GA	30457
Twin Fountains Home	1400 Hogansville Road	LaGrange, GA	30240
Twin View Health Care Center	211 Mathis Avenue	Twin City, GA	30471
Unihealth Post Acute Care - Marietta	50 Saine Drive	Marietta, GA	30008
UniHealth Post Acute Care- Athens Heritage	960 Hawthorne Avenue	Athens, GA	30606
UniHealth Post-Acute Care - Greenville	99 Hillhaven Road	Greenville, GA	30222
Union County Nursing Home	550 Hospital Circle	Blairsville, GA	30512
University Extended Care - Westwood, Inc.	561 University Drive	Evans, GA	30809
University Nursing & Rehabilitation	180 Epps Bridge Road	Athens, GA	30606
UPAC Savannah	12825 White Bluff Road	Savannah, GA	31419
Warrenton Health and Rehabilitation Center	813 Atlanta Highway	Warrenton, GA	30828

Name	Address	City	Zip Code
Wellstar Paulding Nursing Center	600 West Memorial Drive	Dallas, GA	30132
Westbury Health and Rehab Center	1420 Milstead Road	Conyers, GA	30012
Westminster Commons	560 St. Charles Avenue, N.E	Atlanta, GA	30308
Wildwood Health Care Inc	184 Pin Hook Road	Talking Rock, GA	30175
Winthrop Health and Rehab	12 Chateau Drive	Rome, GA	30161
Wood Dale Health and Rehabilitation	1102 Burleyson Drive	Dalton, GA	30720
Woodland Health Care and Rehabilitation Center	625 North Coastal Highway 1	Midway, GA	31320
Wrightsville Nursing Home	337 West Court Street	Wrightsville, GA	31096
Wynfield Park Health and Rehabilitation	223 West 3rd Avenue	Albany, GA	31701
Zebulon Park Health & Rehabilitation	343 Plantation Way	Macon, GA	31210

NURSING HOME DEMENTIA SEPARATE SECURED UNIT

Name	Address	City	Zip Code
A G Rhodes Health and Rehab - Wesley Woods	1819 Clifton Road, N.E.	Atlanta, GA	30329
Amara Healthcare and Rehabilitation	2021 Scott Road	Augusta, GA	30906
Bethany Nursing Center of Millen	466 South Gray Street	Millen, GA	30442
Brandon Wilde Pavilion	4275 Owens Road	Evans, GA	30809
Brentwood Health and Rehabilitation	115 Brentwood Drive	Waynesboro, GA	30830
Budd Terrace at Wesley Woods	1833 Clifton Road, N.E.	Atlanta, GA	30329
Camellia Health and Rehabilitation	700 East Long Street	Claxton, GA	30417
Chaplinwood Nursing Home	325 Allen Memorial Drive	Milledgeville, GA	31061
Chatsworth Health Care Center	102 Hospital Drive	Chatsworth, GA	30705
CHC Woodstock Nursing and Rehabilitation	105 Arnold Mill Road	Woodstock, GA	30188
Christian City Convalescent Center	7300 Lester Road	Union City, GA	30291
Coastal Manor	128 Coastal Manor Drive SE	Ludowici, GA	31316
Cordele Health & Rehabilitation	1106 North 4th Street	Cordele, GA	31015
Crossview Care Center	402 East Bay Street	Pineview, GA	31071

Douglasville Nursing and Rehabilitation Center, LLC	4028 Highway 5	Douglasville, GA	30135
Evergreen Health and Rehab	139 Moran Lake Road	Rome, GA	30161
Fifth Avenue Health Care Center	505 North 5th Avenue	Rome, GA	30165
Fountainview Center for Alzheimers Disease	2631 North Druid Hills Road	Atlanta, GA	30329
Heritage Healthcare of Macon	2255 Anthony Road	Macon, GA	31204
Lake City Nursing and Rehabilitation	2055 Rex Road	Lake City, GA	30260
Life Care Center of Lawrenceville	210 Collins Industrial Way	Lawrenceville, GA	30043
Magnolia Manor - West	2000 Warm Springs Road	Columbus, GA	31904
Magnolia Manor Methodist Nursing Center	2001 South Lee Street	Americus, GA	31709
Maple Ridge Health Care Center	22 Maple Ridge Drive SE	Cartersville, GA	30121
McRae Manor Nursing Home, Inc.	160 South 1st Avenue	McRae, GA	31055
Northeast Atlanta Health and Rehab	1500 South Johnson Ferry R	Atlanta, GA	30319
Nursecare of Buckhead	2920 Pharr Court South, N.W	Atlanta, GA	30305
Oakview Health and Rehabilitation	960 Highland Avenue	Summerville, GA	30747
Orchard Health and Rehabilitation	1321 Pulaski School Road	Pulaski, GA	30451
Powder Springs Nursing and Rehab Center	3460 Powder Springs Road	Powder Springs, GA	30127
Presbyterian Village	2000 East-West Connector	Austell, GA	30106
Ridgewood Manor Health and Rehabilitation	1110 Burleyson Drive	Dalton, GA	30720
River Towne Center	5131 Warm Springs Road	Columbus, GA	31909
Riverdale Place	315 Upper Riverdale Road	Riverdale, GA	30274
Rosemont Of Stone Mountain	5160 Spring View Avenue	Stone Mountain, GA	30083
Roswell Nursing and Rehabilitation Center	1109 Green Street	Roswell, GA	30075
Signature Healthcare of Buckhead	54 Peachtree Park Drive	Atlanta, GA	30309
Sparta Health Care Center	11744 Highway 22	Sparta, GA	31087
Summerhill Senior Community	500 Stanley Street	Perry, GA	31069
Summerhill Senior Community- Veranda West	500 Stanley Street	Perry, GA	31609
Tattnall Healthcare Center	142 Memorial Drive	Reidsville, GA	30453

Thomson Health and Rehabilitation Center	511 Mount Pleasant Road	Thomson, GA	30824
Townsend Park Health and Rehabilitation	196 North Dixie Avenue	Cartersville, GA	30120
Traditions Health and Rehab Center	2816 Evans Mill Road	Lithonia, GA	30058
UniHealth Post-Acute Care - Old Capital	310 Highway 1 Bypass	Louisville, GA	30434
University Extended Care - Westwood, Inc.	561 University Drive	Evans, GA	30809
UPAC Savannah	12825 White Bluff Road	Savannah, GA	31419
Warrenton Health and Rehabilitation Center	813 Atlanta Highway	Warrenton, GA	30828
Wellstar Paulding Nursing Center	600 West Memorial Drive	Dallas, GA	30132
Westbury Health and Rehabilitation Center of McDonough	198 Hampton Street	McDonough, GA	30253
Westminster Commons	560 St. Charles Avenue, N.E	Atlanta, GA	30308
Wood Dale Health and Rehabilitation	1102 Burleyson Drive	Dalton, GA	30720
Woodland Health Care and Rehabilitation Center	625 North Coastal Highway 1	Midway, GA	31320

PERSONAL CARE HOME DEMENTIA CASE BY CASE

Name	Address	City	Zip Code
A 1 Belinda Winfrey PCH	1833 Empress Court	Augusta, GA	30906
A Better Home Care	2700 Stancil Boulevard	Jonesboro, GA	30326
A Home for Mom and Dad	2560 Johnson Drive	Doraville, GA	30340
A Loving Heart Personal Care Home	3437 Gebhart Court	Hephzibah, GA	30815
A Place for Comfort	1766 Big Valley Lane	Stone Mountain, GA	30083
A Touch of Home for the Elderly	503 East Jefferson Street	Americus, GA	31709
AAA Holly House	1680 Northwoods Drive	Marietta, GA	30066
Abundant Living Personal Care	883 Roy Woods Road	Comer, GA	30629
Adam and Eve Personal Care Home	5169 Covington Highway	Decatur, GA	30035
Adonis Personal Care Home	1409 Greenview Way	Lawrenceville, GA	30044
Agape Living	1840 Phinizy Road	Augusta, GA	30906
Agape Personal Care Home of Macon LLC	4732 Sgoda Road	Macon, GA	31217
Akinson Residential and Community Healthcare	5153 Grovefield Place	Lithonia, GA	30038

Name	Address	City	Zip Code
Services			
Alberta Gregory Personal Care Home	2102 Kennedy Drive	Augusta, GA	30904
Alero Personal Care Home Inc	230 Trelawny Circle	Covington, GA	30016
All Partners In Care Services	2266 Stone Drive	Lilburn, GA	30047
All Season Personal Care Home	55 Hickory Circle	Carrollton, GA	30116
Alzheimers Care of Commerce	200 Bolton Drive	Commerce, GA	30529
Amazing Grace Personal Care Home	206 Reynolds Street	Augusta, GA	30901
Amazing Grace Personal Care Home #2 - Augusta	1307 Cabana Court	Augusta, GA	30909
Amelia Gardens I	545 Toonigh Road	Woodstock, GA	30188
Amelia Gardens II	2030 Bascomb Carmel Road	Woodstock, GA	30189
Andras AA Personal Care Home	1736 Jenkins Street	Augusta, GA	30904
Angel 2 Angel TLC	2644 Dogwood Drive	Valdosta, GA	31602
Angels Care Personal Care Home	2620 Richmond Hill Road	Augusta, GA	30906
Angels Royal Gardens Personal Care Home	7752 Marabou Lane	Riverdale, GA	30274
Anna P's Personal Care Home	25 Clarion Court	Covington, GA	30016
Annette Holleys Personal Care Home #2	4515 Colonial Road	Martinez, GA	30907
Anns Phenomenal Care Home	2102 Hillsinger Road	Augusta, GA	30904
Anointed Hands PCH	3193 Old Monroe Madison H	Monroe, GA	30655
Antebellum Grove Assisted Living	1010 Kathryn Ryals Road	Warner Robins, GA	31088
Anthonys Personal Care Home	2329 Cadden Road	Augusta, GA	30906
Antias Tender Touch	725 Fincher Road	Covington, GA	30016
Apache Personal Care Home	3135 Apache Drive	Columbus, GA	31909
Arbor Terrace at Cascade	1001 Research Center	Atlanta, GA	30331
Arbor Terrace at Tucker	5844 Highway 29	Tucker, GA	30084
Arbor Terrace at West Cobb	3829 Floyd Road	Austell, GA	30106
Aryoak PCH	425 Ryoaks Drive	Hampton, GA	30228

Name	Address	City	Zip Code
Ashley Manor Personal Care Home	532 Dickson Road	Marietta, GA	30066
Atherton Place	111 Tower Road	Marietta, GA	30060
Atria Buckhead	2848 Lenox Road	Atlanta, GA	30324
Augusta Gardens Retirement Residence	3725 Wheeler Road	Augusta, GA	30909
Autumn Breeze Assisted Living	2215 Old Hamilton Place	Gainesville, GA	30507
Autumn House	3059 Nottaway Court	Chamblee, GA	30341
Autumn Square Personal Care Home	2455 Oak Grove Church Road	Carrollton, GA	30117
Autumn Terrace II	1026 Keith Drive	Perry, GA	31069
Autumn Terrace III	1026 Keith Drive	Perry, GA	31069
Autumn Years	60 Massell Drive SE	Cartersville, GA	30121
Averett's Personal Care Home	1401 20th Street	Columbus, GA	31901
Avondale Assisted Living at Kensington	3508 Kensington Road	Decatur, GA	30032
Avondale Assisted Living at Northlake	3965 Gloucester Drive	Tucker, GA	30084
Avondale Homes at Tucker	2553 Sandpiper Drive	Tucker, GA	30084
Azalea Estates	105 Autumn Glen Circle	Fayetteville, GA	30215
Azalea House	1896 Ludovie Lane	Decatur, GA	30033
Baptist Village Lake Park	763 Johnston Way	Lake Park, GA	31636
Barbara Ray Halls Personal Care Home	2638 Castletown Drive	Hephzibah, GA	30815
Bargerons Personal Care Home	2903 Milledgeville Road	Augusta, GA	30904
Beasley's Personal Care Home	310 South 3rd Street	Stillmore, GA	30464
Belair at Macon, The	4901 Harrison Road	Macon, GA	31206
Bellevue Manor	903 A Bellevue Avenue	Dublin, GA	31021
Belmont Village	5455 Glenridge Drive	Atlanta, GA	30342
Bentley Assisted Living at Northminster	50 Sumner Way	Jefferson, GA	30549
Bessie Maes Personal Care Home	910 Quaker Road Drive	Waynesboro, GA	30830
BestCare Assisted Living	2775 Cruse Road; #1401	Lawrenceville, GA	30044
Bethany Assisted Living, Inc.	1400 Northeast Main Street	Vidalia, GA	30474
Bethel Gardens Senior Living	3805 Jackson Way	Powder Springs, GA	30127
Betty Saxons Personal Care Home	1125 Piney Grove Road	Augusta, GA	30906
Betty's Personal Care Home	17 Arabian Trail	Swainsboro, GA	30401

Name	Address	City	Zip Code
Blair House Senior Living Community	684 Arlington Place	Macon, GA	31201
Blair Sunshine Home, The	69 Taylor Trail	Wrightsville, GA	31096
Bless To The Max	5870 GA Highway 57	Gordon, GA	31031
Blossom Personal Care Home	2494 Lillies Trace	Dacula, GA	30019
Bradley Place	418 Park Avenue North	Tifton, GA	31794
Brians Personal Care Home	3010 Deerfield Way	Rex, GA	30273
Briceland Personal Care Home	1380 West Poplar Street	Griffin, GA	30223
Brickhaven Assisted Living	1807 12th Avenue	Albany, GA	31707
Bright Way Personal Care Home	8829 Hamilton Road	Pine Mountain, GA	31822
Brighter Beginning PCH	800 Chapel Hill Drive	Lawrenceville, GA	30045
Brighter Day PCH	2720 Colorado Street	Columbus, GA	31906
Brighter Mornings at the Shoals	7456 Highway 82 Spur	Maysville, GA	30558
Brightmoor Assisted Living	3223 Newnan Road	Griffin, GA	30224
Brighton Gardens of Buckhead	3088 Lenox Road	Atlanta, GA	30324
Brittany House at Benson Heights	1788 Sandy Plains Road	Marietta, GA	30066
Brittany's Place Assisted Living	141 Denis Drive	Jeffersonville, GA	31044
Broderick Personal Care Home	114 Chapel Street	Greensboro, GA	30642
Brookdale Place of Augusta	326 Boy Scout Road	Augusta, GA	30909
Brooks Home Care	2408 Mims Road	Hephzibah, GA	30815
Brookside Glen	400 Bradley Park Drive	Columbus, GA	31904
Brown Personal Care Home	554 Idlewood Road	Waynesboro, GA	30830
Bryants of Peace Personal Care Home	339 Marshall Street	Martinez, GA	30907
Buckingham South	5450 Abercorn Street	Savannah, GA	31405
Burst of Joy	396 7th Avenue SE	Cairo, GA	39828
Burton Homecare Assisted Living	21 Ivywood Drive	Hull, GA	30646
Burton Homecare Assisted Living	447 Reese Street	Athens, GA	30601
C & G Care Whispers	841 Overlook Trail	Monroe, GA	30655
Cambridge Farms Assisted Living	4040 Webb Bridge Road	Alpharetta, GA	30005
Camden Place Assisted Living	115 Dodd Circle	Statesboro, GA	30458
Cameron Hall of Ellijay	114 Penland Street	Ellijay, GA	30540
Camilla Retirement Home	161 East Broad Street	Camilla, GA	31730

Name	Address	City	Zip Code
Campbell-Stone Sandy Springs	350 Carpenter Drive, NE	Atlanta, GA	30328
Candler Ridge II	1205 Nunnally Drive	Monroe, GA	30655
Cannonwood Village	2834 Old US Highway 441 S	Tiger, GA	30576
Care Givers & More Elderly Care Services	6602 Shucraft Road	Appling, GA	30802
Carehouse SSHINE LLC Personal Care Home	166 Alfred Payne Road	Danville, GA	31017
Caring 4 U	1508 Jonathan Place	Hephzibah, GA	30815
Caring 4 You	4945 Golden Circle	Mableton, GA	30126
Caring Hands Assisted Living	1741 Highway 138	Riverdale, GA	30296
Caring Hearts PCH	430 South Broad Street	Monroe, GA	30655
Caring Hearts PCH #2	10 Dial Road	Monroe, GA	30658
Carlyle Place - Cambridge Court	5300 Zebulon Road	Macon, GA	31210
Carols Place	2662 Barclay Street	Hephzibah, GA	30815
Carolyn's II	202 East Adair Street	Valdosta, GA	31601
Carolyn's Personal Care Home	525 Green Street	Valdosta, GA	31601
Carriage House of Royal Southern Plantation	690 Tommy Lee Fuller Drive	Loganville, GA	30052
Cecil Rice Personal Care Home	753 Mangham Road	Griffin, GA	30224
Cedar Hill Senior Living Community	402 East Ellawood Avenue	Cedartown, GA	30125
Cedar Personal Care Home	526 Cedar Street	Oglethorpe, GA	31068
Celestial Care Services	6571 Valley Hill Drive	Mableton, GA	30126
Chambrel at Roswell	1000 Applewood Drive	Roswell, GA	30076
Champeunes Personal Care Home	3439 Rushing Road	Augusta, GA	30906
Charis Personal Care Home	1914 Skidaway Road	Savannah, GA	31404
Charms Personal Care Home	900 West Residence Avenue	Albany, GA	31701
Chelsea House	515 Carr Street	Augusta, GA	30904
Cherokee Angel PCH #3	326 Heights Place	Canton, GA	30114
Chestnut Manor Personal Care Home	13 Chestnut Street	Griffin, GA	30223
Choice Care Assisted Living Inc.	4930 Highway 20	Loganville, GA	30052
Christian Care Home #2	114 Jacqueline Terrace	Milledgeville, GA	31061
Church Street Manor	425 West Church Street	Swainsboro, GA	30401
Churchill Manor	143 Mayfield Road	Alpharetta, GA	30009

Name	Address	City	Zip Code
Circle of Care Personal Care Home	3731 Fairington Drive	Hephzibah, GA	30815
Clarice Green Family PCH	1220 Dogwood Road North	Woodville, GA	30669
Clary Care Center	249 Hospital Drive	Toccoa, GA	30577
Coastal Assisted Living of St. Marys	1020 McDowell Street	St. Marys, GA	31558
Cobis Personal Care Home	7200 Manor Road	Columbus, GA	31907
College Manor	205 West College Street	Griffin, GA	30224
Colonial Gardens of Warner Robins #1	903 West Highway 96	Warner Robins, GA	31088
Colquitt Garden Manor	498 5th Street SE	Moultrie, GA	31768
Comforters	2753 Trail Creek Circle	Lithia Springs, GA	30122
Comfy Personal Care Home	2460 Skylars Mill Way	Snellville, GA	30078
Cooper House AL	2213 Augusta Highway	Lincolnton, GA	30817
Corinth Road Personal Care Home	1141 Corinth Road	Newnan, GA	30263
Cornerstone Care Home	594 Shannon Way	Lawrenceville, GA	30044
Cornerstone Care of Georgia PCH	1152 Nimblewood Way	Stone Mountain, GA	30088
Cornerstone Compassion Center, Inc.	420 Warren Road	Augusta, GA	30907
Cornerstone Group Home	919 Lawyers Lane	Columbus, GA	31906
Cornerstone Training and Develop	919 Lawyers Lane	Columbus, GA	31906
Cottage Landing	150 Cottage Lane	Carrollton, GA	30117
Cottages on Wesleyan, The	1633 Wesleyan Drive	Macon, GA	31210
Cottonfields Manor Personal Care Home	55 Plantation Drive	Stockbridge, GA	30281
Country Gardens Assisted Living	19 Hillcrest Circle	Butler, GA	31006
Country Haven Retirement Center	120 Country Haven Lane	Ringgold, GA	30736
Country Heritage II	5761 Conner Road	Flowery Branch, GA	30542
Country Living Personal Care Home	5841 Maysville Road	Commerce, GA	30529
Country Manor Estates	1487 Allen Road	Macon, GA	31216
Countryside Personal Care Home	236 Lawson Hall Drive	Waynesboro, GA	30830
Covenant Care Hamptom	120 West Tisbury Lane	Pooler, GA	31322
Covenant Care Lane	141 West Tisbury Lane	Pooler, GA	31322
Covenant Care Tisbury	126 West Tisbury Lane	Pooler, GA	31322
Covenant Woods	5424 Woodruff Farm Road	Columbus, GA	31907
Coventry Place	2806 North Decatur Road	Decatur, GA	30033

Name	Address	City	Zip Code
Cozy Manor Personal Care Home	706 North Main Street	LaFayette, GA	30728
Crabapple Hall	200 Pine Valley Drive	Alpharetta, GA	30009
Cumming Manor Personal Care	2775 Castleberry Road	Cumming, GA	30040
Cunningham's PCH	195 Bristlecone Court	Winterville, GA	30683
Daisy Vincent Personal Care Home #2	2342 Windsor Spring Road	Augusta, GA	30906
Davis Elderly Care	5275 Hereford Farm Road	Evans, GA	30809
Deep Springs Personal Care Home	20 Deep Springs Way	Covington, GA	30016
Delmar Gardens of Gwinnett	3100 Club Drive	Lawrenceville, GA	30044
Denards Personal Care Home	173 N. Hulin Avenue	Tignall, GA	30668
Denita Care PCH	1616 Flat Shoals Road	College Park, GA	30349
Dennis and Dilsie Adult Care Home	217 St. Andrew Street	Sylvania, GA	30467
Destinys Home of Comfort Personal Care Home	2529 Crosscreek Road	Hephzibah, GA	30815
Devine Trinity Personal Care Home	29 Oak Street	Hinesville, GA	31313
Diane's House II PCH	5283 Winding Glen Drive	Lithonia, GA	30038
Diane's House Personal Care	2038 Mallard Way	Lithonia, GA	30058
Divine Care 1962	1962 Neptune Drive	Augusta, GA	30906
Divine Care Assisted Living	605 Georgia Avenue	Washington, GA	30673
Divine Love Personal Care Home	943 Falling Creek Drive	Macon, GA	31220
Dogwood Bluff Personal Care Home	266 Pony Lake Lane	Dahlonega, GA	30533
Dogwood Forest of Alpharetta	253 North Main Street	Alpharetta, GA	30009
Dogwood Forest of Dunwoody	7400 Peachtree Dunwoody R	Atlanta, GA	30328
Dogwood Forest of Fayetteville	1294 Highway 54 West	Fayetteville, GA	30214
Dogwood Forest of Gainesville	3315 Thompson Bridge Road	Gainesville, GA	30506
Dogwood Gardens Senior Living	1222 Plaza Avenue	Eastman, GA	31023
Dominion Assisted Living	3645-A Cusseta Road	Columbus, GA	31903
Dry Lake Personal Care Home	4829 Dry Lake Road	Dixie, GA	31629
Duncan McRae House	129 South Railroad Avenue	Mount Vernon, GA	30445
Dynamic Personal Care Home	3363 Luxembourg Circle	Decatur, GA	30034

Name	Address	City	Zip Code
East Georgia Personal Care Home II	1371 West Peachtree Avenue	Union Point, GA	30669
Easy Living Personal Care Home	2688 Nub Garland Road	Toccoa, GA	30577
Echols Personal Care Home	5266 Lexington Road	Rayle, GA	30660
Eddie's Care Home	2613 US Hwy 84 East	Valdosta, GA	31606
Eden Personal Care Home	2438 Swan Lake Drive	Grayson, GA	30017
Edgewood of Monticello	1178 College Street	Monticello, GA	31064
Elaine Miller Personal Care Home	5413 Old Augusta Highway	Grovetown, GA	30813
Elaines Personal Care Home	626 East Riverbend Drive	Lilburn, GA	30047
Elaines Personal Care Home II	186 Lockring Drive	Lilburn, GA	30047
Ellens Personal Care Home	3229 Old Louisville Road	Augusta, GA	30906
Elmcroft at Milford Chase	1345 Milford Church Road	Marietta, GA	30008
Elmcroft of Mt. Zion	7493 Mount Zion Boulevard	Jonesboro, GA	30236
Emerald City Lodge	103 Terrace Drive	Dublin, GA	31021
Emerald Isles PCH	1402 Shadowbrook Drive	Marietta, GA	30062
Emeritus at Flint River Memory Care Community	250 Water Tower Court	Macon, GA	31210
Emeritus at Newnan	355 Millard Farmer Industrial	Newnan, GA	30263
Emeritus at Sandy Springs	1260 Hightower Trail	Atlanta, GA	30350
Emeritus at Sandy Springs Place	1262 Hightower Trail	Atlanta, GA	30350
Emeritus at Vinings	2401 Cumberland Parkway S	Atlanta, GA	30309
Emory Senior Living	2795 Scenic Highway 124	Snellville, GA	30078
enAble of Georgia at Barrington	1070 Barrington Lane Court	Alpharetta, GA	30076
enAble of Georgia at Benjamin E. Mays	2729 Benjamin E. Mays Drive	Atlanta, GA	30311
enAble of Georgia at Branchwood	2864 Branchwood Drive	East Point, GA	30344
enAble of Georgia at Crabapple	10500 Crabapple Road	Roswell, GA	30075
enAble of Georgia at Denna Drive	130 Denna Drive	Alpharetta, GA	30004
enAble of Georgia at East Hembree	805 East Hembree Crossing	Roswell, GA	30076
enAble of Georgia at Pine Grove	540 Pine Grove	Roswell, GA	30075
Enchanted Lives Personal Care Home	3613 Larkspur Drive	Augusta, GA	30906
Ettas House	1682 Pharr Road	Snellville, GA	30078

Name	Address	City	Zip Code
Evans Personal Care Home	3680 Highway 15 South	Siloam, GA	30665
Evans Personal Care Home	426 Liberty Street	Gray, GA	31032
Evening Sun Personal Care	1392 Colony East Circle	Stone Mountain, GA	30083
Evergreen Terrace	53 Northwoods Drive	Dahlonega, GA	30533
Fairhaven Assisted Living Residence	1550 Glynco Parkway	Brunswick, GA	31525
Faith Dwellings	4666 Randalwood Drive	Stone Mountain, GA	30083
Faith Hope and Grace Home	279 Cab Drive	Sylvania, GA	30467
Faith Landing Personal Care Home	1215 Hale Street	Waynesboro, GA	30830
Faith Personal Care Home	3623 Mecklinburg Place	Decatur, GA	30032
Faithfully Yours PCH	2512 Melville Avenue	Decatur, GA	30032
Falcon Crest Manor	111 Epps Street	Gordon, GA	31031
Falling Angels Two Assisted Living	4 Tahoe Drive	Savannah, GA	31405
FAM Personal Care Home	5618 Wellborn Creek Drive	Lithonia, GA	30058
FAM1 Personal Care Home	294 Tanners Bridge Road	Bethlehem, GA	30620
Family Affair Personal Care Home	525 Carlton Road	Palmetto, GA	30268
Family Pampering Center PCH #1	2180 Surrey Trail	College Park, GA	30349
Fellowship Assisted Living	277 Medical Way	Riverdale, GA	30274
Felton Manor	16 Roving Road	Cartersville, GA	30121
First Love Personal Care Home #1	2403 Wrightsboro Road	Augusta, GA	30904
First Love Personal Care Home #2	2734 Milledgeville Road	Augusta, GA	30904
Fite Living Centre	5 Fite Street	Cartersville, GA	30120
Five Ponds Personal Care Home	4688 Windsor Spring Road	Hephzibah, GA	30815
Florence Jeffersons T.L.C.	4357 Seago Road	Hephzibah, GA	30815
Foothills II Retirement Home	264 Myers Chance Road	Dahlonega, GA	30533
Foothills Retirement Home I	264 Myers Chance Road	Dahlonega, GA	30533
Frances B. Bell Personal Care Home	106 Joiner-Oglesby Road	Sardis, GA	30456
Franciscan Woods	2425 Williams Road	Columbus, GA	31909
Free Love Personal Care Home	3668 Ellington Airline Road	Dearing, GA	30808
Freedom House Augusta PCH	2006 Sibley Road	Augusta, GA	30909
Freeman Personal Care Home	1945 15th Street	Augusta, GA	30901

Name	Address	City	Zip Code
Fulcher - Nations Personal Care Home	2020 Edgar Street	Augusta, GA	30904
G & M Personal Care Home	1635 Stephenson Road	Lithonia, GA	30058
G and E Assisted Living Home	2260 Highway 77 South	Greensboro, GA	30642
G.S.E. Gantt Personal Care Home	3834 Fairington Drive	Hephzibah, GA	30815
Garden of Eden Personal Care Home	1573 Jett Roberts Road	Jefferson, GA	30549
Garden Of Love	2208 Woodward Avenue	Augusta, GA	30906
Garden View Retirement Assisted Living, Inc.	6134 College Avenue	Blackshear, GA	31516
Gardens at Royal Oaks	1218 Broadrick Drive	Dalton, GA	30720
Gardners Personal Care Home	2024 Wrightsboro Road	Augusta, GA	30901
Garrett Manor	339 Marshall Street	Martinez, GA	30907
Gaynell Hymels Personal Care Home	1029 Mosley Road	Augusta, GA	30906
Gaynell Hymels Personal Care Home II	1015 Mosley Road	Augusta, GA	30906
Gentle Services In Home Care	7363 Ovis Court	Riverdale, GA	30274
Georgia Living Center	182 Head Avenue	Tallapoosa, GA	30176
Gladys Hood Personal Care Home	4820 McComb Road	Hephzibah, GA	30815
Gods Child Personal Care Home	3719 Colbert Street	Augusta, GA	30906
Gold City Personal Care Home	350 Moores Drive	Dahlonega, GA	30533
Golden Crest Assisted Living - Eagles Landing	425 Country Club Drive	Stockbridge, GA	30281
Golden Days Quality Care Home	940 Knollwood Road	Mineral Bluff, GA	30559
Golden Life Christian Centers	2330 Ruby Drive	Augusta, GA	30906
Golden Living Community of Augusta	2237 Lee Street	Augusta, GA	30904
Golden Living Community of Augusta #2	2237 Lee Street	Augusta, GA	30904
Golden Personal Care Home I	257 Golden Road	Eastman, GA	31023
Golden Personal Care Home II	257 Golden Road	Eastman, GA	31023
Golden Pond Assisted Living Center	8167 Eisenhower Parkway	Lizella, GA	31052
Golden Retreat	503 South Goodman Street	Sparks, GA	31647
Golden Royal Orchards PCH	5112 Kelly Drive	Cohutta, GA	30710

Name	Address	City	Zip Code
Golden Rule Personal Care Home	2342 Dorn Road	Augusta, GA	30906
Golden Services Personal Care Home	930 West Magnolia Street	Valdosta, GA	31601
Golden South	705 Denham Road	Sycamore, GA	31790
Golden South II	705 Denham Road	Sycamore, GA	31790
Golff Personal Care Home	439 Drexell Avenue	Millen, GA	30442
Gospel Water Branch Elderly Housing, Inc.	672 King Taylor Road	Evans, GA	30809
Grace Manor	405 North Ridge Avenue	Tifton, GA	31794
Gracemont Assisted Living	4960 Jot-Em-Down Road	Cumming, GA	30041
Gracemont Assisted Living	4940 Jot-Em-Down Road	Cumming, GA	30041
Graces House	2 River Street	Cave Spring, GA	30124
Graces House Two	5 Raintree Drive SE	Silver Creek, GA	30173
Gracey Manor	3400 Youth Monroe Road	Loganville, GA	30052
Gramps N Grannies I	500 North Houston Road	Warner Robins, GA	31093
Gramps N Grannies II	502 North Houston Road	Warner Robins, GA	31093
Great Day PCH	2604 Whittier Place	Hephzibah, GA	30815
Greater Care Services PCH	4265 Parkwood Drive	Augusta, GA	30906
Greater Columbus Protective Care PCH	2425 Third Avenue	Columbus, GA	31901
Green Meadows PCH Corp	155 Abney Road	Cochran, GA	31014
Griffin Manor	207 West College Street	Griffin, GA	30224
Gro Shady Oaks	310 Chestnut Street	Dalton, GA	30721
Grosvenor Personal Care Home	4556 Central Drive	Stone Mountain, GA	30083
Guardian Angel	178 Green Street	Winder, GA	30680
Habersham House Senior Residence	5200 Habersham Street	Savannah, GA	31405
Halls Personal Care Home of Evans	4528 Hereford Farm Road	Evans, GA	30809
Hapeville Manor Assisted Living	601 Coleman Street	Hapeville, GA	30354
Happy Grove Cottage	2809 Club Forest Drive	Conyers, GA	30013
Harison Heights	3648 Walton Way Extension	Augusta, GA	30909
Harold Avenue PCH	1969 Harold Avenue	Smyrna, GA	30080
Harpers Personal Care Home	186 Bootlegger Lane	Washington, GA	30673
Harris House Inc.	605 South Lee Street	Fitzgerald, GA	31750
Haven of Tender Loving Care	407 W Moore Street	Dublin, GA	31021
Hearthstone of Roswell	350 Market Place	Roswell, GA	30075
Heavenly Arms	2764 1/2 Tobacco Road	Hephzibah, GA	30815

Name	Address	City	Zip Code
Heavenly Hands	3365 Tanglewood Drive	Augusta, GA	30909
Helping Hands Assisted Living LLC	525 Highway 24 East	Milledgeville, GA	31061
Helping Hands Personal Care Home 2	6260 Mozart Drive	Riverdale, GA	30296
Heritage Care Home	108 West 3rd Street	Ocilla, GA	31774
Heritage House	811 Bellevue Avenue	Dublin, GA	31021
Heritage Inn Retirement Center	14901 River Street	Blakely, GA	39823
Heritage of Brookstone	5235 Stilesboro Road N.W.	Kennesaw, GA	30152
Hickey Personal Care Home	515 Thomas Drive	Martinez, GA	30907
Higher Living Personal Care Home	650 Main Street	Warrenton, GA	30828
Highland Circle Personal Care Home	1028 Highland Circle	Conyers, GA	30012
Highland Manor	903 B Bellevue Avenue	Dublin, GA	31021
Hills House Personal Care Home	4745 Mike Padgett Highway	Augusta, GA	30906
Hilltop House Personal Care Home	1208 West Gordon Street	Quitman, GA	31643
Hollis House	407 Boulevard	LaGrange, GA	30240
Home Away From Home Personal Care Homes	8412 Red Cedar Way	Riverdale, GA	30274
Home of Love Personal Care Home	2188 Fairway Circle, SW	Atlanta, GA	30331
Home Sweet Home Personal Care Home	2459 Dublin Drive	Augusta, GA	30906
Homeplace Senior Living - Memory Care Community	345 Pearl Bates Avenue	Eastman, GA	31023
Hopewell Assisted Living	1945 Old Concord Drive	Covington, GA	30016
Horizon Bay	180 Woodrow Wilson Way	Rome, GA	30165
Horizon Bay - Vibrant Retirement Living	530 Northside Drive	Carrollton, GA	30117
House of Angels	420 Lavender Road	Athens, GA	30606
House of Angels II	260 General Daniels Avenue	Danielsville, GA	30633
House of Angels Personal Care Home	3554 Evangeline Drive	Augusta, GA	30906
House of Lord Home Care	3802 MacLand Road	Hiram, GA	30141
House of Naum Personal Care Home, The	2880 Olive Grove Church Ro	Roberta, GA	31078
House of Paradise Assisted Living, LLC	42 East Calhoun Street	Wadley, GA	30477
House of Prosperity	3702 Willow Bend Run	Columbus, GA	31907
House of Refuge	452 Cason Road	Cedartown, GA	30125

Name	Address	City	Zip Code
Humming Birds Personal Care Home	2124 Harding Road	Augusta, GA	30906
Idris Twins Personal Care Home	3778 Burnt Leaf Lane	Snellville, GA	30039
IJN Adult Personal Care Home - Atlanta	1949 Vicki Lane	Atlanta, GA	30316
In Loving Hands Care	9343 Thomas Road	Jonesboro, GA	30238
Inez Thomas Personal Care Home	3406 Richmond Hill Road	Augusta, GA	30906
Inez Thomas Personal Care Home #2	3405 Richmond Hill Road Ea	Augusta, GA	30906
Irene Johnson Personal Care Home	5018 Kennedy Street	Columbus, GA	31907
Isaac Haven Assisted Living Center	1939 Isaac Watkins Road	Montrose, GA	31065
Ivy Hall North	5690 State Bridge Road	Alpharetta, GA	30022
Ivy Springs Retirement Cottage	1408 Spring Street SE	Smyrna, GA	30080
Ivydale Personal Care Home	1836 South Main Street	Moultrie, GA	31768
Izes of an Angel	1431 Perry Avenue	Augusta, GA	30901
J R & C Assisted Living Center	2195 Waynesboro Highway	Hiltonia, GA	30467
Jabez Assisted Living II	339 E A Taylor Road	Crawfordville, GA	30631
Jackson Falls	7579 Covington Highway	Lithonia, GA	30058
Jacksons Personal Care Home	2377 Dublin Drive	Augusta, GA	30906
Jamestown Personal Care Home	300 Green Street	Fort Valley, GA	31030
Jane Smiths Personal Care Home	1809 Mavis Street	Augusta, GA	30906
Jinks Personal Care Home	609 Perham Street	Waycross, GA	31503
John Wesley Villas	5471 Thomaston Road	Macon, GA	31220
Johnnie E. Christmas Manor	3891 Manor House Drive	Marietta, GA	30062
Johns Helping Hands	2903 Larkspur Drive	Augusta, GA	30906
Jones Manor	339 Marshall Street	Martinez, GA	30907
Jones Personal Care Home	1618 Cider Lane	Augusta, GA	30906
Jonesboro Assisted Living	2620 Highway 138 S. E.	Jonesboro, GA	30236
Jordan Personal Care Home	1910 Sagemont Drive	Augusta, GA	30906
Joseph Home of Comfort PCH	3908 Fairington Drive	Hephzibah, GA	30815
Joyce Graves PCH	8488 Webb Road	Riverdale, GA	30274
Joyland Personal Care Home	430 West Broad Street	Griffin, GA	30223
Joyland Phase II	418 Meriwether Street	Griffin, GA	30223

Name	Address	City	Zip Code
Joys Manor PCH and Assisted Living	3442 Midway Road	Decatur, GA	30032
Juniper Street Personal Care Home	1313 Juniper Street	LaGrange, GA	30240
Kamga Personal Care Home	2237 Winston Way	Augusta, GA	30906
Kendrick Home	1016 Ell Street (B)	Macon, GA	31206
Kentwood Personal Care Home	1227 West Wheeler Parkway	Augusta, GA	30909
Killian Hill Personal Care Home	1538 Killian Hill Road	Lilburn, GA	30047
Kimberly Assisted Living Home	700 West Memorial Drive	Dallas, GA	30132
Kind Hearts Personal Care	3676 Lee Road	Snellville, GA	30039
Kingdom Kare PCH I	105 Wilson Street	Greensboro, GA	30642
Kingdom Kare PCH II	1061 Adrian Circle	Greensboro, GA	30642
Kings Bridge Retirement Center	3055 Briarcliff Road, N.E.	Atlanta, GA	30329
Kings Personal Kare Facility	111 Elizabeth Way	Ellenwood, GA	30294
Kingsford of Warner Robins	851 Gunn Road	Warner Robins, GA	31093
Kingsford Place	95 Progress Avenue	Hawkinsville, GA	31036
Krisscare Personal Care Home	2793 Skyland Drive	Snellville, GA	30078
L & R Personal Care	14 Sharper Circle	Valdosta, GA	31601
Lake Erma Assisted Living	103 West Main Street	Lakeland, GA	31635
Lake House Legion Lake	2928 Legion Lake Road	Douglasville, GA	30135
Lake Oconee Assisted Living Home IV	108 Oak Street	Greensboro, GA	30642
Lake Oconee Assisted Living Home V	2390 Veazey Road	Greensboro, GA	30642
Lake Pointe Assisted Living & Memory Care Community	45 Walnut Street	Hartwell, GA	30643
Lake Springs	4355 South Lee Street	Buford, GA	30518
Lakeside Rest Home	924 Crump Street	Swainsboro, GA	30401
Lakeview ITR Personal Care Home	349 Shoreline Drive	Thomasville, GA	31757
Lakeview Manor	1321 Price Mill Road	Madison, GA	30650
Lakeview Retirement Center	111 Stephens Avenue	Baxley, GA	31513
Langdale Place	2720 Windemer Drive	Valdosta, GA	31602
Langston Assisted Living	4646 Ruby Forrest Drive	Stone Mountain, GA	30083
Lanham Personal Care Home	2950 Old Highway #1	Hephzibah, GA	30815

Name	Address	City	Zip Code
Lanier Village Estates - OakBridge Terrace	3950 Village View Drive	Gainesville, GA	30506
Lateishas Assisted Living Care II	3268 Linton Road	Sparta, GA	31087
Laties Personal Care Home	9618 Brown Road	Jonesboro, GA	30238
Laurel Creek Manor Assisted Living	7955 Majors Road	Cumming, GA	30041
Lazy-R Personal Care Center	81 Wellborn Street	Blairsville, GA	30512
Le'glen Personal Care Home	2490 Boulder Springs Point	Ellenwood, GA	30294
Leisure Living of LaGrange I	137 Parker Place	LaGrange, GA	30240
Lewis Family Care Home	2870 Effingham Highway	Sylvania, GA	30467
Lewis Personal Care Home	317 West Lake Shore Drive	Martinez, GA	30907
Lifetime CLA	706 High Pointe Drive	Winder, GA	30680
Lighthouse Personal Care Home	1431 Brittain Road	Douglasville, GA	30134
Lighthouse Personal Care Home, The	206 Blue Mountain Parkway	Rocky Face, GA	30740
Longevity Personal Care Home	1520-22 12th Street	Augusta, GA	30901
Longevity Personal Care Home #2	2884 Lumpkin Road	Augusta, GA	30906
Lorraine Young Personal Care Home	2836 Tobacco Road	Hephzibah, GA	30815
Louise Lott Personal Care Home I	420 Colorado Street	Augusta, GA	30901
Lovelace Living Center	4870 Farm Valley Drive	Woodstock, GA	30188
Loves Community Care Center	2366 Dublin Drive	Augusta, GA	30906
Loves Personal Care Facility	2347 Amsterdam Drive	Augusta, GA	30906
Loving Care Senior Citizen Home	4225 Alton Street	Columbus, GA	31903
Loving Grace Personal Care Home #1	1236 12th Street	Augusta, GA	30901
Loving Hands	233 Northstar Drive	Columbus, GA	31907
Loving Hearts Personal Care Home	10241 Deep Creek Place	Union City, GA	30291
Loving Life Personal Care Home	2104 Sanders Road	Augusta, GA	30906
Loving Touch Ministries	1660 Hallmark Hills Drive	Griffin, GA	30223
Lucille Kylers Quality Care Personal Care Home	3231 Ware Road	Augusta, GA	30909
Luckeys Personal Care Home	3169 Highway 88	Blythe, GA	30805

Name	Address	City	Zip Code
Macks Personal Care Home	3603 Richdale Drive	Augusta, GA	30906
Macy Retirement Center	4408 Houston Avenue	Macon, GA	31206
Madison House Assisted Living	167 West Jefferson Street	Madison, GA	30650
Magnolia Estates of Elberton	68 College Avenue	Elberton, GA	30635
Magnolia Estates of Oconee	1641 Virgil Langford Road	Bogart, GA	30622
Magnolia Estates of Winder	624 Gainesville Highway	Winder, GA	30680
Magnolia Hills Retirement Home	504 Historic Highway 441 N	Demorest, GA	30535
Magnolia Lane	6365 Newborn Drive	College Park, GA	30349
Magnolia Manor - On the Coast	141 Timber Trail	Richmond Hill, GA	31324
Magnolia Manor - St. Marys	4695 Charlie Smith Sr. Highw	St. Marys, GA	31558
Magnolia Manor - St. Simons	100 Heritage Drive	St. Simons Island, GA	31522
Magnolia Manor South	3011 Veterans Parkway	Moultrie, GA	31788
Magnolia Place Inc.	6430 Newton Road	Albany, GA	31721
Majestic Manor	67 Pin Oak Drive	Rock Spring, GA	30739
Maliha Personal Care Home	32 Marvin Avenue	Summerville, GA	30747
Mapleview Personal Care Home #2	2622 Cawana Road	Statesboro, GA	30461
Mapleview Personal Care Home - 3	10 Church Street	Statesboro, GA	30458
Marable Manor PCH	235 East Marable Street	Monroe, GA	30655
Maranatha Personal Care Home	4414 Reef Road	Marietta, GA	30066
Maries Adult Personal Care Home	3524 Wrightsboro Road	Augusta, GA	30909
Marks Personal Care Home	1721 Hephzibah-McBean Ro	Hephzibah, GA	30815
Mary and Marthas Personal Care Home	616 Mohawk Street	Rossville, GA	30741
Mary Washington Personal Care Home	590 Mountain Oaks Parkway	Stone Mountain, GA	30087
Mary's Haven Personal Care Home	310 South Hutchinson Avenue	Adel, GA	31620
Masters Personal Care Home	362 Carver Street, S.E.	Thomson, GA	30824
Matrel's Personal Care Home	1008 East 12th Street	West Point, GA	31833
Maya Assistant Living	321 South 12th Street	Griffin, GA	30223
McClendon Personal Care Home	3050 Johnny Long Road	Newton, GA	39870
McMullen Personal Care Home	4770 Old Lake Park Road	Valdosta, GA	31606

Name	Address	City	Zip Code
Medlock Gardens Decatur	460 Medlock Road	Decatur, GA	30030
Memory Lane of Bremen Bldg A	524 Gordon Street	Bremen, GA	30110
Memory Lane of Bremen Bldg B	524 Gordon Street	Bremen, GA	30110
Memory Lane of Bremen Bldg C	524 Gordon Street	Bremen, GA	30110
Mercy Personal Care Home	3630 Brushy Wood Drive	Loganville, GA	30052
Merrill Gardens at Dunwoody	1460 South Johnson Ferry R	Dunwoody, GA	30319
Merrys Personal Care	4070 Janice Drive	East Point, GA	30344
Misty Meadows Personal Care Home	3464 Wolf Pen Gap Road	Suches, GA	30572
Mitchells Personal Care Home	405 Lawton Street	Atlanta, GA	30310
Mitchells Personal Care Home	684 Cascade Avenue	Atlanta, GA	30310
Morning Pointe Assisted Living	660 Jolly Road NW	Calhoun, GA	30701
Morning Starr Personal Care Home	519 Lawrenceville Street	Norcross, GA	30071
Morningside of Columbus	4500 South Stadium Drive	Columbus, GA	31909
Morningside of Dalton	2470 Dug Gap Road	Dalton, GA	30720
Morningside of Gainesville	2435 Limestone Parkway	Gainesville, GA	30501
Morningside of Macon	6191 Peake Road	Macon, GA	31220
Morris Assisted Living	1103 Bedford Avenue	Columbus, GA	31907
Morris Assisted Living II	4547 Moline Avenue	Columbus, GA	31907
Mosleys Personal Care Home	309 Walker Street	Augusta, GA	30901
Mossy Oak Assisted Living	1150 River Road	Jesup, GA	31546
Mother & Daughter Personal Care Home	1923 Kissingbower Road	Augusta, GA	30904
Mount Sinai Home Care	862 Split Rock Lane	Douglasville, GA	30134
Mountain Breeze PCH	167 Habersham Landing Drive	Demorest, GA	30535
Mt. Pleasant Alternative Care	311 Johnson Avenue	Thomson, GA	30824
Murry's PCH	230 McKenzie Drive	Swainsboro, GA	30401
My House 2 Community Care Facility	2836 Ravenwood Drive	Snellville, GA	30078
Naja Personal Care Home	935 Donington Circle	Lawrenceville, GA	30045
Nasworthy Care Home	4896 Stanfield Road	Patterson, GA	31557
Neals Personal Care Home	4520 Hereford Farm Road	Evans, GA	30809
New Haven	615 South Hutchinson Avenue	Adel, GA	31620

Name	Address	City	Zip Code
New Hope Assisted Living of Georgia	3985 Flat Shoals Road	Union City, GA	30291
North Spring Assisted Living	4 North Spring Street	Claxton, GA	30417
Northside Villa	8828 Hwy 112 North	Rochelle, GA	31079
Northwoods Retirement Home	54 Northwoods Drive	Dahlonega, GA	30533
Norwood Christian Care Personal Care Home	1793 Parkhill Drive	Decatur, GA	30032
Oak Ridge	160 Moores Road	Mineral Bluff, GA	30559
Odom, Pam Personal Care Home	129 Leonard Lane	Swainsboro, GA	30401
Opals Personal Care Home	100 Oakridge Drive	LaGrange, GA	30241
Open Arms Assisted Living - Sylvania	425 Gilgail Road	Sylvania, GA	30467
Open Arms Care Home	133 Apple Street	Midville, GA	30441
Open Arms Elderly Care	1864 Central Avenue	Augusta, GA	30904
Open Arms Personal Care Home	3725 Millstone Run	Augusta, GA	30906
Orchid Personal Care Home II	5809 Glenlake Court	Columbus, GA	31909
Overall Group Home	4462 Parmalee Path	Conley, GA	30288
Palm Shade Villa Assisted Living	175 Crowell Road North	Covington, GA	30014
Palm Shade Villa Assisted Living II	12166 Highway 212	Covington, GA	30014
Palmer Family Care Home	4550 Janice Drive	College Park, GA	30337
Panola Care, Inc.	3169 Pequea Drive	Lithonia, GA	30038
Paradise Living Personal Care Home	2571 Hwy 36 East	Jackson, GA	30233
Parker Hill Manor	1218 Parker Avenue	Albany, GA	31701
Pathways Center IGR - Female Only	403 Northlake Drive	Carrollton, GA	30117
Pathways Center IGR - Male Only	405 Northlake Drive	Carrollton, GA	30117
Patricias Adults Care Home	206 St. Andrews Street	Sylvania, GA	30467
Patron Place PCH	1992 Sewing Circle	Lithonia, GA	30058
Patterson Personal Care Home - Augusta	1605 Cornell Drive	Augusta, GA	30906
Payne Care Home II	2740 West Antler Drive	Augusta, GA	30906
Peaceful Living Personal Care Home - Augusta	2714 Coleman Avenue	Augusta, GA	30906
Peaceful Manor Retirement Home	2412 Cardinal Street	Albany, GA	31701
Peaceful Personal Care Home	168 Peaceful Lane	Portal, GA	30450

Name	Address	City	Zip Code
Peachtree Plantation	4251 Hudson Drive	Oakwood, GA	30566
Peachtree Village Senior Living	199 West W Gary Road	Commerce, GA	30529
Perfect Care, Inc.	114 Sullivan Drive	Americus, GA	31709
Petal's PCH	3371 Glen Summit Lane	Snellville, GA	30039
Philchris Assisted Living	297 Academy Drive	Thomasville, GA	31792
Picture of Life	351 South Hill Street	Toccoa, GA	30577
Pike Manor, Inc.	10642 U.S. Highway 19 North	Zebulon, GA	30295
Pine Shadows Retirement Manor	202 Bryant Drive	Sylvester, GA	31791
Pine Shadows Too	407 North McPhaul Street	Sylvester, GA	31791
Pineland Personal Care Home	235 Broxton Highway	Hazlehurst, GA	31539
Pines Retirement Living	801 Darling Avenue	Waycross, GA	31501
Pineview Gardens of Evans	4393 Owens Road	Evans, GA	30809
Pineview Gardens Personal Care Home	4255 Highway 25 North	Hephzibah, GA	30815
Pinewood Retirement Villa	7 Slappey Drive	Hawkinsville, GA	31036
Pinnacle Way	825 Wright Street	Thomasville, GA	31792
Plair Personal Care Home	2016 Scott Road	Augusta, GA	30906
Plair Personal Care Home II	2014 Scott Road	Augusta, GA	30906
Plantation South of Duluth	3450 Duluth Park Lane	Duluth, GA	30096
Plantation South of Dunwoody	4594 Barclay Drive	Dunwoody, GA	30338
Platinum Care Personal Care Home	2358 Oak Avenue	Morrow, GA	30260
Pleasant Valley Retirement Home	510 Reed Road	Dalton, GA	30720
Port City Personal Care Home	720 East Shotwell Street	Bainbridge, GA	39819
Precious Care Home	1105 Mt. Vernon Road	Vidalia, GA	30474
Precious Touch PCH	6631 Chason Woods Court	Jonesboro, GA	30238
Presbyterian Home and Retirement Community	1901 West Screven Street	Quitman, GA	31643
Presbyterian Village	2000 East-West Connector	Austell, GA	30106
Presbyterian Village - Hearthstone	2000 East-West Connector	Austell, GA	30106
Priscilla Davis Personal Care Home	3674 Old Ferry Road	Martinez, GA	30907
PRN Nursing Alternative Living Family Care Solutions, Inc. (DD)	103 South 4th Street	McIntyre, GA	31054
Providence Assisted Living of Milton	17210 Birmingham Highway	Alpharetta, GA	30004

Name	Address	City	Zip Code
Providence of Alpharetta	12775 Providence Road	Alpharetta, GA	30009
Quality Choice Personal Care Home	3075 Antioch Road, Building	Macon, GA	31206
Quality Living Homes	3204 Chamblee Tucker Road	Atlanta, GA	30341
Rainbow Retirement Home	109 Meyer Farm Road	Arnoldsville, GA	30619
Raynna Personal Care Home	2532 Kensington Drive West	Augusta, GA	30906
Re-Creation of Hope	3600 Brushy Wood Drive	Loganville, GA	30052
Reagans Personal Care Home	4527-C Ogeechee Road	Savannah, GA	31504
Red Hill Personal Care Home	530 Red Hill Road	Jesup, GA	31545
Remington House	1504 Renaissance Drive	Conyers, GA	30012
Renaissance Marquis Retirement Village	3126 Cedartown Highway	Rome, GA	30161
Renaissance On Peachtree	3755 Peachtree Road, N.E.	Atlanta, GA	30319
Residential Living, Inc.	7861 Collinswood Court	Jonesboro, GA	30236
Resting Nest	4884 Price Road	Gainesville, GA	30506
Restorative Assisted Living Facility	3740 Wingate Drive	Columbus, GA	31909
Retirement Inn	414 West Main Street	Swainsboro, GA	30401
Rhema Personal Care Facilities	3144 Macedonia Road	Powder Springs, GA	30127
Ritchglow Personal Care Home	2717 Rainbow Forest Drive	Decatur, GA	30034
Riverside Place	1151 West College Street	Bainbridge, GA	39817
Riverwood Retirement Life Community	511 West 10th Street	Rome, GA	30165
Rock Creek Manor	50 Cagle Mill Road South	Jasper, GA	30143
Roman Court	1168 Chulio Road	Rome, GA	30161
Rose-Anns Personal Care Home	2016 Country Place Drive	Augusta, GA	30906
Rosemaude Personal Care Home	642 Erin Avenue, SW	Atlanta, GA	30310
Rosewood at Fort Oglethorpe	14 Fort Town Drive	Fort Oglethorpe, GA	30742
Rosewood Manor	1107 Tanner Street	Nicholls, GA	31554
Royal Care	568 Highway 26 E	Cochran, GA	31014
Royal Cottage Personal Care Home	65 Stoney Point Terrace	Covington, GA	30014
Royal Oaks	211 West College Street	Adrian, GA	31002
Royal Southern Plantation	580 Tommy Lee Fuller Drive	Loganville, GA	30052
Ruby Place	705 Cleland Street	Savannah, GA	31415
Ruthies Assisted Living	1441 Jeffersonville Road	Macon, GA	31217

Name	Address	City	Zip Code
Ryans Hope Personal Care Home	4472 Malibu Drive	Decatur, GA	30035
S. N. Waters Personal Care Home	3166 Highway 88	Blythe, GA	30805
Sacred Hands Personal Care Homes	141 St Ann Circle	Dallas, GA	30157
Safe Haven at Lenox Park	1137 Lynmoor Drive	Atlanta, GA	30319
Saint James Place	2027 Alta Vista Drive	Columbus, GA	31907
Samuda's Personal Care Home	2752 Skyland Drive	Snellville, GA	30078
Sandy Springs Assisted Living	300 Johnson Ferry Road, N.	Sandy Springs, GA	30328
Sara's Personal Care Home	129 Leonard Lane	Swainsboro, GA	30401
Savannah Court of Lake Oconee	1061 Willow Run Road	Greensboro, GA	30642
Savannah Court of Milledgeville	61 Marshall Road	Milledgeville, GA	31061
Savannah Plantation PCH	102 Level Creek Road	Buford, GA	30518
Savannah Square	167 Murrow Street	Blythe, GA	30805
Seasons Assisted Living	2724 Ledo Road	Albany, GA	31707
Senior Care America	1165 Hillcrest Glenn Circle	Sugar Hill, GA	30518
Senior Care America II	828 Rock Springs Road	Lawrenceville, GA	30043
Senior Citizens Care Center Annex	223 Harmon Road	Swainsboro, GA	30401
Serenity 1 Personal Care Home	3967 Lenora Church Road	Snellville, GA	30039
Serenity Assisted Living	206 Pine Street	Sparks, GA	31647
Serenity House	8599 Sheridan Drive	Jonesboro, GA	30236
Serenity Mountain Manor	309 Price Creek Farms Lane	Jasper, GA	30143
Serenity Personal Care Home	120 E. Winthorpe Avenue	Millen, GA	30442
Sha Sha's Leisure Living	1465 Teagle Road	Forsyth, GA	31029
Sha-Lyndas Personal Care Home	2313 Cadden Court	Augusta, GA	30906
Shady Lane	4901 La Roche Avenue	Savannah, GA	31404
Shady Lane II PCH	1133 Cornell Avenue	Savannah, GA	31406
Shady Lane IV	4901 LaRoche Avenue	Savannah, GA	31404
Shady Pines Estate	124 Airport Road	Abbeville, GA	31001
Shenices Assisted Living Home	3216 Highway 16	Sparta, GA	31087
Sheppard Personal Care Home	123 Emma Lane	Waynesboro, GA	30830
Sheridan Place - Assistive Living Unit	504 Firetower Road	Dublin, GA	31021

Name	Address	City	Zip Code
Sheridan Place - Clare Bridge Place Memory Care Unit	504 Firetower Road	Dublin, GA	31021
Shiloh Personal Care Home	300 West Second Street	Ocilla, GA	31774
Sibors Manor	3890 Wrightsboro Road	Augusta, GA	30909
Sillah Group Home	3510 Rockfort Drive	College Park, GA	30349
Silver Linings Personal Care Home	407 Harvey Street	Stapleton, GA	30823
Silverleaf of Athens	705 Whitehead Road	Athens, GA	30606
Sirmons Personal Care Home	623 Davis Avenue	Lakeland, GA	31635
Smith PCH	315 Advance Street	Swainsboro, GA	30401
Sonshine Manor Personal Care Home	115 Stephens View Road	Jasper, GA	30143
South Columbus Personal Care Home	2440 Mesa Street	Columbus, GA	31903
South Dooley Retirement Center II	1400 Swift Street	Perry, GA	31069
South Haven II	1335 Lake Ridge Parkway	Riverdale, GA	30296
Southern Breeze Assisted Living	127 S. Belair Road	Martinez, GA	30907
Southern Care Retirement Home	1934 Whiddon Mill Road	Tifton, GA	31793
Southern Charm	110 South Third Avenue	McRae, GA	31055
Southern Comfort Personal Care	6735 Pulaski Highway	Statesboro, GA	30458
Southern Escapes Assisted Living	3047 Johnson Road	Loganville, GA	30052
Southern Heritage I	812 Carl Vinson Parkway	Centerville, GA	31028
Southern Heritage II	814 Carl Vinson Parkway	Centerville, GA	31028
Southern Magnolia	405 Thompson Street	Vidalia, GA	30474
Southern Manor Retirement Inn	1532 Fair Road	Statesboro, GA	30458
Southern Pines Senior Care Inc.	258 College Avenue	Maysville, GA	30558
Southern Pines Senior Living	423 Covington Avenue	Thomasville, GA	31792
Southern Retreat	307 Charles Street	Vienna, GA	31092
Southern Senior Living	215 East Sellers Street	Douglas, GA	31533
Sparks Community Care Home, LLC	207 Forestside Circle	Americus, GA	31709
Sparks Retirement Home, Inc.	304 South Goodman Street	Sparks, GA	31647
Sparks Serenity Phase III	1701 Maxwell Street	Americus, GA	31709
Spice of Life	1458 Mill Street	Augusta, GA	30901

Name	Address	City	Zip Code
Spring Garden Personal Care Home	3361 Glen Summit Lane	Snellville, GA	30039
Spring Harbor at Green Island	100 Spring Harbor Drive	Columbus, GA	31904
Spring Lane Personal Care Home	1570 Spring Lane NW	Atlanta, GA	30314
Spring Villa Personal Care	620 Monroe Street	Macon, GA	31201
Springfield Personal Care Home	3342 Springfield Road	Sparta, GA	31087
St Irene PCH	44 Clairmont Avenue	Elberton, GA	30635
St Marys Highland Hills Village	1660 Jennings Mill Road	Bogart, GA	30622
St. George Village - Wellington Court	11350 Woodstock Road	Roswell, GA	30075
St. Ives Assisted Living	5835 Medlock Bridge Parkway	Alpharetta, GA	30022
Star Manor	241 Nelson Street	Cartersville, GA	30120
Stonehenge Assisted Living 3	168 Stonehenge Drive	Blairsville, GA	30512
Stonehenge Assisted Living One	168 Stonehenge Drive	Blairsville, GA	30512
Stonehenge Too	168 Stonehenge Drive	Blairsville, GA	30512
Suites at Oak View	55 Stockade Road	Summerville, GA	30747
Summer Street Community Services	132 Summer Street	Adairsville, GA	30103
Summer Street Community Services II	32 Horseshaw Road	Adairsville, GA	30103
Summer Willow Assisted Living	259 Nunez Lexsy Road	Swainsboro, GA	30401
Summer Willow at James Place	213 Industrial Blvd	Dublin, GA	31021
Summer's Landing at Green Island	6830 River Road	Columbus, GA	31904
Summer's Landing Tilly Mill	4821 North Peachtree Road	Dunwoody, GA	30338
Summers Landing	419 Airport Road	Griffin, GA	30224
Summers Landing - Douglas	1360 West Gordon Street	Douglas, GA	31533
Summers Landing Limestone	2030 Windward Lane	Gainesville, GA	30501
Summers Landing Northland Assisted Living	5399 Northland Drive	Atlanta, GA	30342
Summers Landing PCH	171 Highway 78 NW	Monroe, GA	30655
Sunny Mills Assisted Living	402 North West Street	Greensboro, GA	30642
Sunrise at East Cobb	1551 Johnson Ferry Road	Marietta, GA	30062
Sunrise at Huntcliff Summit	8480 Roswell Road	Sandy Springs, GA	30350

Name	Address	City	Zip Code
Sunrise at Johns Creek	11405 Medlock Bridge Road	Johns Creek, GA	30093
Sunset Nellee	6420 Bennett Drive	Rex, GA	30273
Sunshine Care	1103 Beard McCord Drive	Lincolnton, GA	30817
Sunshine Residential Care	3949 Pine Gorge Circle	Dacula, GA	30019
Sweet Sadies Personal Care Home	434 Railroad Avenue	Blythe, GA	30805
Tanglewood Assisted Living Facility	50 Tanglewood Drive	Dawsonville, GA	30534
Tapleys Personal Care Home	4602 Hereford Farm Road	Evans, GA	30809
Tebeau House Retirement Home	2019 Tebeau Street	Waycross, GA	31501
Tender Care Assisted Living at Snellville	3922 Centerville Highway #1	Snellville, GA	30039
Tender Care Personal Care Home	1560 Twin Bridge Lane	Lawrenceville, GA	30043
Tennille Assisted Living	525 North Main Street	Tennille, GA	31089
Terris Personal Care Home	1680 Lawrenceville - Suwane	Lawrenceville, GA	30043
The Blossom Personal Care Home	1245 Augusta Avenue	Augusta, GA	30901
The Carlton	690 Mt. Vernon Highway	Atlanta, GA	30328
The Colonnade at Brandon Wilde	4275 Owens Road	Evans, GA	30809
The Cottage Senior Living	818 Round Tree Court	Lawrenceville, GA	30045
The Gables at Cobb Village	12 Cobb Village Drive	Royston, GA	30662
The Hallmark Buckhead	650 Phipps Boulevard, NE	Atlanta, GA	30326
The Hampton House Assisted Living Facility	432 South Fourth Street	Colbert, GA	30628
The Home Place	801 Walnut Street	Louisville, GA	30434
The Home Place PCH	602 Hamilton E. Holmes Drive	Atlanta, GA	30318
The Mann House	5413 Northland Drive	Atlanta, GA	30342
The Mews III PCH	621 North Cherokee Road	Social Circle, GA	30025
The Nightingale Song Personal Care Home	2548 US 27 South	Carrollton, GA	30117
The Oaks Assisted Living at The Marshes of Skidaway Island	95 Skidaway Island Park Road	Savannah, GA	31411
The Oaks at Peake Assisted Living	400 Foster Road	Macon, GA	31210
The Oaks at Post Road	3875 Post Road	Cumming, GA	30040
The Oaks at Scenic View Assisted Living	205 Peach Orchard Drive	Baldwin, GA	30511
The Oaks of Carrollton Assisted Living	921 Old Newnan Road	Carrollton, GA	30116

Name	Address	City	Zip Code
The Oaks Personal Care Home	777 Nursing Home Road	Marshallville, GA	31057
The Plaza At Talmage Terrace	801 Riverhill Drive	Athens, GA	30606
The Plaza Personal Care at St. John Towers	724 Greene Street	Augusta, GA	30901
The Providers, Inc.	799 Moreland Avenue	Atlanta, GA	30316
The Rachel House, Inc.	204 West Colquitt Street	Sparks, GA	31647
The Retreat	1207 East McPherson Street	Nashville, GA	31639
The Retreat II	1207 East McPherson Street	Nashville, GA	31639
The Southern Living Center	434 Beall Springs Road	Gibson, GA	30810
The Stewart House	102 South Street	Carrollton, GA	30117
The Suites at Cypress Pond	15 Kent Road	Tifton, GA	31794
The Veranda at Carnesville	29 McEntire Street	Carnesville, GA	30521
The White House Personal Care Home	452 State Street	Waycross, GA	31501
The Willows	4179 Wheeler Road	Martinez, GA	30907
The Woods Assisted Senior Living	1401 Macon Road	Griffin, GA	30224
Thomaston Manor	409 West Gordon Street	Thomaston, GA	30286
Thompson Manor	107 Rowe Street	Dublin, GA	31021
Thompsons Personal Care Home	3435 Linderwood Drive	Augusta, GA	30906
Tignall Assisted Living	185 S. Hulin Avenue	Tignall, GA	30668
TLC Family Home	3605 Shallowford Road	Marietta, GA	30062
TLC Personal Care Home	2861 Greenville Street	LaGrange, GA	30241
Touch By An Angel PCH #2	2815 Dean's Bridge Road	Augusta, GA	30906
Traces of Tiger II	382 Bridge Creek Road	Tiger, GA	30576
Treutlen Living Center	5590 Third Street North	Soperton, GA	30457
Trinity Personal Care Home of Georgia, LLC	718 Weed Street	Augusta, GA	30904
True Comfort Care Home 3	476 Briarwood Lane	Hull, GA	30646
True Comfort Care Home 4	1081 Helican Spring Road	Athens, GA	30601
True Comfort Care Home 5	1905 Danielsville Rd	Athens, GA	30601
True Comfort Care Home 6	185 Catalpa Drive	Athens, GA	30601
Truly Living Well Personal Care Home	7078 Bethel Court	Riverdale, GA	30296
Tudor Castle Personal Care Home	2056 Tudor Castle Circle	Decatur, GA	30035
Twelve Oaks Senior Living	2000 Bellevue Road	Dublin, GA	31021
Tylers Assisted Living	208 Flowing Wells Road	Martinez, GA	30907
U2 Concepts Personal Care	2900 Keenan Road	College Park, GA	30349
Universal Healthcare	1766 Enclave Place	Conley, GA	30288

Name	Address	City	Zip Code
Service			
V & T Shady Rest PC Home	1386 New Petersburg Road	Lincolnton, GA	30817
Vanderpoole's Senior Living Center	1718 Mossy Rock Cove	Lithonia, GA	30058
Vernon Woods	101 Vernon Woods Drive	LaGrange, GA	30240
Victoria Personal Care Home	2666 Nancy Drive	Macon, GA	31206
Victory House	310 West Washington Avenue	Nashville, GA	31639
Victory Villa	308 West Washington Avenue	Nashville, GA	31639
Victory Village	3650 Salem Church Road	Jasper, GA	30143
Villa Rose	430 Mosley Road	Byron, GA	31008
Vina Mae Robinson Retirement Center - VMR	566 West 16th Avenue	Albany, GA	31701
Vina Mae Robinson Retirement Center 2 - Monroe House	566 West 16th Avenue	Albany, GA	31701
Vincent's Village Personal Care	3113 Washington Road	East Point, GA	30344
Vision Personal Care Home #1	960 Curry Place	Macon, GA	31202
Vital Place	985 Waldwick Drive	Lawrenceville, GA	30045
Waldrop Personal Care Inc	89 Burnt Hickory Road	Cartersville, GA	30120
Walnut Creek Manor	1033 Highway 155 North	McDonough, GA	30253
Wanda Shelly Personal Care Home	1055 Hephzibah-McBean Ro	Hephzibah, GA	30815
Ware Group Home	214 Edison Drive	Albany, GA	31705
Washington Manor	184 Pine Lane	Washington, GA	30673
Watson Manor	115 Watson Street	Thomson, GA	30824
Waverly Gardens of Evans	550 Gibbs Road	Evans, GA	30809
We Care 2 Personal Care Home	1483 Virgil Pond Lane	Loganville, GA	30052
We Care Assisted Living	1022 Fisk Avenue	Columbus, GA	31906
We Care Assisted Living #2	2036 7th Street	Columbus, GA	31907
We Care Personal Care Home Facility	206 Walnut Drive	Americus, GA	31719
We Care Personal Home Phase II	813 Parker Street	Americus, GA	31709
Weavers Manor	803 West Ogeechee Street	Sylvania, GA	30467
Welcome Home PCH	2366 Centerville Rosebud Ro	Loganville, GA	30052
Welcome Home Personal Care Home	5780 Rock Road	Union City, GA	30291
Well Care	2433 Powder Springs Road	Marietta, GA	30064

Name	Address	City	Zip Code
WellCare Assisted Living	2433 Powder Springs Road	Marietta, GA	30064
Wesbys Personal Care Home, Inc.	1429 Highway 23 South	Waynesboro, GA	30830
Wesley Woods Towers	1825 Clifton Road, N.E.	Atlanta, GA	30329
West Assistive Living II	116 Maple Circle	Greensboro, GA	30642
West Forrest Personal Care Home	280 West Forrest Street	Harlem, GA	30814
West Village Retirement Community, Inc.	409 West Goodrich Avenue	Thomaston, GA	30286
Whispering Pines	6273 Highway 41 South	Bolingbroke, GA	31004
Whispering Pines 1	110 East Paces Drive	Athens, GA	30605
Whispering Pines 2	100 East Paces Drive	Athens, GA	30605
Whispering Pines Personal Care Home	10096 Burkhalter Road	Statesboro, GA	30458
White Dove Personal Care Home	2229 Highway 98 East	Danielsville, GA	30633
White Oaks	130 Moores Road	Mineral Bluff, GA	30559
White Oaks	867 Longstreet Road	Cochran, GA	31014
White Oaks at Lanier	255 Elm Street	Cumming, GA	30040
Wilkinson Center	249 Hospital Drive	Toccoa, GA	30577
Willow Creek, Centerville	404 North Houston Lake Bou	Centerville, GA	31028
Willow Creek, Perry	1900 Macon Road	Perry, GA	31069
Willow Ridge Personal Care Home	801 Faceville Highway	Bainbridge, GA	39819
Willows Edge	401 Dixie Street	Sparta, GA	31087
Wilsons Personal Care Home	1527 Dade Street	Augusta, GA	30904
Wings of Faith PCH	12433 Highway 16 East	Monticello, GA	31064
Winnwood Retirement Community - Sullivan House	100 Whitlock Avenue	Marietta, GA	30064
Winterville Retirement Center	124 Avery Street	Winterville, GA	30683
Winthrop at Polk	131 Melissa Lane	Cedartown, GA	30125
Winthrop Court Assisted Living	10 Highway 411 East	Rome, GA	30161
Winthrop West Senior Living	279 Technology Parkway	Rome, GA	30165
Wise Choice Personal Care Home	318 Meadow Court	Martinez, GA	30907
Wonderland Assisted Living, LLC	3780 Napier Avenue	Macon, GA	31204
Woodhaven Personal Care Home	6246 Highway 136	Trenton, GA	30752

Name	Address	City	Zip Code
Xtraordinary Personal Care Home	328 Rockdale Road	Martinez, GA	30907
Yellow Brick House	6903 Main Street	Lithonia, GA	30058

PERSONAL CARE HOMES SEPARATE UNIT

Name	Address	City	Zip Code
Antebellum Grove Assisted Living	1010 Kathryn Ryals Road	Warner Robins, GA	31088
Arbor Terrace	170 Marilyn Farmer Way	Athens, GA	30606
Arbor Terrace at Cascade	1001 Research Center	Atlanta, GA	30331
Arbor Terrace at Tucker	5844 Highway 29	Tucker, GA	30084
Arbor Terrace at West Cobb	3829 Floyd Road	Austell, GA	30106
Arbor Terrace of Decatur	425 Winn Way	Decatur, GA	30030
Arbor Terrace of East Cobb	866 Johnson Ferry Road	Marietta, GA	30068
Ashley Glen	441 Prime Point	Peachtree City, GA	30269
Ashton Hall	1155 Lawrenceville Highway	Lawrenceville, GA	30046
Atria Buckhead	2848 Lenox Road	Atlanta, GA	30324
Atria Johnson Ferry	9 Sherwood Lane	Marietta, GA	30067
Augusta Gardens Retirement Residence	3725 Wheeler Road	Augusta, GA	30909
Belmont Village	5455 Glenridge Drive	Atlanta, GA	30342
Bentley Assisted Living at Northminster	50 Sumner Way	Jefferson, GA	30549
Benton House at Benton Village	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House at Benton Village - Transitional Step Down Program	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House of Covington	7155 Dearing Road	Covington, GA	30014
Benton House of Dublin and Beacon Neighborhood	212 Fairview Park Drive	Dublin, GA	31021
Benton House of Newnan Lakes	25 Newnan Lakes Boulevard	Newnan, GA	30263
Bickford Senior Living	840 LeCroy Drive	Marietta, GA	30068
Blair House Senior Living Community	684 Arlington Place	Macon, GA	31201
Brasstown Manor	108 Church Street	Hiawassee, GA	30546
Brighton Gardens of Buckhead	3088 Lenox Road	Atlanta, GA	30324

Brighton Gardens of Dunwoody	1240 Ashford Center Parkway	Dunwoody, GA	30338
Brookside Glen	400 Bradley Park Drive	Columbus, GA	31904
Cameron Hall	240 Marietta Highway	Canton, GA	30114
Carlyle Place - Cambridge Court	5300 Zebulon Road	Macon, GA	31210
Carriage House of Royal Southern Plantation	690 Tommy Lee Fuller Drive	Loganville, GA	30052
Cedar Hill Senior Living Community	402 East Ellawood Avenue	Cedartown, GA	30125
Cedar Plantation Assisted Living and Alzheimers Community	46637 Highway 46 East	Metter, GA	30439
Cobis Personal Care Home	7200 Manor Road	Columbus, GA	31907
Courtyard Gardens	1000 River Center Place	Lawrenceville, GA	30043
Cumming Manor Personal Care	2775 Castleberry Road	Cumming, GA	30040
Dogwood Forest at Eagles Landing	475 Country Club Drive	Stockbridge, GA	30281
Dogwood Forest of Alpharetta	253 North Main Street	Alpharetta, GA	30009
Dogwood Forest of Dunwoody	7400 Peachtree Dunwoody R	Atlanta, GA	30328
Dogwood Forest of Fayetteville	1294 Highway 54 West	Fayetteville, GA	30214
Dogwood Forest of Gainesville	3315 Thompson Bridge Road	Gainesville, GA	30506
Eastside Gardens	2078 Scenic Highway	Snellville, GA	30078
Elmcroft at Milford Chase	1345 Milford Church Road	Marietta, GA	30008
Elmcroft of Mt. Zion	7493 Mount Zion Boulevard	Jonesboro, GA	30236
Elmcroft of Roswell	400 Marietta Highway	Roswell, GA	30075
Elmcroft Senior Living	515 The Pass	Martinez, GA	30907
Emeritus at Decatur	475 Irvin Court	Decatur, GA	30030
Emeritus at Heritage Hills	3607 Weems Road	Columbus, GA	31909
Emeritus at Riverstone Senior Living	125 Riverstone Terrace	Canton, GA	30114
Emeritus at Sandy Springs Place	1262 Hightower Trail	Atlanta, GA	30350
Emeritus at Spring Mountain	1790 Powder Springs Road	Marietta, GA	30064
Emeritus at Vinings	2401 Cumberland Parkway S	Atlanta, GA	30309
Emeritus at Woodstock Senior Living Community	756 Neese Road	Woodstock, GA	30188
Evans Personal Care Home	426 Liberty Street	Gray, GA	31032
Evergreen Assisted Living	2823 Gillionville Road	Albany, GA	31721
Fairhaven Assisted Living Residence	1550 Glynco Parkway	Brunswick, GA	31525
FAM Personal Care Home	5618 Wellborn Creek Drive	Lithonia, GA	30058

Gardens of Roswell	9212 Nesbit Ferry Road	Alpharetta, GA	30022
Gentilly Gardens	625 Gentilly Road	Statesboro, GA	30458
Golden Crest	2160 Lake Harbin Road	Morrow, GA	30260
Governors Glen	5000 Governors Drive	Forest Park, GA	30297
Greenwood Gardens	1160 Whitlock Avenue	Marietta, GA	30064
Griffin House South, The	107 West Liberty Street	Claxton, GA	30417
Grosvenor Personal Care Home	4556 Central Drive	Stone Mountain, GA	30083
Habersham House Senior Residence	5200 Habersham Street	Savannah, GA	31405
Heritage of Sandy Plains	3039 Sandy Plains Road	Marietta, GA	30066
House of Angels	420 Lavender Road	Athens, GA	30606
Kendrick Home	1016 Ell Street (B)	Macon, GA	31206
Lake Springs	4355 South Lee Street	Buford, GA	30518
Langdale Place	2720 Windemer Drive	Valdosta, GA	31602
Lanier Village Estates - OakBridge Terrace	3950 Village View Drive	Gainesville, GA	30506
Laurel Creek Manor Assisted Living	7955 Majors Road	Cumming, GA	30041
Leisure Living of LaGrange I	137 Parker Place	LaGrange, GA	30240
Magnolia Manor Retirement Center	2001 South Lee Street	Americus, GA	31709
Mattie H. Marshall Center	2001 South Lee Street	Americus, GA	31709
Memory Lane of Bremen Bldg A	524 Gordon Street	Bremen, GA	30110
Morning Pointe Assisted Living	660 Jolly Road NW	Calhoun, GA	30701
Morning Starr Personal Care Home	519 Lawrenceville Street	Norcross, GA	30071
Morningside of Albany	1721 Beattie Road	Albany, GA	31721
Morningside of Conyers	1352 Wellbrook Circle	Conyers, GA	30012
Mountain View Personal Care Home	3675 Kensington Road	Decatur, GA	30032
Mt. Carmel Personal Care Home	3084 Mt. Carmel Road	Hampton, GA	30228
Northlake Gardens	1300 Montreal Road	Tucker, GA	30084
Palm Shade Villa Assisted Living II	12166 Highway 212	Covington, GA	30014
Park Regency Personal Care Home	3000 Veterans Parkway	Moultrie, GA	31768
Peachtree Plantation	4251 Hudson Drive	Oakwood, GA	30566
Peachtree Village Senior Living	199 West W Gary Road	Commerce, GA	30529
Plantation Manor Personal Care Home	220 Park Avenue	Thomasville, GA	31792
Plantation South of Dunwoody	4594 Barclay Drive	Dunwoody, GA	30338
Presbyterian Village	2000 East-West Connector	Austell, GA	30106

Presbyterian Village - Hearthstone	2000 East-West Connector	Austell, GA	30106
Renaissance Marquis Retirement Village	3126 Cedartown Highway	Rome, GA	30161
Riverwood Retirement Life Community	511 West 10th Street	Rome, GA	30165
Roman Court	1168 Chulio Road	Rome, GA	30161
Royal Southern Plantation	580 Tommy Lee Fuller Drive	Loganville, GA	30052
Safe Haven at Lenox Park	1137 Lynmoor Drive	Atlanta, GA	30319
Sandy Springs Assisted Living	300 Johnson Ferry Road, N.	Sandy Springs, GA	30328
Savannah Commons Retirement Community - Verra Spring	1 Peachtree Drive	Savannah, GA	31419
Savannah Court of Lake Oconee	1061 Willow Run Road	Greensboro, GA	30642
Savannah Court of Newnan	27 Belt Road	Newnan, GA	30263
Scepter Living Center of Snellville LLC	3000 Lenora Church Road	Snellville, GA	30078
Sheridan Place - Clare Bridge Place Memory Care Unit	504 Firetower Road	Dublin, GA	31021
Southern Care Retirement Home	1934 Whiddon Mill Road	Tifton, GA	31793
Southern Pines Senior Living	423 Covington Avenue	Thomasville, GA	31792
Sparks Inn at Christian City	7290 Lester Road	Union City, GA	30291
St Marys Center for Alzheimer's and Dementia Care	1660 Jennings Mill Road	Bogart, GA	30622
St. Ives Assisted Living	5835 Medlock Bridge Parkway	Alpharetta, GA	30022
Summers Landing PCH	171 Highway 78 NW	Monroe, GA	30655
Summerset Assisted Living Community	3711 Benjamin E. Mays Drive	Atlanta, GA	30331
Sunrise at Buckhead	1000 Lenox Park	Atlanta, GA	30319
Sunrise at Decatur	920 Clairemont Avenue	Decatur, GA	30030
Sunrise at East Cobb	1551 Johnson Ferry Road	Marietta, GA	30062
Sunrise at Five Forks	3997 Five Forks Trickum	Lilburn, GA	30047
Sunrise at Huntcliff Summit	8480 Roswell Road	Sandy Springs, GA	30350
Sunrise at Johns Creek	11405 Medlock Bridge	Johns Creek, GA	30093
Susans Personal Care Home	114 Hambleton Street	Thomasville, GA	31792
Tara Plantation Assisted Living	440 Tribble Gap Road	Cumming, GA	30040
The Carlton	690 Mt. Vernon Highway	Atlanta, GA	30328
The Cohen Home	10485 Jones Bridge Road	Alpharetta, GA	30022
The Court at Sandy Springs - Memory Care (Emeritus)	1262 Hightower Trail	Atlanta, GA	30350
The Mews III PCH	621 North Cherokee Road	Social Circle, GA	30025

The Oaks Assisted Living at The Marshes of Skidway Island	95 Skidaway Island Park Road	Savannah, GA	31411
The Oaks at Post Road	3875 Post Road	Cumming, GA	30040
The Oaks of Carrollton Assisted Living	921 Old Newnan Road	Carrollton, GA	30116
The Plaza Personal Care Center - Wesley Wood	2280 North Highway 29	Newnan, GA	30265
The Suites at Poplar Creek	114 Old Airport Road	LaGrange, GA	30240
Winterville Retirement Center	124 Avery Street	Winterville, GA	30683
Winthrop at Polk	131 Melissa Lane	Cedartown, GA	30125
Winthrop West Senior Living	279 Technology Parkway	Rome, GA	30165
Woodland Ridge	4005 South Cobb Drive	Smyrna, GA	30080
Woodstock Estates	1000 Professional Way	Woodstock, GA	30188
Yellow Brick House	6903 Main Street	Lithonia, GA	30058

PERSONAL CARE HOMES SECURED UNIT

Name	Address	City	Zip Code
Alzheimers Care of Commerce	200 Bolton Drive	Commerce, GA	30529
Amelia Gardens I	545 Toonigh Road	Woodstock, GA	30188
Amelia Gardens II	2030 Bascomb Carmel Road	Woodstock, GA	30189
Antebellum Grove Assisted Living	1010 Kathryn Ryals Road	Warner Robins, GA	31088
Arbor Terrace	170 Marilyn Farmer Way	Athens, GA	30606
Arbor Terrace at Cascade	1001 Research Center	Atlanta, GA	30331
Arbor Terrace at Tucker	5844 Highway 29	Tucker, GA	30084
Arbor Terrace at West Cobb	3829 Floyd Road	Austell, GA	30106
Arbor Terrace of Decatur	425 Winn Way	Decatur, GA	30030
Arbor Terrace of East Cobb	866 Johnson Ferry Road	Marietta, GA	30068
Ashley Glen	441 Prime Point	Peachtree City, GA	30269
Ashton Hall	1155 Lawrenceville Highway	Lawrenceville, GA	30046
Atherton Place	111 Tower Road	Marietta, GA	30060
Atria Buckhead	2848 Lenox Road	Atlanta, GA	30324
Atria Johnson Ferry	9 Sherwood Lane	Marietta, GA	30067
Augusta Gardens Retirement Residence	3725 Wheeler Road	Augusta, GA	30909
Avondale Assisted Living at Kensington	3508 Kensington Road	Decatur, GA	30032
Avondale Assisted Living at Northlake	3965 Gloucester Drive	Tucker, GA	30084

Avondale Homes at Tucker	2553 Sandpiper Drive	Tucker, GA	30084
Belair at Macon, The	4901 Harrison Road	Macon, GA	31206
Bella's Cottage	7275 Timberline Overlook	Cumming, GA	30041
Belmont Village	5455 Glenridge Drive	Atlanta, GA	30342
Bentley Assisted Living at Northminster	50 Sumner Way	Jefferson, GA	30549
Benton House at Benton Village	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House at Benton Village - Transitional Step Down Program	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House of Covington	7155 Dearing Road	Covington, GA	30014
Benton House of Dublin and Beacon Neighborhood	212 Fairview Park Drive	Dublin, GA	31021
Benton House of Newnan Lakes	25 Newnan Lakes Boulevard	Newnan, GA	30263
BestCare Assisted Living	2775 Cruse Road; #1401	Lawrenceville, GA	30044
Bickford Senior Living	840 LeCroy Drive	Marietta, GA	30068
Blair House Senior Living Community	684 Arlington Place	Macon, GA	31201
Bless To The Max	5870 GA Highway 57	Gordon, GA	31031
Brasstown Manor	108 Church Street	Hiawassee, GA	30546
Brighton Gardens of Buckhead	3088 Lenox Road	Atlanta, GA	30324
Brighton Gardens of Dunwoody	1240 Ashford Center Parkway	Dunwoody, GA	30338
Brittany House at Benson Heights	1788 Sandy Plains Road	Marietta, GA	30066
Brittany's Place Assisted Living	141 Denis Drive	Jeffersonville, GA	31044
Brookside Glen	400 Bradley Park Drive	Columbus, GA	31904
Cambridge Farms Assisted Living	4040 Webb Bridge Road	Alpharetta, GA	30005
Cameron Hall	240 Marietta Highway	Canton, GA	30114
Camilla Retirement Home	161 East Broad Street	Camilla, GA	31730
Carlyle Place - Cambridge Court	5300 Zebulon Road	Macon, GA	31210
Carriage House of Royal Southern Plantation	690 Tommy Lee Fuller Drive	Loganville, GA	30052
Cedar Hill Senior Living Community	402 East Ellawood Avenue	Cedartown, GA	30125

Cedar Plantation Assisted Living and Alzheimers Community	46637 Highway 46 East	Metter, GA	30439
Cherokee Angel PCH #3	326 Heights Place	Canton, GA	30114
Cobis Personal Care Home	7200 Manor Road	Columbus, GA	31907
Colonial Gardens of Warner Robins #1	903 West Highway 96	Warner Robins, GA	31088
Comforters	2753 Trail Creek Circle	Lithia Springs, GA	30122
Country Manor Estates	1487 Allen Road	Macon, GA	31216
Courtyard Gardens	1000 River Center Place	Lawrenceville, GA	30043
Cumming Manor Personal Care	2775 Castleberry Road	Cumming, GA	30040
Cunningham's PCH	195 Bristlecone Court	Winterville, GA	30683
Divine Love Personal Care Home	943 Falling Creek Drive	Macon, GA	31220
Dogwood Forest at Eagles Landing	475 Country Club Drive	Stockbridge, GA	30281
Dogwood Forest of Alpharetta	253 North Main Street	Alpharetta, GA	30009
Dogwood Forest of Dunwoody	7400 Peachtree Dunwoody R	Atlanta, GA	30328
Dogwood Forest of Fayetteville	1294 Highway 54 West	Fayetteville, GA	30214
Dogwood Forest of Gainesville	3315 Thompson Bridge Road	Gainesville, GA	30506
Eastside Gardens	2078 Scenic Highway	Snellville, GA	30078
Elmcroft at Milford Chase	1345 Milford Church Road	Marietta, GA	30008
Elmcroft of Mt. Zion	7493 Mount Zion Boulevard	Jonesboro, GA	30236
Elmcroft of Roswell	400 Marietta Highway	Roswell, GA	30075
Elmcroft Senior Living	515 The Pass	Martinez, GA	30907
Emeritus at Decatur	475 Irvin Court	Decatur, GA	30030
Emeritus at Flint River Memory Care Community	250 Water Tower Court	Macon, GA	31210
Emeritus at Heritage Hills	3607 Weems Road	Columbus, GA	31909
Emeritus at Riverstone Senior Living	125 Riverstone Terrace	Canton, GA	30114
Emeritus at Sandy Springs Place	1262 Hightower Trail	Atlanta, GA	30350
Emeritus at Spring Mountain	1790 Powder Springs Road	Marietta, GA	30064
Emeritus at Vinings	2401 Cumberland Parkway S	Atlanta, GA	30309
Emeritus at Woodstock Senior Living Community	756 Neese Road	Woodstock, GA	30188
Evans Personal Care Home	426 Liberty Street	Gray, GA	31032
Evergreen Assisted Living	2823 Gillionville Road	Albany, GA	31721

Fairhaven Assisted Living Residence	1550 Glynco Parkway	Brunswick, GA	31525
Falcon Crest Manor	111 Epps Street	Gordon, GA	31031
FAM Personal Care Home	5618 Wellborn Creek Drive	Lithonia, GA	30058
Franciscan Woods	2425 Williams Road	Columbus, GA	31909
Gardens of Roswell	9212 Nesbit Ferry Road	Alpharetta, GA	30022
Gentilly Gardens	625 Gentilly Road	Statesboro, GA	30458
Golden Crest	2160 Lake Harbin Road	Morrow, GA	30260
Golden Pond Assisted Living Center	8167 Eisenhower Parkway	Lizella, GA	31052
Governors Glen	5000 Governors Drive	Forest Park, GA	30297
Gracemont Assisted Living	4940 Jot-Em-Down Road	Cumming, GA	30041
Gracemont Assisted Living	4960 Jot-Em-Down Road	Cumming, GA	30041
Greenwood Gardens	1160 Whitlock Avenue	Marietta, GA	30064
Griffin House South, The	107 West Liberty Street	Claxton, GA	30417
Habersham House Senior Residence	5200 Habersham Street	Savannah, GA	31405
Haven of Tender Loving Care	407 W Moore Street	Dublin, GA	31021
Helping Hands Assisted Living LLC	525 Highway 24 East	Milledgeville, GA	31061
Heritage of Sandy Plains	3039 Sandy Plains Road	Marietta, GA	30066
Home Away From Home Personal Care Homes	8412 Red Cedar Way	Riverdale, GA	30274
Homeplace Senior Living - Memory Care Community	345 Pearl Bates Avenue	Eastman, GA	31023
House of Angels	420 Lavender Road	Athens, GA	30606
House of Naum Personal Care Home, The	2880 Olive Grove Church Ro	Roberta, GA	31078
Ivy Springs Retirement Cottage	1408 Spring Street SE	Smyrna, GA	30080
Kendrick Home	1016 Ell Street (B)	Macon, GA	31206
Kingsford of Warner Robins	851 Gunn Road	Warner Robins, GA	31093
Lake Pointe Assisted Living & Memory Care Community	45 Walnut Street	Hartwell, GA	30643
Lake Springs	4355 South Lee Street	Buford, GA	30518
Langdale Place	2720 Windemer Drive	Valdosta, GA	31602
Laurel Creek Manor Assisted Living	7955 Majors Road	Cumming, GA	30041
Leisure Living of LaGrange I	137 Parker Place	LaGrange, GA	30240
Loving Care Senior Citizen Home	4225 Alton Street	Columbus, GA	31903
Macy Retirement Center	4408 Houston Avenue	Macon, GA	31206

Magnolia Manor Retirement Center	2001 South Lee Street	Americus, GA	31709
Marshview Senior Living	7410 Skidaway Road	Savannah, GA	31406
Mattie H. Marshall Center	2001 South Lee Street	Americus, GA	31709
Memory Lane of Bremen Bldg A	524 Gordon Street	Bremen, GA	30110
Merryvale Assisted Living	11980 Highway 142 North	Oxford, GA	30054
Morning Pointe Assisted Living	660 Jolly Road NW	Calhoun, GA	30701
Morning Starr Personal Care Home	519 Lawrenceville Street	Norcross, GA	30071
Morningside of Albany	1721 Beattie Road	Albany, GA	31721
Morningside of Conyers	1352 Wellbrook Circle	Conyers, GA	30012
Morningside of Macon	6191 Peake Road	Macon, GA	31220
Mountain View Personal Care Home	3675 Kensington Road	Decatur, GA	30032
Mt. Carmel Personal Care Home	3084 Mt. Carmel Road	Hampton, GA	30228
Northlake Gardens	1300 Montreal Road	Tucker, GA	30084
Northwoods Retirement Home	54 Northwoods Drive	Dahlonega, GA	30533
Odom, Pam Personal Care Home	129 Leonard Lane	Swainsboro, GA	30401
Palm Shade Villa Assisted Living II	12166 Highway 212	Covington, GA	30014
Palmer Family Care Home	4550 Janice Drive	College Park, GA	30337
Park Regency Personal Care Home	3000 Veterans Parkway	Moultrie, GA	31768
Peachtree Plantation	4251 Hudson Drive	Oakwood, GA	30566
Peachtree Village Senior Living	199 West W Gary Road	Commerce, GA	30529
Petal's PCH	3371 Glen Summit Lane	Snellville, GA	30039
Pinewood Retirement Villa	7 Slappey Drive	Hawkinsville, GA	31036
Plantation Manor Personal Care Home	220 Park Avenue	Thomasville, GA	31792
Plantation South of Dunwoody	4594 Barclay Drive	Dunwoody, GA	30338
Presbyterian Village	2000 East-West Connector	Austell, GA	30106
Presbyterian Village - Hearthstone	2000 East-West Connector	Austell, GA	30106
Quality Choice Personal Care Home	3075 Antioch Road, Building	Macon, GA	31206
Renaissance Marquis Retirement Village	3126 Cedartown Highway	Rome, GA	30161
Riverwood Retirement Life Community	511 West 10th Street	Rome, GA	30165
Roman Court	1168 Chulio Road	Rome, GA	30161

Royal Southern Plantation	580 Tommy Lee Fuller Drive	Loganville, GA	30052
Safe Haven at Lenox Park	1137 Lynmoor Drive	Atlanta, GA	30319
Sandy Springs Assisted Living	300 Johnson Ferry Road, N.	Sandy Springs, GA	30328
Sara's Personal Care Home	129 Leonard Lane	Swainsboro, GA	30401
Savannah Commons Retirement Community - Verra Spring	1 Peachtree Drive	Savannah, GA	31419
Savannah Court of Milledgeville	61 Marshall Road	Milledgeville, GA	31061
Savannah Court of Newnan	27 Belt Road	Newnan, GA	30263
Savannah Plantation PCH	102 Level Creek Road	Buford, GA	30518
Scepter Living Center of Snellville LLC	3000 Lenora Church Road	Snellville, GA	30078
Seasons Assisted Living	2724 Ledo Road	Albany, GA	31707
Serenity of Jefferson	1442 Johnson Mill Road	Jefferson, GA	30549
Sha Sha's Leisure Living	1465 Teagle Road	Forsyth, GA	31029
Shadowmoss Plantation	249 Holland Drive	Savannah, GA	31419
Sheridan Place - Clare Bridge Place Memory Care Unit	504 Firetower Road	Dublin, GA	31021
Silverleaf of Athens	705 Whitehead Road	Athens, GA	30606
Silverleaf of Snellville	2106 McGee Road	Snellville, GA	30078
South Dooley Retirement Center II	1400 Swift Street	Perry, GA	31069
South Haven II	1335 Lake Ridge Parkway	Riverdale, GA	30296
Southern Care Retirement Home	1934 Whiddon Mill Road	Tifton, GA	31793
Southern Pines Senior Living	423 Covington Avenue	Thomasville, GA	31792
Spanish Oaks Retreat	8510 Whitfield Avenue	Savannah, GA	31406
Sparks Inn at Christian City	7290 Lester Road	Union City, GA	30291
St Marys Center for Alzheimer's and Dementia Care	1660 Jennings Mill Road	Bogart, GA	30622
St. George Village - Wellington Court	11350 Woodstock Road	Roswell, GA	30075
St. Ives Assisted Living	5835 Medlock Bridge Parkway	Alpharetta, GA	30022
Summers Landing Limestone	2030 Windward Lane	Gainesville, GA	30501
Summers Landing Northland Assisted Living	5399 Northland Drive	Atlanta, GA	30342
Summers Landing PCH	171 Highway 78 NW	Monroe, GA	30655
Summerset Assisted Living Community	3711 Benjamin E. Mays Drive	Atlanta, GA	30331

Sunrise at Buckhead	1000 Lenox Park Boulevard,	Atlanta, GA	30319
Sunrise at Decatur	920 Clairemont Avenue	Decatur, GA	30030
Sunrise at East Cobb	1551 Johnson Ferry Road	Marietta, GA	30062
Sunrise at Five Forks	3997 Five Forks Trickum Ro	Lilburn, GA	30047
Sunrise at Huntcliff Summit	8480 Roswell Road	Sandy Springs, GA	30350
Sunrise at Johns Creek	11405 Medlock Bridge Road	Johns Creek, GA	30093
Sunrise Harbour Personal Care Home	139 Orchard Pass	Warner Robins, GA	31088
Sunshine Residential Care	3949 Pine Gorge Circle	Dacula, GA	30019
Sweetwater Springs Assisted Living	1600 Lee Road	Lithia Springs, GA	30122
Tara Plantation Assisted Living	440 Tribble Gap Road	Cumming, GA	30040
The Carlton	690 Mt. Vernon Highway	Atlanta, GA	30328
The Court at Sandy Springs - Memory Care (Emeritus)	1262 Hightower Trail	Atlanta, GA	30350
The Green House II at Calvary	7462 Old Moon Road	Columbus, GA	31909
The Mann House	5413 Northland Drive	Atlanta, GA	30342
The Mews III PCH	621 North Cherokee Road	Social Circle, GA	30025
The Oaks Assisted Living at The Marshes of Skidaway Island	95 Skidaway Island Park Road	Savannah, GA	31411
The Oaks at Post Road	3875 Post Road	Cumming, GA	30040
The Oaks of Carrollton Assisted Living	921 Old Newnan Road	Carrollton, GA	30116
The Plaza Personal Care Center - Wesley Wood	2280 North Highway 29	Newnan, GA	30265
The Suites at Poplar Creek	114 Old Airport Road	LaGrange, GA	30240
The Valencia Personal Care Home Inc.	605 South Valencia Drive	Albany, GA	31707
The Woods Assisted Senior Living	1401 Macon Road	Griffin, GA	30224
Victoria Personal Care Home	2666 Nancy Drive	Macon, GA	31206
Virginia Gardens Assisted Living Center	404 East Church Street	Fort Valley, GA	31030
We Care 2 Personal Care Home	1483 Virgil Pond Lane	Loganville, GA	30052
Winterville Retirement Center	124 Avery Street	Winterville, GA	30683
Winthrop at Polk	131 Melissa Lane	Cedartown, GA	30125
Winthrop West Senior Living	279 Technology Parkway	Rome, GA	30165
Woodland Ridge	4005 South Cobb Drive	Smyrna, GA	30080

Woodstock Estates	1000 Professional Way	Woodstock, GA	30188
Yellow Brick House	6903 Main Street	Lithonia, GA	30058

PERSONAL CARE HOMES LATER STAGE

Name	Address	City	Zip Code
A Better Home Care	2700 Stancil Boulevard	Jonesboro, GA	30326
A Place for Comfort	1766 Big Valley Lane	Stone Mountain, GA	30083
Agape Living	1840 Phinizy Road	Augusta, GA	30906
Amelia Gardens I	545 Toonigh Road	Woodstock, GA	30188
Amelia Gardens II	2030 Bascomb Carmel Road	Woodstock, GA	30189
Angels Royal Gardens Personal Care Home	7752 Marabou Lane	Riverdale, GA	30274
Antebellum Grove Assisted Living	1010 Kathryn Ryals Road	Warner Robins, GA	31088
Arbor Terrace	170 Marilyn Farmer Way	Athens, GA	30606
Arbor Terrace at Cascade	1001 Research Center Atlanta	Atlanta, GA	30331
Arbor Terrace at Tucker	5844 Highway 29	Tucker, GA	30084
Arbor Terrace at West Cobb	3829 Floyd Road	Austell, GA	30106
Arbor Terrace of Decatur	425 Winn Way	Decatur, GA	30030
Arbor Terrace of East Cobb	866 Johnson Ferry Road	Marietta, GA	30068
Ashley Glen	441 Prime Point	Peachtree City, GA	30269
Ashton Hall	1155 Lawrenceville Highway	Lawrenceville, GA	30046
Atria Buckhead	2848 Lenox Road	Atlanta, GA	30324
Atria Johnson Ferry	9 Sherwood Lane	Marietta, GA	30067
Augusta Gardens Retirement Residence	3725 Wheeler Road	Augusta, GA	30909
Autumn Village 2A	746 McDonough Road	Jackson, GA	30233
Autumn Village 2B	746 McDonough Road	Jackson, GA	30233
Autumn Village 2C	746 McDonough Road	Jackson, GA	30233

Belair at Macon, The	4901 Harrison Road	Macon, GA	31206
Belmont Village	5455 Glenridge Drive	Atlanta, GA	30342
Benton House at Benton Village	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House at Benton Village - Transitional Step Down Program	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House of Covington	7155 Dearing Road	Covington, GA	30014
Benton House of Dublin and Beacon Neighborhood	212 Fairview Park Drive	Dublin, GA	31021
Benton House of Newnan Lakes	25 Newnan Lakes Boulevard	Newnan, GA	30263
BestCare Assisted Living	2775 Cruse Road; #1401	Lawrenceville, GA	30044
Bickford Senior Living	840 LeCroy Drive	Marietta, GA	30068
Blair House Senior Living Community	684 Arlington Place	Macon, GA	31201
Brasstown Manor	108 Church Street	Hiawassee, GA	30546
Brightmoor Assisted Living	3223 Newnan Road	Griffin, GA	30224
Brighton Gardens of Buckhead	3088 Lenox Road	Atlanta, GA	30324
Brighton Gardens of Dunwoody	1240 Ashford Center Parkway	Dunwoody, GA	30338
Brittany House at Benson Heights	1788 Sandy Plains Road	Marietta, GA	30066
Brittany House at Holly Springs	2852 Holly Springs Road	Marietta, GA	30062
Brittany's Place Assisted Living	141 Denis Drive	Jeffersonville, GA	31044
Cambridge Farms Assisted Living	4040 Webb Bridge Road	Alpharetta, GA	30005
Cameron Hall	240 Marietta Highway	Canton, GA	30114
Candler Ridge II	1205 Nunnally Drive	Monroe, GA	30655
Carlyle Place - Cambridge Court	5300 Zebulon Road	Macon, GA	31210
Cedar Hill Senior Living Community	402 East Ellawood Avenue	Cedartown, GA	30125
Cedar Plantation Assisted Living and Alzheimers Community	46637 Highway 46 East	Metter, GA	30439
Covenant Care Hamptom	120 West Tisbury Lane	Pooler, GA	31322

Covenant Care Lane	141 West Tisbury Lane	Pooler, GA	31322
Covenant Care Tisbury	126 West Tisbury Lane	Pooler, GA	31322
Divine Love Personal Care Home	943 Falling Creek Drive	Macon, GA	31220
Dogwood Forest at Eagles Landing	475 Country Club Drive	Stockbridge, GA	30281
Dogwood Forest of Fayetteville	1294 Highway 54 West	Fayetteville, GA	30214
Dream Catcher Farm Personal Care Home	286 Four Points Road	Jackson, GA	30233
Dream Catcher in the Woods	286 Four Points Road	Jackson, GA	30233
Eden Personal Care Home	2438 Swan Lake Drive	Grayson, GA	30017
Elmcroft at Milford Chase	1345 Milford Church Road	Marietta, GA	30008
Elmcroft of Mt. Zion	7493 Mount Zion Boulevard	Jonesboro, GA	30236
Elmcroft of Roswell	400 Marietta Highway	Roswell, GA	30075
Elmcroft Senior Living	515 The Pass	Martinez, GA	30907
Emeritus at Decatur	475 Irvin Court	Decatur, GA	30030
Emeritus at Flint River Memory Care Community	250 Water Tower Court	Macon, GA	31210
Emeritus at Heritage Hills	3607 Weems Road	Columbus, GA	31909
Emeritus at Riverstone Senior Living	125 Riverstone Terrace	Canton, GA	30114
Emeritus at Sandy Springs Place	1262 Hightower Trail	Atlanta, GA	30350
Emeritus at Spring Mountain	1790 Powder Springs Road	Marietta, GA	30064
Emeritus at Vinings	2401 Cumberland Parkway S	Atlanta, GA	30309
Emeritus at Woodstock Senior Living Community	756 Neese Road	Woodstock, GA	30188
Ettas House	1682 Pharr Road	Snellville, GA	30078
Evergreen Assisted Living	2823 Gillionville Road	Albany, GA	31721
FAM Personal Care Home	5618 Wellborn Creek Drive	Lithonia, GA	30058
G.S.E. Gantt Personal Care Home	3834 Fairington Drive	Hephzibah, GA	30815
Gardens of Roswell	9212 Nesbit Ferry Road	Alpharetta, GA	30022
Generous Care Giving	2769 Kilgore Road	Buford, GA	30519

Gentilly Gardens	625 Gentilly Road	Statesboro, GA	30458
Golden Crest	2160 Lake Harbin Road	Morrow, GA	30260
Golden Rule Personal Care Home	2342 Dorn Road	Augusta, GA	30906
Gracemont Assisted Living	4960 Jot-Em-Down Road	Cumming, GA	30041
Grosvenor Personal Care Home	4556 Central Drive	Stone Mountain, GA	30083
Habersham House Senior Residence	5200 Habersham Street	Savannah, GA	31405
Heritage of Sandy Plains	3039 Sandy Plains Road	Marietta, GA	30066
Homeplace Senior Living - Memory Care Community	345 Pearl Bates Avenue	Eastman, GA	31023
Lake Pointe Assisted Living & Memory Care Community	45 Walnut Street	Hartwell, GA	30643
Leisure Living of LaGrange I	137 Parker Place	LaGrange, GA	30240
Lorraine Young Personal Care Home	2836 Tobacco Road	Hephzibah, GA	30815
Loving Grace Personal Care Home #1	1236 12th Street	Augusta, GA	30901
Macy Retirement Center	4408 Houston Avenue	Macon, GA	31206
Magnolia Manor Retirement Center	2001 South Lee Street	Americus, GA	31709
Mattie H. Marshall Center	2001 South Lee Street	Americus, GA	31709
Memory Lane of Bremen Bldg A	524 Gordon Street	Bremen, GA	30110
Mercy Personal Care Home	3630 Brushy Wood Drive	Loganville, GA	30052
Merryvale Assisted Living	11980 Highway 142 North	Oxford, GA	30054
Morning Starr Personal Care Home	519 Lawrenceville Street	Norcross, GA	30071
Morningside of Albany	1721 Beattie Road	Albany, GA	31721
Morningside of Conyers	1352 Wellbrook Circle	Conyers, GA	30012
Morningside of Macon	6191 Peake Road	Macon, GA	31220
Mountain View Personal Care Home	3675 Kensington Road	Decatur, GA	30032
Mt. Carmel Personal Care Home	3084 Mt. Carmel Road	Hampton, GA	30228
Naja Personal Care Home	935 Donington Circle	Lawrenceville, GA	30045
Northlake Gardens	1300 Montreal Road	Tucker, GA	30084

Pineview Gardens of Evans	4393 Owens Road	Evans, GA	30809
Pineview Gardens Personal Care Home	4255 Highway 25 North	Hephzibah, GA	30815
Plair Personal Care Home	2016 Scott Road	Augusta, GA	30906
Plair Personal Care Home II	2014 Scott Road	Augusta, GA	30906
Plantation Manor Personal Care Home	220 Park Avenue	Thomasville, GA	31792
Plantation South of Dunwoody	4594 Barclay Drive	Dunwoody, GA	30338
Platinum Care Personal Care Home	2358 Oak Avenue	Morrow, GA	30260
Precious Touch PCH	6631 Chason Woods Court	Jonesboro, GA	30238
Presbyterian Village	2000 East-West Connector	Austell, GA	30106
Presbyterian Village - Hearthstone	2000 East-West Connector	Austell, GA	30106
Providence of Alpharetta	12775 Providence Road	Alpharetta, GA	30009
Rainbow Retirement Home	109 Meyer Farm Road	Arnoldsville, GA	30619
Renaissance On Peachtree	3755 Peachtree Road, N.E.	Atlanta, GA	30319
Riverwood Retirement Life Community	511 West 10th Street	Rome, GA	30165
Roman Court	1168 Chulio Road	Rome, GA	30161
Royal Southern Plantation	580 Tommy Lee Fuller Drive	Loganville, GA	30052
Safe Haven at Lenox Park	1137 Lynmoor Drive	Atlanta, GA	30319
Savannah Court of Milledgeville	61 Marshall Road	Milledgeville, GA	31061
Savannah Court of Newnan	27 Belt Road	Newnan, GA	30263
Scepter Living Center of Snellville LLC	3000 Lenora Church Road	Snellville, GA	30078
Senior Citizens Care Center Annex	223 Harmon Road	Swainsboro, GA	30401
Serenity of Jefferson	1442 Johnson Mill Road	Jefferson, GA	30549
Sha Sha's Leisure Living	1465 Teagle Road	Forsyth, GA	31029
Sheridan Place - Clare Bridge Place Memory Care Unit	504 Firetower Road	Dublin, GA	31021
Silverleaf of Snellville	2106 McGee Road	Snellville, GA	30078
Sonshine Manor Personal Care Home	115 Stephens View Road	Jasper, GA	30143
Southern Heritage II	814 Carl Vinson Parkway	Centerville, GA	31028

Southern Pines Senior Care Inc.	258 College Avenue	Maysville, GA	30558
Southern Pines Senior Living	423 Covington Avenue	Thomasville, GA	31792
St Marys Center for Alzheimer's and Dementia Care	1660 Jennings Mill Road	Bogart, GA	30622
Stonehenge Assisted Living 3	168 Stonehenge Drive	Blairsville, GA	30512
Stonehenge Assisted Living One	168 Stonehenge Drive	Blairsville, GA	30512
Stonehenge Too	168 Stonehenge Drive	Blairsville, GA	30512
Summers Landing PCH	171 Highway 78 NW	Monroe, GA	30655
Summerset Assisted Living Community	3711 Benjamin E. Mays Drive	Atlanta, GA	30331
Sunrise at Buckhead	1000 Lenox Park Boulevard,	Atlanta, GA	30319
Sunrise at Decatur	920 Clairemont Avenue	Decatur, GA	30030
Sunrise at East Cobb	1551 Johnson Ferry Road	Marietta, GA	30062
Sunrise at Five Forks	3997 Five Forks Trickum Ro	Lilburn, GA	30047
Sunrise at Huntcliff Summit	8480 Roswell Road	Sandy Springs, GA	30350
Sunrise Harbour Personal Care Home	139 Orchard Pass	Warner Robins, GA	31088
Sweetwater Springs Assisted Living	1600 Lee Road	Lithia Springs, GA	30122
Tapleys Personal Care Home	4602 Hereford Farm Road	Evans, GA	30809
Tara Plantation Assisted Living	440 Tribble Gap Road	Cumming, GA	30040
Tender Care Assisted Living at Snellville	3922 Centerville Highway #1	Snellville, GA	30039
Tender Care Personal Care Home	1560 Twin Bridge Lane	Lawrenceville, GA	30043
The Carlton	690 Mt. Vernon Highway	Atlanta, GA	30328
The Cottage Senior Living	818 Round Tree Court	Lawrenceville, GA	30045
The Court at Sandy Springs - Memory Care (Emeritus)	1262 Hightower Trail	Atlanta, GA	30350
The Green House at Calvary	7490 Old Moon Road	Columbus, GA	31909
The Green House II at Calvary	7462 Old Moon Road	Columbus, GA	31909

The Mann House	5413 Northland Drive	Atlanta, GA	30342
The Oaks Assisted Living at The Marshes of Skidway Island	95 Skidaway Island Park Road	Savannah, GA	31411
The Plaza Personal Care Center - Wesley Wood	2280 North Highway 29	Newnan, GA	30265
The Suites at Poplar Creek	114 Old Airport Road	LaGrange, GA	30240
Trinity Personal Care Home of Georgia, LLC	718 Weed Street	Augusta, GA	30904
Tudor Castle Personal Care Home	2056 Tudor Castle Circle	Decatur, GA	30035
Tylers Assisted Living	208 Flowing Wells Road	Martinez, GA	30907
Victoria Personal Care Home	2666 Nancy Drive	Macon, GA	31206
Vital Place	985 Waldwick Drive	Lawrenceville, GA	30045
Washington Manor	184 Pine Lane	Washington, GA	30673
We Care 2 Personal Care Home	1483 Virgil Pond Lane	Loganville, GA	30052
Whispering Pines	6273 Highway 41 South	Bolingbroke, GA	31004
Willow Gardens	16 Crestwood Drive	Toccoa, GA	30577
Winthrop at Polk	131 Melissa Lane	Cedartown, GA	30125
Winthrop West Senior Living	279 Technology Parkway	Rome, GA	30165
Woodland Ridge	4005 South Cobb Drive	Smyrna, GA	30080
Woodstock Estates	1000 Professional Way	Woodstock, GA	30188
Yellow Brick House	6903 Main Street	Lithonia, GA	30058
Yellow Brick Road PCH	5063 Upper Elm Street	Atlanta, GA	30349

PERSONAL CARE HOMES MODERATE STAGE

Name	Address	City	Zip Code
A 1 Belinda Winfrey PCH	1833 Empress Court	Augusta, GA	30906
A Better Home Care	2700 Stancil Boulevard	Jonesboro, GA	30326
A Loving Heart Personal Care Home	3437 Gebhart Court	Hephzibah, GA	30815
A Place for Comfort	1766 Big Valley Lane	Stone Mountain, GA	30083

AAN Center	414 Rigby Street	Marietta, GA	30060
Agape Living	1840 Phinizy Road	Augusta, GA	30906
Alberta Gregory Personal Care Home	2102 Kennedy Drive	Augusta, GA	30904
Alero Personal Care Home Inc	230 Trelawny Circle	Covington, GA	30016
Amazing Grace Personal Care Home	206 Reynolds Street	Augusta, GA	30901
Amelia Gardens	576 Nickajack Road	Mableton, GA	30126
Amelia Gardens I	545 Toonigh Road	Woodstock, GA	30188
Amelia Gardens II	2030 Bascomb Carmel Road	Woodstock, GA	30189
Andras AA Personal Care Home	1736 Jenkins Street	Augusta, GA	30904
Angels Care Personal Care Home	2620 Richmond Hill Road	Augusta, GA	30906
Angels Royal Gardens Personal Care Home	7752 Marabou Lane	Riverdale, GA	30274
Annette Holleys Personal Care Home #2	4515 Colonial Road	Martinez, GA	30907
Antebellum Grove Assisted Living	1010 Kathryn Ryals Road	Warner Robins, GA	31088
Anthonys Personal Care Home	2329 Cadden Road	Augusta, GA	30906
Arbor Terrace	170 Marilyn Farmer Way	Athens, GA	30606
Arbor Terrace at Cascade	1001 Research Center	Atlanta, GA	30331
Arbor Terrace at Tucker	5844 Highway 29	Tucker, GA	30084
Arbor Terrace at West Cobb	3829 Floyd Road	Austell, GA	30106
Arbor Terrace of Decatur	425 Winn Way	Decatur, GA	30030
Arbor Terrace of East Cobb	866 Johnson Ferry Road	Marietta, GA	30068
Ashley Glen	441 Prime Point	Peachtree City, GA	30269
Ashton Hall	1155 Lawrenceville Highway	Lawrenceville, GA	30046
Atria Buckhead	2848 Lenox Road	Atlanta, GA	30324
Atria Johnson Ferry	9 Sherwood Lane	Marietta, GA	30067

Augusta Gardens Retirement Residence	3725 Wheeler Road	Augusta, GA	30909
Autumn Breeze Assisted Living	2215 Old Hamilton Place	Gainesville, GA	30507
Autumn Village	753 Covington Street	Jackson, GA	30233
Autumn Village 2A	746 McDonough Road	Jackson, GA	30233
Autumn Village 2B	746 McDonough Road	Jackson, GA	30233
Autumn Village 2C	746 McDonough Road	Jackson, GA	30233
Avondale Assisted Living at Kensington	3508 Kensington Road	Decatur, GA	30032
Avondale Assisted Living at Northlake	3965 Gloucester Drive	Tucker, GA	30084
Avondale Homes at Tucker	2553 Sandpiper Drive	Tucker, GA	30084
Barbara Ray Halls Personal Care Home	2638 Castletown Drive	Hephzibah, GA	30815
Belair at Macon, The	4901 Harrison Road	Macon, GA	31206
Belmont Village	5455 Glenridge Drive	Atlanta, GA	30342
Benton House at Benton Village	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House at Benton Village - Transitional Step Down Program	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House of Dublin and Beacon Neighborhood	212 Fairview Park Drive	Dublin, GA	31021
Benton House of Newnan Lakes	25 Newnan Lakes Boulevard	Newnan, GA	30263
Bessie Maes Personal Care Home	910 Quaker Road Drive	Waynesboro, GA	30830
BestCare Assisted Living	2775 Cruse Road; #1401	Lawrenceville, GA	30044
Bethany Assisted Living, Inc.	1400 Northeast Main Street	Vidalia, GA	30474
Bickford Senior Living	840 LeCroy Drive	Marietta, GA	30068
Blair House Senior Living Community	684 Arlington Place	Macon, GA	31201
Blossom Personal Care Home	2494 Lillies Trace	Dacula, GA	30019
Brasstown Manor	108 Church Street	Hiawassee, GA	30546
Brightmoor Assisted Living	3223 Newnan Road	Griffin, GA	30224
Brighton Gardens of Buckhead	3088 Lenox Road	Atlanta, GA	30324
Brittany House at Benson Heights	1788 Sandy Plains Road	Marietta, GA	30066
Brittany House at Holly Springs	2852 Holly Springs Road	Marietta, GA	30062
Brookdale Place of Augusta	326 Boy Scout Road	Augusta, GA	30909

Brooks Home Care	2408 Mims Road	Hephzibah, GA	30815
Brown Personal Care Home	554 Idlewood Road	Waynesboro, GA	30830
Bryants of Peace Personal Care Home	339 Marshall Street	Martinez, GA	30907
Cambridge Farms Assisted Living	4040 Webb Bridge Road	Alpharetta, GA	30005
Cameron Hall	240 Marietta Highway	Canton, GA	30114
Cameron Hall of Ellijay	114 Penland Street	Ellijay, GA	30540
Camilla Retirement Home	161 East Broad Street	Camilla, GA	31730
Candler Ridge II	1205 Nunnally Drive	Monroe, GA	30655
Care Givers & More Elderly Care Services	6602 Shucraft Road	Appling, GA	30802
Carlyle Place - Cambridge Court	5300 Zebulon Road	Macon, GA	31210
Carols Place	2662 Barclay Street	Hephzibah, GA	30815
Cedar Hill Senior Living Community	402 East Ellawood Avenue	Cedartown, GA	30125
Cedar Plantation Assisted Living and Alzheimers Community	46637 Highway 46 East	Metter, GA	30439
Champeunes Personal Care Home	3439 Rushing Road	Augusta, GA	30906
Charms Personal Care Home	900 West Residence Avenue	Albany, GA	31701
Colonial Gardens of Warner Robins #1	903 West Highway 96	Warner Robins, GA	31088
Colquitt Garden Manor	498 5th Street SE	Moultrie, GA	31768
Cordelia Manor Personal Care Home	1307 Blackshear Road	Cordele, GA	31015
Country Manor Estates	1487 Allen Road	Macon, GA	31216
Courtyard Gardens	1000 River Center Place	Lawrenceville, GA	30043
Covenant Care Hamptom	120 West Tisbury Lane	Pooler, GA	31322
Covenant Care Lane	141 West Tisbury Lane	Pooler, GA	31322
Covenant Care Tisbury	126 West Tisbury Lane	Pooler, GA	31322
Cozy Manor Personal Care Home	706 North Main Street	LaFayette, GA	30728
Davis Elderly Care	5275 Hereford Farm Road	Evans, GA	30809
Delmar Gardens of Gwinnett	3100 Club Drive	Lawrenceville, GA	30044
Dennis and Dilsie Adult Care Home	217 St. Andrew Street	Sylvania, GA	30467

Destinys Home of Comfort Personal Care Home	2529 Crosscreek Road	Hephzibah, GA	30815
Divine Love Personal Care Home	943 Falling Creek Drive	Macon, GA	31220
Dogwood Bluff Personal Care Home	266 Pony Lake Lane	Dahlonega, GA	30533
Dogwood Forest at Eagles Landing	475 Country Club Drive	Stockbridge, GA	30281
Dogwood Forest of Fayetteville	1294 Highway 54 West	Fayetteville, GA	30214
Dogwood Forest of Gainesville	3315 Thompson Bridge Road	Gainesville, GA	30506
Dream Catcher Farm Personal Care Home	286 Four Points Road	Jackson, GA	30233
Dream Catcher in the Woods	286 Four Points Road	Jackson, GA	30233
Echols Personal Care Home	5266 Lexington Road	Rayle, GA	30660
Eden Personal Care Home	2438 Swan Lake Drive	Grayson, GA	30017
Elaine Miller Personal Care Home	5413 Old Augusta Highway	Grovetown, GA	30813
Elmcroft at Milford Chase	1345 Milford Church Road	Marietta, GA	30008
Elmcroft of Mt. Zion	7493 Mount Zion Boulevard	Jonesboro, GA	30236
Elmcroft of Roswell	400 Marietta Highway	Roswell, GA	30075
Elmcroft Senior Living	515 The Pass	Martinez, GA	30907
Emeritus at Decatur	475 Irvin Court	Decatur, GA	30030
Emeritus at Flint River Memory Care Community	250 Water Tower Court	Macon, GA	31210
Emeritus at Heritage Hills	3607 Weems Road	Columbus, GA	31909
Emeritus at Riverstone Senior Living	125 Riverstone Terrace	Canton, GA	30114
Emeritus at Sandy Springs Place	1262 Hightower Trail	Atlanta, GA	30350
Emeritus at Spring Mountain	1790 Powder Springs Road	Marietta, GA	30064
Emeritus at Vinings	2401 Cumberland Parkway S	Atlanta, GA	30309
Emeritus at Woodstock Senior Living Community	756 Neese Road	Woodstock, GA	30188
Englewood Health Care I	507 North Madison	Albany, GA	31701
Ettas House	1682 Pharr Road	Snellville, GA	30078
Evans Personal Care Home	426 Liberty Street	Gray, GA	31032
Evergreen Assisted Living	2823 Gillionville Road	Albany, GA	31721
Faith and Hope Personal Care Home	773 Chapman Street	Jonesboro, GA	30238

Faith Landing Personal Care Home	1215 Hale Street	Waynesboro, GA	30830
FAM Personal Care Home	5618 Wellborn Creek Drive	Lithonia, GA	30058
Family Pampering Center PCH #1	2180 Surrey Trail	College Park, GA	30349
Fern's Tender Loving Care Home	3547 Spring Valley Road	Decatur, GA	30032
First Love Personal Care Home #1	2403 Wrightsboro Road	Augusta, GA	30904
First Love Personal Care Home #2	2734 Milledgeville Road	Augusta, GA	30904
Fite Living Centre	5 Fite Street	Cartersville, GA	30120
Five Ponds Personal Care Home	4688 Windsor Spring Road	Hephzibah, GA	30815
Florence Jeffersons T.L.C.	4357 Seago Road	Hephzibah, GA	30815
Freeman Personal Care Home	1945 15th Street	Augusta, GA	30901
Fulcher - Nations Personal Care Home	2020 Edgar Street	Augusta, GA	30904
G.S.E. Gantt Personal Care Home	3834 Fairington Drive	Hephzibah, GA	30815
Gardens at Royal Oaks	1218 Broadrick Drive	Dalton, GA	30720
Gardens of Roswell	9212 Nesbit Ferry Road	Alpharetta, GA	30022
Gardners Personal Care Home	2024 Wrightsboro Road	Augusta, GA	30901
Gaynell Hymels Personal Care Home	1029 Mosley Road	Augusta, GA	30906
Gaynell Hymels Personal Care Home II	1015 Mosley Road	Augusta, GA	30906
Generous Care Giving	2769 Kilgore Road	Buford, GA	30519
Gentilly Gardens	625 Gentilly Road	Statesboro, GA	30458
Georgia Living Center	182 Head Avenue	Tallapoosa, GA	30176
Gods Child Personal Care Home	3719 Colbert Street	Augusta, GA	30906
Golden Crest	2160 Lake Harbin Road	Morrow, GA	30260
Golden Crest Assisted Living - Eagles Landing	425 Country Club Drive	Stockbridge, GA	30281
Golden Pond Assisted Living Center	8167 Eisenhower Parkway	Lizella, GA	31052
Golden Rule Personal Care Home	2342 Dorn Road	Augusta, GA	30906
Golff Personal Care Home	439 Drexell Avenue	Millen, GA	30442
Gospel Water Branch Elderly Housing, Inc.	672 King Taylor Road	Evans, GA	30809
Governors Glen	5000 Governors Drive	Forest Park, GA	30297
Gracemont Assisted Living	4940 Jot-Em-Down Road	Cumming, GA	30041

Gracemont Assisted Living	4960 Jot-Em-Down Road	Cumming, GA	30041
Graces House	2 River Street	Cave Spring, GA	30124
Great Day PCH	2604 Whittier Place	Hephzibah, GA	30815
Greenwood Gardens	1160 Whitlock Avenue	Marietta, GA	30064
Griffin House South, The	107 West Liberty Street	Claxton, GA	30417
Grosvenor Personal Care Home	4556 Central Drive	Stone Mountain, GA	30083
Habersham House Senior Residence	5200 Habersham Street	Savannah, GA	31405
Halls Personal Care Home of Evans	4528 Hereford Farm Road	Evans, GA	30809
Hapeville Manor Assisted Living	601 Coleman Street	Hapeville, GA	30354
Heather House	11965 Old Mountain Park Ro	Roswell, GA	30075
Heather House Crabapple	290 Ranchette Road	Alpharetta, GA	30004
Heavenly Arms	2764 1/2 Tobacco Road	Hephzibah, GA	30815
Helping Hands Personal Care Home 2	6260 Mozart Drive	Riverdale, GA	30296
Heritage of Sandy Plains	3039 Sandy Plains Road	Marietta, GA	30066
Horizon Bay	180 Woodrow Wilson Way	Rome, GA	30165
House of Naum Personal Care Home, The	2880 Olive Grove Church Ro	Roberta, GA	31078
Isaac Haven Assisted Living Center	1939 Isaac Watkins Road	Montrose, GA	31065
Ivy Hall North	5690 State Bridge Road	Alpharetta, GA	30022
J R & C Assisted Living Center	2195 Waynesboro Highway	Hiltonia, GA	30467
Jacksons Personal Care Home	2377 Dublin Drive	Augusta, GA	30906
Jamestown Personal Care Home	300 Green Street	Fort Valley, GA	31030
Jane Smiths Personal Care Home	1809 Mavis Street	Augusta, GA	30906
Johns Helping Hands	2903 Larkspur Drive	Augusta, GA	30906
Jones Personal Care Home	1618 Cider Lane	Augusta, GA	30906
Joseph Home of Comfort PCH	3908 Fairington Drive	Hephzibah, GA	30815
Krisscare Personal Care Home	2793 Skyland Drive	Snellville, GA	30078
Lake Pointe Assisted Living & Memory Care Community	45 Walnut Street	Hartwell, GA	30643
Lakeside Rest Home	924 Crump Street	Swainsboro, GA	30401
Lakeview Retirement Center	111 Stephens Avenue	Baxley, GA	31513
Laurel Creek Manor Assisted Living	7955 Majors Road	Cumming, GA	30041

Leisure Living of LaGrange I	137 Parker Place	LaGrange, GA	30240
Lifetime CLA	706 High Pointe Drive	Winder, GA	30680
Lighthouse Personal Care Home	1431 Brittain Road	Douglasville, GA	30134
Lighthouse Personal Care Home, The	206 Blue Mountain Parkway	Rocky Face, GA	30740
Lorraine Young Personal Care Home	2836 Tobacco Road	Hephzibah, GA	30815
Loves Community Care Center	2366 Dublin Drive	Augusta, GA	30906
Loves Personal Care Facility	2347 Amsterdam Drive	Augusta, GA	30906
Loving Grace Personal Care Home #1	1236 12th Street	Augusta, GA	30901
Lucille Kylers Quality Care Personal Care Home	3231 Ware Road	Augusta, GA	30909
Macy Retirement Center	4408 Houston Avenue	Macon, GA	31206
Magnolia Lane	6365 Newborn Drive	College Park, GA	30349
Magnolia Manor of Columbus Assisted Living	2040 Warm Springs Road	Columbus, GA	31904
Magnolia Manor Retirement Center	2001 South Lee Street	Americus, GA	31709
Majestic Manor	67 Pin Oak Drive	Rock Spring, GA	30739
Maries Adult Personal Care Home	3524 Wrightsboro Road	Augusta, GA	30909
Mattie H. Marshall Center	2001 South Lee Street	Americus, GA	31709
Memory Lane of Bremen Bldg A	524 Gordon Street	Bremen, GA	30110
Mercy Personal Care Home	3630 Brushy Wood Drive	Loganville, GA	30052
Merryvale Assisted Living	11980 Highway 142 North	Oxford, GA	30054
Miller and Son Personal Care Home	136 Salem Church-Miller Ro	Gray, GA	31032
Mitchells Personal Care Home	405 Lawton Street	Atlanta, GA	30310
Mitchells Personal Care Home	684 Cascade Avenue	Atlanta, GA	30310
Morning Pointe Assisted Living	660 Jolly Road NW	Calhoun, GA	30701
Morning Starr Personal Care Home	519 Lawrenceville Street	Norcross, GA	30071
Morningside of Conyers	1352 Wellbrook Circle	Conyers, GA	30012
Morningside of Dalton	2470 Dug Gap Road	Dalton, GA	30720
Morningside of Macon	6191 Peake Road	Macon, GA	31220
Mountain View Personal Care Home	3675 Kensington Road	Decatur, GA	30032
Mt. Carmel Personal Care Home	3084 Mt. Carmel Road	Hampton, GA	30228
Naja Personal Care Home	935 Donington	Lawrenceville, GA	30045

	Circle		
Northlake Gardens	1300 Montreal Road	Tucker, GA	30084
Northside Villa	8828 Hwy 112 North	Rochelle, GA	31079
Palmer Family Care Home	4550 Janice Drive	College Park, GA	30337
Park Regency Personal Care Home	3000 Veterans Parkway	Moultrie, GA	31768
Patricias Adults Care Home	206 St. Andrews Street	Sylvania, GA	30467
Patterson Personal Care Home - Augusta	1605 Cornell Drive	Augusta, GA	30906
Peaceful Living Personal Care Home - Augusta	2714 Coleman Avenue	Augusta, GA	30906
Peachtree Plantation	4251 Hudson Drive	Oakwood, GA	30566
Pineview Gardens of Evans	4393 Owens Road	Evans, GA	30809
Pineview Gardens Personal Care Home	4255 Highway 25 North	Hephzibah, GA	30815
Plair Personal Care Home	2016 Scott Road	Augusta, GA	30906
Plair Personal Care Home II	2014 Scott Road	Augusta, GA	30906
Plantation South of Dunwoody	4594 Barclay Drive	Dunwoody, GA	30338
Pleasant Valley Retirement Home	510 Reed Road	Dalton, GA	30720
Precious Touch PCH	6631 Chason Woods Court	Jonesboro, GA	30238
Presbyterian Village	2000 East-West Connector	Austell, GA	30106
Presbyterian Village - Hearthstone	2000 East-West Connector	Austell, GA	30106
Providence of Alpharetta	12775 Providence Road	Alpharetta, GA	30009
Q & N Personal Care Home	1859 Keith Drive	Marietta, GA	30064
Rainbow Retirement Home	109 Meyer Farm Road	Arnoldsville, GA	30619
Renaissance Marquis Retirement Village	3126 Cedartown Highway	Rome, GA	30161
Renaissance On Peachtree	3755 Peachtree Road, N.E.	Atlanta, GA	30319
Rhema Personal Care Facilities	3144 Macedonia Road	Powder Springs, GA	30127
Riverwood Retirement Life Community	511 West 10th Street	Rome, GA	30165
Rock Creek Manor	50 Cagle Mill Road South	Jasper, GA	30143
Roman Court	1168 Chulio Road	Rome, GA	30161
Rosaleana's Community Assisted Living Care	350 Schoen Street, SE	Atlanta, GA	30315
Rosewood at Fort Oglethorpe	14 Fort Town Drive	Fort Oglethorpe, GA	30742
Royal Southern Plantation	580 Tommy Lee Fuller Drive	Loganville, GA	30052

Ruby Place	705 Cleland Street	Savannah, GA	31415
Sacred Hands Personal Care Homes	141 St Ann Circle	Dallas, GA	30157
Safe Haven at Lenox Park	1137 Lynmoor Drive	Atlanta, GA	30319
Safe Haven Transitional Home	305 E Mulberry Street	LaGrange, GA	30241
Savannah Court of Newnan	27 Belt Road	Newnan, GA	30263
Savannah Plantation PCH	102 Level Creek Road	Buford, GA	30518
Scepter Living Center of Snellville LLC	3000 Lenora Church Road	Snellville, GA	30078
Schnora's Happy Home	2690 Shady Hill Court	Snellville, GA	30039
Senior Citizens Care Center Annex	223 Harmon Road	Swainsboro, GA	30401
Serenity Mountain Manor	309 Price Creek Farms Lane	Jasper, GA	30143
Serenity of Jefferson	1442 Johnson Mill Road	Jefferson, GA	30549
Sha Sha's Leisure Living	1465 Teagle Road	Forsyth, GA	31029
Sha-Lyndas Personal Care Home	2313 Cadden Court	Augusta, GA	30906
Shady Lane	4901 La Roche Avenue	Savannah, GA	31404
Shady Lane II PCH	1133 Cornell Avenue	Savannah, GA	31406
Shady Lane IV	4901 LaRoche Avenue	Savannah, GA	31404
Sheppard Personal Care Home	123 Emma Lane	Waynesboro, GA	30830
Sheridan Place - Clare Bridge Place Memory Care Unit	504 Firetower Road	Dublin, GA	31021
Silverleaf of Snellville	2106 McGee Road	Snellville, GA	30078
Smith PCH	315 Advance Street	Swainsboro, GA	30401
Sonshine Manor Personal Care Home	115 Stephens View Road	Jasper, GA	30143
Southern Comfort Personal Care Home	580 Old Bremen Road	Temple, GA	30179
Southern Heritage II	814 Carl Vinson Parkway	Centerville, GA	31028
Southern Pines Senior Care Inc.	258 College Avenue	Maysville, GA	30558
Southern Pines Senior Living	423 Covington Avenue	Thomasville, GA	31792
Sparks Inn at Christian City	7290 Lester Road	Union City, GA	30291
Springfield Personal Care Home	3342 Springfield Road	Sparta, GA	31087
St Irene PCH	44 Clairmont Avenue	Elberton, GA	30635
St Marys Center for Alzheimer's and Dementia	1660 Jennings Mill Road	Bogart, GA	30622
Care			

Star Manor	241 Nelson Street	Cartersville, GA	30120
Stonehenge Assisted Living 3	168 Stonehenge Drive	Blairsville, GA	30512
Stonehenge Assisted Living One	168 Stonehenge Drive	Blairsville, GA	30512
Stonehenge Too	168 Stonehenge Drive	Blairsville, GA	30512
Suites at Oak View	55 Stockade Road	Summerville, GA	30747
Summer Willow Assisted Living	259 Nunez Lexsy Road	Swainsboro, GA	30401
Summer's Landing	311 Jerriel Street	Vidalia, GA	30474
Summer's Landing Tilly Mill	4821 North Peachtree Road	Dunwoody, GA	30338
Summers Landing Limestone	2030 Windward Lane	Gainesville, GA	30501
Summers Landing PCH	171 Highway 78 NW	Monroe, GA	30655
Summerset Assisted Living Community	3711 Benjamin E. Mays Drive	Atlanta, GA	30331
Sunrise at Buckhead	1000 Lenox Park Boulevard,	Atlanta, GA	30319
Sunrise at Decatur	920 Clairemont Avenue	Decatur, GA	30030
Sunrise at East Cobb	1551 Johnson Ferry Road	Marietta, GA	30062
Sunrise at Five Forks	3997 Five Forks Trickum Ro	Lilburn, GA	30047
Sunrise at Huntcliff Summit	8480 Roswell Road	Sandy Springs, GA	30350
Sunrise at Johns Creek	11405 Medlock Bridge Road	Johns Creek, GA	30093
Sunrise Harbour Personal Care Home	139 Orchard Pass	Warner Robins, GA	31088
Sweetwater Springs Assisted Living	1600 Lee Road	Lithia Springs, GA	30122
Tapleys Personal Care Home	4602 Hereford Farm Road	Evans, GA	30809
Tara Plantation Assisted Living	440 Tribble Gap Road	Cumming, GA	30040
Tebeau House Retirement Home	2019 Tebeau Street	Waycross, GA	31501
Tender Care Assisted Living at Snellville	3922 Centerville Highway #1	Snellville, GA	30039
Tender Care Personal Care Home	1560 Twin Bridge Lane	Lawrenceville, GA	30043
Tennille Assisted Living	525 North Main Street	Tennille, GA	31089
The Carlton	690 Mt. Vernon Highway	Atlanta, GA	30328
The Cohen Home	10485 Jones Bridge Road	Alpharetta, GA	30022
The Colonnade at Brandon Wilde	4275 Owens Road	Evans, GA	30809

The Cottage Senior Living	818 Round Tree Court	Lawrenceville, GA	30045
The Court at Sandy Springs - Memory Care (Emeritus)	1262 Hightower Trail	Atlanta, GA	30350
The Green House at Calvary	7490 Old Moon Road	Columbus, GA	31909
The Green House II at Calvary	7462 Old Moon Road	Columbus, GA	31909
The Home Place	801 Walnut Street	Louisville, GA	30434
The Mann House	5413 Northland Drive	Atlanta, GA	30342
The Oaks Assisted Living at The Marshes of Skidaway Island	95 Skidaway Island Park Road	Savannah, GA	31411
The Plaza Personal Care Center - Wesley Wood	2280 North Highway 29	Newnan, GA	30265
The Suites at Poplar Creek	114 Old Airport Road	LaGrange, GA	30240
The Willows	4179 Wheeler Road	Martinez, GA	30907
TLC Family Home	3605 Shallowford Road	Marietta, GA	30062
Trinity Personal Care Home of Georgia, LLC	718 Weed Street	Augusta, GA	30904
Tudor Castle Personal Care Home	2056 Tudor Castle Circle	Decatur, GA	30035
Tylers Assisted Living	208 Flowing Wells Road	Martinez, GA	30907
Victoria Personal Care Home	2666 Nancy Drive	Macon, GA	31206
Victory Village	3650 Salem Church Road	Jasper, GA	30143
Villa Rose	430 Mosley Road	Byron, GA	31008
Vision Personal Care Home #1	960 Curry Place	Macon, GA	31202
Vital Place	985 Waldwick Drive	Lawrenceville, GA	30045
Waldrop Personal Care Inc	89 Burnt Hickory Road	Cartersville, GA	30120
Walkers Lakebreeze Personal Care Home	440-A Lang Road	Covington, GA	30014
Washington Manor	184 Pine Lane	Washington, GA	30673
We Care 2 Personal Care Home	1483 Virgil Pond Lane	Loganville, GA	30052
Welcoming Arms	210 Crabapple Road	Fayetteville, GA	30215
Whispering Pines	6273 Highway 41 South	Bolingbroke, GA	31004
Willow Gardens	16 Crestwood Drive	Toccoa, GA	30577
Winthrop at Polk	131 Melissa Lane	Cedartown, GA	30125
Winthrop Court Assisted Living	10 Highway 411 East	Rome, GA	30161
Winthrop West Senior Living	279 Technology Parkway	Rome, GA	30165

Wise Choice Personal Care Home	318 Meadow Court	Martinez, GA	30907
Woodhaven Personal Care Home	6246 Highway 136	Trenton, GA	30752
Woodland Ridge	4005 South Cobb Drive	Smyrna, GA	30080
Woodstock Estates	1000 Professional Way	Woodstock, GA	30188
Yellow Brick House	6903 Main Street	Lithonia, GA	30058
Yellow Brick Road PCH	5063 Upper Elm Street	Atlanta, GA	30349

PERSONAL CARE HOMES EARLY STAGE

Name	Address	City	Zip Code
A 1 Belinda Winfrey PCH	1833 Empress Court	Augusta, GA	30906
A Better Home Care	2700 Stancil Boulevard	Jonesboro, GA	30326
A Loving Heart Personal Care Home	3437 Gebhart Court	Hephzibah, GA	30815
A Place for Comfort	1766 Big Valley Lane	Stone Mountain, GA	30083
AAA Holly House	1680 Northwoods Drive	Marietta, GA	30066
AAN Center	414 Rigby Street	Marietta, GA	30060
Agape Living	1840 Phinizy Road	Augusta, GA	30906
Alberta Gregory Personal Care Home	2102 Kennedy Drive	Augusta, GA	30904
Alero Personal Care Home Inc	230 Trelawny Circle	Covington, GA	30016
Amazing Grace Personal Care Home	206 Reynolds Street	Augusta, GA	30901
Amelia Gardens	576 Nickajack Road	Mableton, GA	30126
Amelia Gardens I	545 Toonigh Road	Woodstock, GA	30188
Amelia Gardens II	2030 Bascomb Carmel Road	Woodstock, GA	30189
Andras AA Personal Care Home	1736 Jenkins Street	Augusta, GA	30904
Angels Care Personal Care Home	2620 Richmond Hill Road	Augusta, GA	30906
Angels Royal Gardens Personal Care Home	7752 Marabou Lane	Riverdale, GA	30274

Annette Holleys Personal Care Home #2	4515 Colonial Road	Martinez, GA	30907
Anns Phenomenal Care Home	2102 Hillsinger Road	Augusta, GA	30904
Antebellum Grove Assisted Living	1010 Kathryn Ryals Road	Warner Robins, GA	31088
Anthonys Personal Care Home	2329 Cadden Road	Augusta, GA	30906
Arbor Terrace	170 Marilyn Farmer Way	Athens, GA	30606
Arbor Terrace at Cascade	1001 Research Center	Atlanta, GA	30331
Arbor Terrace at Tucker	5844 Highway 29	Tucker, GA	30084
Arbor Terrace at West Cobb	3829 Floyd Road	Austell, GA	30106
Arbor Terrace of Decatur	425 Winn Way	Decatur, GA	30030
Arbor Terrace of East Cobb	866 Johnson Ferry Road	Marietta, GA	30068
Ashley Glen	441 Prime Point	Peachtree City, GA	30269
Ashton Hall	1155 Lawrenceville Highway	Lawrenceville, GA	30046
Atlanta Residential Care	4760 Cascade Road SW	Atlanta, GA	30331
Atria Buckhead	2848 Lenox Road	Atlanta, GA	30324
Atria Johnson Ferry	9 Sherwood Lane	Marietta, GA	30067
Attentive Needs Assisted Living	7264 Amanda Court	Riverdale, GA	30274
Augusta Gardens Retirement Residence	3725 Wheeler Road	Augusta, GA	30909
Autumn Leaf Assisted Living	5815 Stagecoach Road	Rex, GA	30273
Autumn Village	753 Covington Street	Jackson, GA	30233
Autumn Village 2A	746 McDonough Road	Jackson, GA	30233
Autumn Village 2B	746 McDonough Road	Jackson, GA	30233
Autumn Village 2C	746 McDonough Road	Jackson, GA	30233
Autumn Years	60 Massell Drive SE	Cartersville, GA	30121
Avondale Assisted Living at Kensington	3508 Kensington Road	Decatur, GA	30032

Avondale Assisted Living at Northlake	3965 Gloucester Drive	Tucker, GA	30084
Avondale Homes at Tucker	2553 Sandpiper Drive	Tucker, GA	30084
Azalea House	1896 Ludovie Lane	Decatur, GA	30033
Azalea Way	125 Hambleton Street	Thomasville, GA	31792
B & E Personal Care Home	5786 Mableton Parkway	Mableton, GA	30126
Barbara Ray Halls Personal Care Home	2638 Castletown Drive	Hephzibah, GA	30815
Bargerons Personal Care Home	2903 Milledgeville Road	Augusta, GA	30904
Bebes Cottage	290 Meadow Drive	Alpharetta, GA	30009
Belair at Macon, The	4901 Harrison Road	Macon, GA	31206
Bella's Cottage	7275 Timberline Overlook	Cumming, GA	30041
Belmont Village	5455 Glenridge Drive	Atlanta, GA	30342
Benton House at Benton Village	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House at Benton Village - Transitional Step Down Program	201 Evergreen Terrace	Stockbridge, GA	30281
Benton House of Dublin and Beacon Neighborhood	212 Fairview Park Drive	Dublin, GA	31021
Benton House of Newnan Lakes	25 Newnan Lakes Boulevard	Newnan, GA	30263
Bessie Maes Personal Care Home	910 Quaker Road Drive	Waynesboro, GA	30830
BestCare Assisted Living	2775 Cruse Road; #1401	Lawrenceville, GA	30044
Bethany Assisted Living, Inc.	1400 Northeast Main Street	Vidalia, GA	30474
Bethel Gardens Senior Living	3805 Jackson Way	Powder Springs, GA	30127
Bickford Senior Living	840 LeCroy Drive	Marietta, GA	30068
Blackshear Retirement Villa	1110 Blackshear Road	Cordele, GA	31015
Blair House Senior Living Community	684 Arlington Place	Macon, GA	31201
Bless To The Max	5870 GA Highway 57	Gordon, GA	31031
Blossom Personal Care Home	2494 Lillies Trace	Dacula, GA	30019
Brasstown Manor	108 Church Street	Hiawassee, GA	30546

Brickhaven Assisted Living	1807 12th Avenue	Albany, GA	31707
Brightmoor Assisted Living	3223 Newnan Road	Griffin, GA	30224
Brighton Gardens of Buckhead	3088 Lenox Road	Atlanta, GA	30324
Brighton Gardens of Dunwoody	1240 Ashford Center Parkway	Dunwoody, GA	30338
Brittany House at Benson Heights	1788 Sandy Plains Road	Marietta, GA	30066
Brittany House at Holly Springs	2852 Holly Springs Road	Marietta, GA	30062
Brittany's Place Assisted Living	141 Denis Drive	Jeffersonville, GA	31044
Brookdale Place of Augusta	326 Boy Scout Road	Augusta, GA	30909
Brooks Home Care	2408 Mims Road	Hephzibah, GA	30815
Brown Personal Care Home	554 Idlewood Road	Waynesboro, GA	30830
Bryants of Peace Personal Care Home	339 Marshall Street	Martinez, GA	30907
Buckingham South	5450 Abercorn Street	Savannah, GA	31405
Cambridge Farms Assisted Living	4040 Webb Bridge Road	Alpharetta, GA	30005
Cameron Hall	240 Marietta Highway	Canton, GA	30114
Cameron Hall of Ellijay	114 Penland Street	Ellijay, GA	30540
Camilla Retirement Home	161 East Broad Street	Camilla, GA	31730
Candler Ridge II	1205 Nunnally Drive	Monroe, GA	30655
Care Givers & More Elderly Care Services	6602 Shucraft Road	Appling, GA	30802
Caring Hands Assisted Living	1741 Highway 138	Riverdale, GA	30296
Caring Hearts PCH #2	10 Dial Road	Monroe, GA	30658
Carlyle Place - Cambridge Court	5300 Zebulon Road	Macon, GA	31210
Carols Place	2662 Barclay Street	Hephzibah, GA	30815
Carolyn's II	202 East Adair Street	Valdosta, GA	31601
Carolyn's Personal Care Home	525 Green Street	Valdosta, GA	31601
Carousel House II	173 South Lee Street	Forsyth, GA	31029
Carter Country Home	4447 U.S. 41 South	Lake Park, GA	31636

Cedar Hill Senior Living Community	402 East Ellawood Avenue	Cedartown, GA	30125
Cedar Plantation Assisted Living and Alzheimers Community	46637 Highway 46 East	Metter, GA	30439
Celestial Care Services	6571 Valley Hill Drive	Mableton, GA	30126
Champeunes Personal Care Home	3439 Rushing Road	Augusta, GA	30906
Charms Personal Care Home	900 West Residence Avenue	Albany, GA	31701
Choice Care Assisted Living Inc.	4930 Highway 20	Loganville, GA	30052
Church Street Manor	425 West Church Street	Swainsboro, GA	30401
Clarice Green Family PCH	1220 Dogwood Road North	Woodville, GA	30669
Colonial Gardens of Warner Robins #1	903 West Highway 96	Warner Robins, GA	31088
Colonial Gardens of Warner Robins #2	903 West Highway 96	Warner Robins, GA	31088
Colonial Guest House, Inc.	131 East Main Street	Franklin, GA	30217
Colquitt Alternative Living Care Inc.	258 East College Street	Colquitt, GA	39837
Colquitt Garden Manor	498 5th Street SE	Moultrie, GA	31768
Comfy Personal Care Home	2460 Skylars Mill Way	Snellville, GA	30078
Cooper House AL	2213 Augusta Highway	Lincolnton, GA	30817
Cordelia Manor Personal Care Home	1307 Blackshear Road	Cordele, GA	31015
Cottages on Wesleyan, The	1633 Wesleyan Drive	Macon, GA	31210
Country Heritage II	5761 Conner Road	Flowery Branch, GA	30542
Country Living Personal Care Home	5841 Maysville Road	Commerce, GA	30529
Country Manor Estates	1487 Allen Road	Macon, GA	31216
Countryside Personal Care Home	236 Lawson Hall Drive	Waynesboro, GA	30830
Courtyard Gardens	1000 River Center Place	Lawrenceville, GA	30043
Covenant Care Hamptom	120 West Tisbury Lane	Pooler, GA	31322
Covenant Care Lane	141 West Tisbury Lane	Pooler, GA	31322
Covenant Care Tisbury	126 West Tisbury Lane	Pooler, GA	31322

Cozy Manor Personal Care Home	706 North Main Street	LaFayette, GA	30728
Cunningham's PCH	195 Bristlecone Court	Winterville, GA	30683
Davis Elderly Care	5275 Hereford Farm Road	Evans, GA	30809
Delmar Gardens of Gwinnett	3100 Club Drive	Lawrenceville, GA	30044
Dennis and Dilsie Adult Care Home	217 St. Andrew Street	Sylvania, GA	30467
Destinys Home of Comfort Personal Care Home	2529 Crosscreek Road	Hephzibah, GA	30815
Divine Love Personal Care Home	943 Falling Creek Drive	Macon, GA	31220
Dogwood Bluff Personal Care Home	266 Pony Lake Lane	Dahlonega, GA	30533
Dogwood Forest at Eagles Landing	475 Country Club Drive	Stockbridge, GA	30281
Dogwood Forest of Fayetteville	1294 Highway 54 West	Fayetteville, GA	30214
Dogwood Forest of Gainesville	3315 Thompson Bridge Road	Gainesville, GA	30506
Dogwood Gardens Senior Living	1222 Plaza Avenue	Eastman, GA	31023
Dream Catcher Farm Personal Care Home	286 Four Points Road	Jackson, GA	30233
Dream Catcher in the Woods	286 Four Points Road	Jackson, GA	30233
Duncan McRae House	129 South Railroad Avenue	Mount Vernon, GA	30445
East Georgia Personal Care Home II	1371 West Peachtree Avenue	Union Point, GA	30669
Eastside Gardens	2078 Scenic Highway	Snellville, GA	30078
Easy Living Personal Care Home	2688 Nub Garland Road	Toccoa, GA	30577
Echols Personal Care Home	5266 Lexington Road	Rayle, GA	30660
Eden Personal Care Home	2438 Swan Lake Drive	Grayson, GA	30017
Edgewood of Monticello	1178 College Street	Monticello, GA	31064
Elaine Miller Personal Care Home	5413 Old Augusta Highway	Grovetown, GA	30813
Elaines Personal Care Home	626 East Riverbend Drive	Lilburn, GA	30047
Ellens Personal Care Home	3229 Old Louisville Road	Augusta, GA	30906
Elmcroft at Milford Chase	1345 Milford Church Road	Marietta, GA	30008

Elmcroft of Mt. Zion	7493 Mount Zion Boulevard	Jonesboro, GA	30236
Elmcroft of Roswell	400 Marietta Highway	Roswell, GA	30075
Elmcroft Senior Living	515 The Pass	Martinez, GA	30907
Emeritus at Decatur	475 Irvin Court	Decatur, GA	30030
Emeritus at Flint River Memory Care Community	250 Water Tower Court	Macon, GA	31210
Emeritus at Newnan	355 Millard Farmer Industrial	Newnan, GA	30263
Emeritus at Riverstone Senior Living	125 Riverstone Terrace	Canton, GA	30114
Emeritus at Sandy Springs	1260 Hightower Trail	Atlanta, GA	30350
Emeritus at Sandy Springs Place	1262 Hightower Trail	Atlanta, GA	30350
Emeritus at Spring Mountain	1790 Powder Springs Road	Marietta, GA	30064
Emeritus at Vinings	2401 Cumberland Parkway S	Atlanta, GA	30309
Emeritus at Woodstock Senior Living Community	756 Neese Road	Woodstock, GA	30188
Emory Senior Living	2795 Scenic Highway 124	Snellville, GA	30078
Enchanted Lives Personal Care Home	3613 Larkspur Drive	Augusta, GA	30906
Englewood Health Care I	507 North Madison	Albany, GA	31701
Englewood Health Care II	286 Stonewall Street SE	Dawson, GA	31742
Ettas House	1682 Pharr Road	Snellville, GA	30078
Evans Personal Care Home	426 Liberty Street	Gray, GA	31032
Evergreen Assisted Living	2823 Gillionville Road	Albany, GA	31721
Faith and Hope Personal Care Home	773 Chapman Street	Jonesboro, GA	30238
Faith Hope and Grace Home	279 Cab Drive	Sylvania, GA	30467
Faith Landing Personal Care Home	1215 Hale Street	Waynesboro, GA	30830
Falcon Crest Manor	111 Epps Street	Gordon, GA	31031
FAM Personal Care Home	5618 Wellborn Creek Drive	Lithonia, GA	30058
Family Pampering Center PCH #1	2180 Surrey Trail	College Park, GA	30349
Felton Manor	16 Roving Road	Cartersville, GA	30121
Fern's Tender Loving Care Home	3547 Spring Valley Road	Decatur, GA	30032

First Love Personal Care Home #1	2403 Wrightsboro Road	Augusta, GA	30904
First Love Personal Care Home #2	2734 Milledgeville Road	Augusta, GA	30904
Fite Living Centre	5 Fite Street	Cartersville, GA	30120
Five Ponds Personal Care Home	4688 Windsor Spring Road	Hephzibah, GA	30815
Florence Jeffersons T.L.C.	4357 Seago Road	Hephzibah, GA	30815
Four Seasons Personal Care Home	918 East Evans	Bainbridge, GA	39819
Foxcroft Assisted Living	3507 Dean Still Road	Blackshear, GA	31516
Frances B. Bell Personal Care Home	106 Joiner-Oglesby Road	Sardis, GA	30456
Freedom House Augusta PCH	2006 Sibley Road	Augusta, GA	30909
Freeman Personal Care Home	1945 15th Street	Augusta, GA	30901
Friendship Personal Care Home	723 West Oglethorpe Blvd.	Albany, GA	31701
Fulcher - Nations Personal Care Home	2020 Edgar Street	Augusta, GA	30904
G.S.E. Gantt Personal Care Home	3834 Fairington Drive	Hephzibah, GA	30815
Garden Of Love	2208 Woodward Avenue	Augusta, GA	30906
Gardens at Royal Oaks	1218 Broadrick Drive	Dalton, GA	30720
Gardens of Roswell	9212 Nesbit Ferry Road	Alpharetta, GA	30022
Gardners Personal Care Home	2024 Wrightsboro Road	Augusta, GA	30901
Garrison Personal Care Home	519 Perkins Road	Palmetto, GA	30268
Gaynell Hymels Personal Care Home	1029 Mosley Road	Augusta, GA	30906
Gaynell Hymels Personal Care Home II	1015 Mosley Road	Augusta, GA	30906
Generous Care Giving	2769 Kilgore Road	Buford, GA	30519
Gentilly Gardens	625 Gentilly Road	Statesboro, GA	30458
Gentle Services In Home Care	7363 Ovis Court	Riverdale, GA	30274
Georgia Living Center	182 Head Avenue	Tallapoosa, GA	30176
Gods Child Personal Care Home	3719 Colbert Street	Augusta, GA	30906
Gold City Personal Care Home	350 Moores Drive	Dahlonega, GA	30533
Golden Apple Carriage	606 5th Avenue	Moultrie, GA	31768

House	SE		
Golden Apple Personal Care Home	606 5th Avenue SE	Moultrie, GA	31788
Golden Apple Personal Care Home II	606 Fifth Avenue SE	Moultrie, GA	31788
Golden Crest	2160 Lake Harbin Road	Morrow, GA	30260
Golden Crest Assisted Living - Eagles Landing	425 Country Club Drive	Stockbridge, GA	30281
Golden Generations II Personal Care Home	386 Tower Drive	Martinez, GA	30907
Golden Personal Care Home I	257 Golden Road	Eastman, GA	31023
Golden Personal Care Home II	257 Golden Road	Eastman, GA	31023
Golden Retreat	503 South Goodman Street	Sparks, GA	31647
Golden Royal Orchards PCH	5112 Kelly Drive	Cohutta, GA	30710
Golden Rule Personal Care Home	2342 Dorn Road	Augusta, GA	30906
Golden Services Personal Care Home	930 West Magnolia Street	Valdosta, GA	31601
Golff Personal Care Home	439 Drexell Avenue	Millen, GA	30442
Gospel Water Branch Elderly Housing, Inc.	672 King Taylor Road	Evans, GA	30809
Governors Glen	5000 Governors Drive	Forest Park, GA	30297
Grace Gardens	30 South College Street	Metter, GA	30439
Gracemont Assisted Living	4940 Jot-Em-Down Road	Cumming, GA	30041
Gracemont Assisted Living	4960 Jot-Em-Down Road	Cumming, GA	30041
Graces House	2 River Street	Cave Spring, GA	30124
Great Day PCH	2604 Whittier Place	Hephzibah, GA	30815
Great Grans Personal Care Home	1002 North Wiley Avenue	Donalsonville, GA	39845
Green Park PCH	2941 Sandy Plains Road	Marietta, GA	30066
Greenwood Gardens	1160 Whitlock Avenue	Marietta, GA	30064
Griffin House South, The	107 West Liberty Street	Claxton, GA	30417
Gro Shady Oaks	310 Chestnut Street	Dalton, GA	30721
Grosvenor Personal Care Home	4556 Central Drive	Stone Mountain, GA	30083

Habersham House Senior Residence	5200 Habersham Street	Savannah, GA	31405
Halls Personal Care Home of Evans	4528 Hereford Farm Road	Evans, GA	30809
Hapeville Manor Assisted Living	601 Coleman Street	Hapeville, GA	30354
Haven of Tender Loving Care	407 W Moore Street	Dublin, GA	31021
Hearthstone of Roswell	350 Market Place	Roswell, GA	30075
Heather House	11965 Old Mountain Park Ro	Roswell, GA	30075
Heather House Crabapple	290 Ranchette Road	Alpharetta, GA	30004
Heavenly Arms	2764 1/2 Tobacco Road	Hephzibah, GA	30815
Heavenly Arms	11230 Hwy 278 East	Covington, GA	30014
Helping Hands Personal Care Home 2	6260 Mozart Drive	Riverdale, GA	30296
Heritage of Brookstone	5235 Stilesboro Road N.W.	Kennesaw, GA	30152
Heritage of Peachtree	1967 Highway 54 West	Fayetteville, GA	30214
Heritage of Sandy Plains	3039 Sandy Plains Road	Marietta, GA	30066
Higher Living Personal Care Home	650 Main Street	Warrenton, GA	30828
Hilltop House Personal Care Home	1208 West Gordon Street	Quitman, GA	31643
Home Away From Home Personal Care Homes	8412 Red Cedar Way	Riverdale, GA	30274
Home Sweet Home Personal Care Home	2459 Dublin Drive	Augusta, GA	30906
Homeplace Senior Living - Memory Care Community	345 Pearl Bates Avenue	Eastman, GA	31023
Horizon Bay	180 Woodrow Wilson Way	Rome, GA	30165
House of Angels	420 Lavender Road	Athens, GA	30606
House of Angels Personal Care Home	3554 Evangeline Drive	Augusta, GA	30906
House of Lord Home Care	3802 MacLand Road	Hiram, GA	30141
House of Naum Personal Care Home, The	2880 Olive Grove Church Ro	Roberta, GA	31078
House of Prosperity	3702 Willow Bend Run	Columbus, GA	31907
Humming Birds Personal Care Home	2124 Harding Road	Augusta, GA	30906

Isaac Haven Assisted Living Center	1939 Isaac Watkins Road	Montrose, GA	31065
Ivy Hall North	5690 State Bridge Road	Alpharetta, GA	30022
Ivydale Personal Care Home	1836 South Main Street	Moultrie, GA	31768
J and J Retirement Home	1214 Whispering Pines Road	Albany, GA	31707
J R & C Assisted Living Center	2195 Waynesboro Highway	Hiltonia, GA	30467
Jacksons Personal Care Home	2377 Dublin Drive	Augusta, GA	30906
Jamestown Personal Care Home	300 Green Street	Fort Valley, GA	31030
Jane Smiths Personal Care Home	1809 Mavis Street	Augusta, GA	30906
Jean Gibson Personal Care Home	914 Greer Road	Griffin, GA	30223
John-Wesley Villas of Savannah, Inc.	231 West Montgomery Cross	Savannah, GA	31406
Johns Helping Hands	2903 Larkspur Drive	Augusta, GA	30906
Johnsons Personal Care Home	1007 Hall Street	Bainbridge, GA	39819
Jones Personal Care Home	1618 Cider Lane	Augusta, GA	30906
Jordan Personal Care Home	1910 Sagemont Drive	Augusta, GA	30906
Joseph Home of Comfort PCH	3908 Fairington Drive	Hephzibah, GA	30815
Kentwood Personal Care Home	1227 West Wheeler Parkway	Augusta, GA	30909
Killian Hill Personal Care Home	1538 Killian Hill Road	Lilburn, GA	30047
Kimberly Assisted Living Home	700 West Memorial Drive	Dallas, GA	30132
Kings Bridge Retirement Center	3055 Briarcliff Road, N.E.	Atlanta, GA	30329
Kings Personal Kare Facility	111 Elizabeth Way	Ellenwood, GA	30294
Kingsford of Warner Robins	851 Gunn Road	Warner Robins, GA	31093
Kingsford Place	95 Progress Avenue	Hawkinsville, GA	31036
Krisscare Personal Care Home	2793 Skyland Drive	Snellville, GA	30078
L & R Personal Care	14 Sharper Circle	Valdosta, GA	31601
Lake Erma Assisted Living	103 West Main Street	Lakeland, GA	31635

Lake Pointe Assisted Living & Memory Care Community	45 Walnut Street	Hartwell, GA	30643
Lakeside Rest Home	924 Crump Street	Swainsboro, GA	30401
Lakeview Retirement Center	111 Stephens Avenue	Baxley, GA	31513
Langdale Place	2720 Windemer Drive	Valdosta, GA	31602
Lanham Personal Care Home	2950 Old Highway #1	Hephzibah, GA	30815
Lanier Village Estates - OakBridge Terrace	3950 Village View Drive	Gainesville, GA	30506
Lazy-R Personal Care Center	81 Wellborn Street	Blairsville, GA	30512
Leisure Life Care Home	301 Beacham Street	Unadilla, GA	31091
Leisure Living of LaGrange I	137 Parker Place	LaGrange, GA	30240
Lifetime CLA	706 High Pointe Drive	Winder, GA	30680
Lighthouse Personal Care Home	1431 Brittain Road	Douglasville, GA	30134
Lighthouse Personal Care Home, The	206 Blue Mountain Parkway	Rocky Face, GA	30740
Longevity Personal Care Home	1520-22 12th Street	Augusta, GA	30901
Longevity Personal Care Home #2	2884 Lumpkin Road	Augusta, GA	30906
Lorraine Young Personal Care Home	2836 Tobacco Road	Hephzibah, GA	30815
Loves Community Care Center	2366 Dublin Drive	Augusta, GA	30906
Loves Personal Care Facility	2347 Amsterdam Drive	Augusta, GA	30906
Loving Grace Personal Care Home #1	1236 12th Street	Augusta, GA	30901
Lucille Kylers Quality Care Personal Care Home	3231 Ware Road	Augusta, GA	30909
Macks Personal Care Home	3603 Richdale Drive	Augusta, GA	30906
Macy Retirement Center	4408 Houston Avenue	Macon, GA	31206
Magnolia Lane	6365 Newborn Drive	College Park, GA	30349
Magnolia Manor of Columbus Assisted Living	2040 Warm Springs Road	Columbus, GA	31904
Magnolia Manor Retirement Center	2001 South Lee Street	Americus, GA	31709
Magnolia Manor South	3011 Veterans Parkway	Moultrie, GA	31788

Magnolia Place Inc.	6430 Newton Road	Albany, GA	31721
Magnolia Place of Cairo	1710 South Broad Street	Cairo, GA	39828
Majestic Manor	67 Pin Oak Drive	Rock Spring, GA	30739
Maliha Personal Care Home	32 Marvin Avenue	Summerville, GA	30747
Maple Court Senior Residents	2408 North Tift Avenue	Tifton, GA	31794
Mapleview Personal Care Home - 3	10 Church Street	Statesboro, GA	30458
Maries Adult Personal Care Home	3524 Wrightsboro Road	Augusta, GA	30909
Marks Personal Care Home	1721 Hephzibah-McBean Ro	Hephzibah, GA	30815
Mary and Marthas Personal Care Home	616 Mohawk Street	Rossville, GA	30741
Mary's Care Home	129 East Side Road	Twin City, GA	30471
Masters Personal Care Home	362 Carver Street, S.E.	Thomson, GA	30824
Matrel's Personal Care Home	1008 East 12th Street	West Point, GA	31833
Mattie H. Marshall Center	2001 South Lee Street	Americus, GA	31709
McClendon Personal Care Home	3050 Johnny Long Road	Newton, GA	39870
Memory Lane of Bremen Bldg A	524 Gordon Street	Bremen, GA	30110
Memory Lane of Bremen Bldg B	524 Gordon Street	Bremen, GA	30110
Memory Lane of Bremen Bldg C	524 Gordon Street	Bremen, GA	30110
Mercy Personal Care Home	3630 Brushy Wood Drive	Loganville, GA	30052
Merrill Gardens at Dunwoody	1460 South Johnson Ferry R	Dunwoody, GA	30319
Merryvale Assisted Living	11980 Highway 142 North	Oxford, GA	30054
Morning Pointe Assisted Living	660 Jolly Road NW	Calhoun, GA	30701
Morning Starr Personal Care Home	519 Lawrenceville Street	Norcross, GA	30071
Morningside Assisted Living	353 North Belair Road	Evans, GA	30809
Morningside of Albany	1721 Beattie Road	Albany, GA	31721
Morningside of Athens	1291 Cedar Shoals Drive	Athens, GA	30605

Morningside of Conyers	1352 Wellbrook Circle	Conyers, GA	30012
Morningside of Dalton	2470 Dug Gap Road	Dalton, GA	30720
Morningside of Gainesville	2435 Limestone Parkway	Gainesville, GA	30501
Mother & Daughter Personal Care Home	1923 Kissingbower Road	Augusta, GA	30904
Mountain View Personal Care Home	3675 Kensington Road	Decatur, GA	30032
Mt. Carmel Personal Care Home	3084 Mt. Carmel Road	Hampton, GA	30228
Mulberry Grove	343 Price Street	Statham, GA	30666
Musgrove Manor Personal Care Home	13 Birnam Woods Road	Griffin, GA	30223
My House 2 Community Care Facility	2836 Ravenwood Drive	Snellville, GA	30078
Naja Personal Care Home	935 Donington Circle	Lawrenceville, GA	30045
Nasworthy Care Home	4896 Stanfield Road	Patterson, GA	31557
New Beginnings PCH - Ludowici	209 W Kenny Drive	Ludowici, GA	31316
New Haven	615 South Hutchinson Avenue	Adel, GA	31620
Northlake Gardens	1300 Montreal Road	Tucker, GA	30084
Northside Villa	8828 Hwy 112 North	Rochelle, GA	31079
Oak Ridge	160 Moores Road	Mineral Bluff, GA	30559
Oasis of Love PCH II	4660 Sunridge Trail	Fairburn, GA	30213
Oconee House Senior Living	126 Parks Mill Road	Buckhead, GA	30625
Odom, Pam Personal Care Home	129 Leonard Lane	Swainsboro, GA	30401
Open Arms Elderly Care	1864 Central Avenue	Augusta, GA	30904
Overall Group Home	4462 Parmalee Path	Conley, GA	30288
Ovie Brantley-Cauley House The	1628 College Street	Soperton, GA	30457
Palmer Family Care Home	4550 Janice Drive	College Park, GA	30337
Park Regency Personal Care Home	3000 Veterans Parkway	Moultrie, GA	31768
Patricias Adults Care Home	206 St. Andrews Street	Sylvania, GA	30467

Patterson Personal Care Home - Augusta	1605 Cornell Drive	Augusta, GA	30906
Payne Care Home II	2740 West Antler Drive	Augusta, GA	30906
Peaceful Living Personal Care Home - Augusta	2714 Coleman Avenue	Augusta, GA	30906
Peaceful Personal Care Home	168 Peaceful Lane	Portal, GA	30450
Peachtree Plantation	4251 Hudson Drive	Oakwood, GA	30566
Personal Home Care By Betsy	429 Faircloth Road	Whigham, GA	39897
Petal's PCH	3371 Glen Summit Lane	Snellville, GA	30039
Pineland Personal Care Home	235 Broxton Highway	Hazlehurst, GA	31539
Pines Personal Care Home Inc. B	2121-B Martin Luther King Jr	Albany, GA	31701
Pines Personal Care Home Inc. C	2121-C Martin Luther King Jr	Albany, GA	31701
Pines Personal Care Home Inc. D	2121-D Martin Luther King Jr	Albany, GA	31701
Pineview Gardens of Evans	4393 Owens Road	Evans, GA	30809
Pineview Gardens Personal Care Home	4255 Highway 25 North	Hephzibah, GA	30815
Plair Personal Care Home	2016 Scott Road	Augusta, GA	30906
Plair Personal Care Home II	2014 Scott Road	Augusta, GA	30906
Plantation Manor Personal Care Home	220 Park Avenue	Thomasville, GA	31792
Plantation South of Duluth	3450 Duluth Park Lane	Duluth, GA	30096
Plantation South of Dunwoody	4594 Barclay Drive	Dunwoody, GA	30338
Platinum Care Personal Care Home	2358 Oak Avenue	Morrow, GA	30260
Pleasant Valley Retirement Home	510 Reed Road	Dalton, GA	30720
Precious Touch PCH	6631 Chason Woods Court	Jonesboro, GA	30238
Presbyterian Home and Retirement Community	1901 West Screven Street	Quitman, GA	31643
Presbyterian Village	2000 East-West Connector	Austell, GA	30106
Presbyterian Village - Hearthstone	2000 East-West Connector	Austell, GA	30106
Providence of Alpharetta	12775 Providence Road	Alpharetta, GA	30009
Pure Heart Personal Care Home	5404 McEver Road	Oakwood, GA	30517

Q & N Personal Care Home	1859 Keith Drive	Marietta, GA	30064
Rainbow Retirement Home	109 Meyer Farm Road	Arnoldsville, GA	30619
Rayford Care Home	620 First Avenue	Columbus, GA	31901
Rejuvenate - Eden PCH	1918 Panola Road	Lithonia, GA	30058
Renaissance Marquis Retirement Village	3126 Cedartown Highway	Rome, GA	30161
Renaissance On Peachtree	3755 Peachtree Road, N.E.	Atlanta, GA	30319
Residential Living, Inc.	7861 Collinswood Court	Jonesboro, GA	30236
Rhema Personal Care Facilities	3144 Macedonia Road	Powder Springs, GA	30127
Ritchglow Personal Care Home	2717 Rainbow Forest Drive	Decatur, GA	30034
Riverwood Retirement Life Community	511 West 10th Street	Rome, GA	30165
Rock Creek Manor	50 Cagle Mill Road South	Jasper, GA	30143
Roman Court	1168 Chulio Road	Rome, GA	30161
Rosaleana's Community Assisted Living Care	350 Schoen Street, SE	Atlanta, GA	30315
Rose-Anns Personal Care Home	2016 Country Place Drive	Augusta, GA	30906
Rosewood at Fort Oglethorpe	14 Fort Town Drive	Fort Oglethorpe, GA	30742
Rosewood Manor	1107 Tanner Street	Nicholls, GA	31554
Royal Care	568 Highway 26 E	Cochran, GA	31014
Royal Oaks	211 West College Street	Adrian, GA	31002
Royal Southern Plantation	580 Tommy Lee Fuller Drive	Loganville, GA	30052
Ruby Place	705 Cleland Street	Savannah, GA	31415
Sacred Hands Personal Care Homes	141 St Ann Circle	Dallas, GA	30157
Safe Haven at Lenox Park	1137 Lynmoor Drive	Atlanta, GA	30319
Safe Haven Transitional Home	305 E Mulberry Street	LaGrange, GA	30241
Saint James Place	2027 Alta Vista Drive	Columbus, GA	31907
Sara's Personal Care Home	129 Leonard Lane	Swainsboro, GA	30401
Savannah Court of Lake Oconee	1061 Willow Run Road	Greensboro, GA	30642
Savannah Court of Milledgeville	61 Marshall Road	Milledgeville, GA	31061
Savannah Court of Newnan	27 Belt Road	Newnan, GA	30263

Savannah Grand	1835 Eagle Drive	Woodstock, GA	30189
Savannah Plantation PCH	102 Level Creek Road	Buford, GA	30518
Scepter Living Center of Snellville LLC	3000 Lenora Church Road	Snellville, GA	30078
Schnora's Happy Home	2690 Shady Hill Court	Snellville, GA	30039
Senior Care America	1165 Hillcrest Glenn Circle	Sugar Hill, GA	30518
Senior Care America II	828 Rock Springs Road	Lawrenceville, GA	30043
Senior Citizens Care Center Annex	223 Harmon Road	Swainsboro, GA	30401
Serenity Assisted Living	206 Pine Street	Sparks, GA	31647
Serenity House	8599 Sheridan Drive	Jonesboro, GA	30236
Serenity Mountain Manor	309 Price Creek Farms Lane	Jasper, GA	30143
Serenity of Jefferson	1442 Johnson Mill Road	Jefferson, GA	30549
Serenity Personal Care Home	120 E. Winthorpe Avenue	Millen, GA	30442
Seymour Southern Comforts Personal Care Home	202 East Main Street	Bronwood, GA	39826
Sha Sha's Leisure Living	1465 Teagle Road	Forsyth, GA	31029
Sha-Lyndas Personal Care Home	2313 Cadden Court	Augusta, GA	30906
Shady Lane	4901 La Roche Avenue	Savannah, GA	31404
Shady Lane II PCH	1133 Cornell Avenue	Savannah, GA	31406
Shady Lane IV	4901 LaRoche Avenue	Savannah, GA	31404
Shady Pines Estate	124 Airport Road	Abbeville, GA	31001
Sheppard Personal Care Home	123 Emma Lane	Waynesboro, GA	30830
Sheridan Place - Assistive Living Unit	504 Firetower Road	Dublin, GA	31021
Sheridan Place - Clare Bridge Place Memory Care Unit	504 Firetower Road	Dublin, GA	31021
Silverleaf of Snellville	2106 McGee Road	Snellville, GA	30078
Sirmons Personal Care Home	623 Davis Avenue	Lakeland, GA	31635
Smith PCH	315 Advance Street	Swainsboro, GA	30401
Sonshine Manor Personal Care Home	115 Stephens View Road	Jasper, GA	30143

South Haven Personal Care Home	6490 West Fayetteville Road	Riverdale, GA	30296
Southern Breeze Assisted Living	127 S. Belair Road	Martinez, GA	30907
Southern Care Retirement Home	1934 Whiddon Mill Road	Tifton, GA	31793
Southern Charm	110 South Third Avenue	McRae, GA	31055
Southern Comfort Personal Care Home	580 Old Bremen Road	Temple, GA	30179
Southern Escapes Assisted Living	3047 Johnson Road	Loganville, GA	30052
Southern Heritage II	814 Carl Vinson Parkway	Centerville, GA	31028
Southern Magnolia	405 Thompson Street	Vidalia, GA	30474
Southern Pines Senior Care Inc.	258 College Avenue	Maysville, GA	30558
Southern Pines Senior Living	423 Covington Avenue	Thomasville, GA	31792
Southern Senior Living	215 East Sellers Street	Douglas, GA	31533
Southside Garden	6693 Highway 11 South	Hillsboro, GA	31038
Sparks Inn at Christian City	7290 Lester Road	Union City, GA	30291
Sparks Retirement Home, Inc.	304 South Goodman Street	Sparks, GA	31647
Spring Garden Personal Care Home	3361 Glen Summit Lane	Snellville, GA	30039
Spring Villa Personal Care	620 Monroe Street	Macon, GA	31201
Springfield Personal Care Home	3342 Springfield Road	Sparta, GA	31087
St Irene PCH	44 Clairmont Avenue	Elberton, GA	30635
St Marys Center for Alzheimer's and Dementia Care	1660 Jennings Mill Road	Bogart, GA	30622
Star Manor	241 Nelson Street	Cartersville, GA	30120
Stockbridge Personal Care Home	170 Shields Road	Stockbridge, GA	30281
Stonehenge Assisted Living 3	168 Stonehenge Drive	Blairsville, GA	30512
Stonehenge Assisted Living One	168 Stonehenge Drive	Blairsville, GA	30512
Stonehenge Too	168 Stonehenge Drive	Blairsville, GA	30512
Suites at Oak View	55 Stockade Road	Summerville, GA	30747

Suites of Woodleaf Assisted Senior Living	2022 East Pinetree Boulevar	Thomasville, GA	31792
Sulfur Springs Retreat-Elderly	1154 Magnolia Drive	Macon, GA	31217
Summer Willow Assisted Living	259 Nunez Lexsy Road	Swainsboro, GA	30401
Summer's Landing	311 Jerriel Street	Vidalia, GA	30474
Summer's Landing Tilly Mill	4821 North Peachtree Road	Dunwoody, GA	30338
Summers Landing Limestone	2030 Windward Lane	Gainesville, GA	30501
Summers Landing Northland Assisted Living	5399 Northland Drive	Atlanta, GA	30342
Summers Landing PCH	171 Highway 78 NW	Monroe, GA	30655
Summerset Assisted Living Community	3711 Benjamin E. Mays Drive	Atlanta, GA	30331
Sumter Retirement Village	2124 Highway 280 West	Plains, GA	31780
Sunrise at Buckhead	1000 Lenox Park Boulevard,	Atlanta, GA	30319
Sunrise at Decatur	920 Clairemont Avenue	Decatur, GA	30030
Sunrise at East Cobb	1551 Johnson Ferry Road	Marietta, GA	30062
Sunrise at Five Forks	3997 Five Forks Trickum Ro	Lilburn, GA	30047
Sunrise at Huntcliff Summit	8480 Roswell Road	Sandy Springs, GA	30350
Sunrise at Johns Creek	11405 Medlock Bridge Road	Johns Creek, GA	30093
Sunrise Harbour Personal Care Home	139 Orchard Pass	Warner Robins, GA	31088
Sutton Place	306 West Mann Street	Glennville, GA	30427
Sweetwater Springs Assisted Living	1600 Lee Road	Lithia Springs, GA	30122
Tanglewood Assisted Living Facility	50 Tanglewood Drive	Dawsonville, GA	30534
Tapleys Personal Care Home	4602 Hereford Farm Road	Evans, GA	30809
Tara Plantation Assisted Living	440 Tribble Gap Road	Cumming, GA	30040
Tebeau House Retirement Home	2019 Tebeau Street	Waycross, GA	31501
Tender Care Assisted Living at Snellville	3922 Centerville Highway #1	Snellville, GA	30039
Tender Care Personal Care Home	1560 Twin Bridge Lane	Lawrenceville, GA	30043

Tennille Assisted Living	525 North Main Street	Tennille, GA	31089
Terris Personal Care Home	1680 Lawrenceville - Suwane	Lawrenceville, GA	30043
The Bridges Assisted Living of Lawrenceville	220 Collins Industrial Way	Lawrenceville, GA	30043
The Carlton	690 Mt. Vernon Highway	Atlanta, GA	30328
The Cohen Home	10485 Jones Bridge Road	Alpharetta, GA	30022
The Colonnade at Brandon Wilde	4275 Owens Road	Evans, GA	30809
The Cottage Senior Living	818 Round Tree Court	Lawrenceville, GA	30045
The Court at Sandy Springs - Memory Care (Emeritus)	1262 Hightower Trail	Atlanta, GA	30350
The Gables at Cobb Village	12 Cobb Village Drive	Royston, GA	30662
The Gardens at Calvary	7595 Moon Road	Columbus, GA	31909
The Green House at Calvary	7490 Old Moon Road	Columbus, GA	31909
The Green House II at Calvary	7462 Old Moon Road	Columbus, GA	31909
The Home Place	801 Walnut Street	Louisville, GA	30434
The Mann House	5413 Northland Drive	Atlanta, GA	30342
The Montclair at Clairmont Place	2100 Clairmont Lake	Decatur, GA	30033
The Oaks Assisted Living at The Marshes of Skidaway Island	95 Skidaway Island Park Road	Savannah, GA	31411
The Oaks at Peake Assisted Living	400 Foster Road	Macon, GA	31210
The Oaks at Scenic View Assisted Living	205 Peach Orchard Drive	Baldwin, GA	30511
The Olive Branch PCH	639 Davenport Road	Braselton, GA	30517
The Plaza Personal Care Center - Wesley Wood	2280 North Highway 29	Newnan, GA	30265
The Providers, Inc.	799 Moreland Avenue	Atlanta, GA	30316
The Rachel House, Inc.	204 West Colquitt Street	Sparks, GA	31647
The Retreat	1207 East McPherson Street	Nashville, GA	31639
The Retreat II	1207 East McPherson Street	Nashville, GA	31639
The Suites at Cypress Pond	15 Kent Road	Tifton, GA	31794

The Suites at Poplar Creek	114 Old Airport Road	LaGrange, GA	30240
The Valencia Personal Care Home Inc.	605 South Valencia Drive	Albany, GA	31707
The White House Personal Care Home	452 State Street	Waycross, GA	31501
The Willows	4179 Wheeler Road	Martinez, GA	30907
Tignall Assisted Living	185 S. Hulin Avenue	Tignall, GA	30668
TLC Family Home	3605 Shallowford Road	Marietta, GA	30062
Treutlen Living Center	5590 Third Street North	Soperton, GA	30457
Trinity Personal Care Home of Georgia, LLC	718 Weed Street	Augusta, GA	30904
Tudor Castle Personal Care Home	2056 Tudor Castle Circle	Decatur, GA	30035
Tylers Assisted Living	208 Flowing Wells Road	Martinez, GA	30907
V & T Shady Rest PC Home	1386 New Petersburg Road	Lincolnton, GA	30817
Victoria Personal Care Home	2666 Nancy Drive	Macon, GA	31206
Victory House	310 West Washington Avenue	Nashville, GA	31639
Victory Village	3650 Salem Church Road	Jasper, GA	30143
Villa Rose	430 Mosley Road	Byron, GA	31008
Village Lake Suites	715 Village Lake Drive	Waycross, GA	31503
Vina Mae Robinson Retirement Center - VMR	566 West 16th Avenue	Albany, GA	31701
Vina Mae Robinson Retirement Center 2 - Monroe House	566 West 16th Avenue	Albany, GA	31701
Virginia Gardens Assisted Living Center	404 East Church Street	Fort Valley, GA	31030
Vision Personal Care Home #1	960 Curry Place	Macon, GA	31202
Vital Place	985 Waldwick Drive	Lawrenceville, GA	30045
Waldrop Personal Care Inc	89 Burnt Hickory Road	Cartersville, GA	30120
Walkers Lakebreeze Personal Care Home	440-A Lang Road	Covington, GA	30014
Washington Manor	184 Pine Lane	Washington, GA	30673
We Care 2 Personal Care Home	1483 Virgil Pond Lane	Loganville, GA	30052

Webers Creek Missions	2118 Claxton Dairy Road	Dublin, GA	31021
Welcome Home PCH	2366 Centerville Rosebud Ro	Loganville, GA	30052
Welcoming Arms	210 Crabapple Road	Fayetteville, GA	30215
Wesbys Personal Care Home, Inc.	1429 Highway 23 South	Waynesboro, GA	30830
Whispering Pines	6273 Highway 41 South	Bolingbroke, GA	31004
White Oaks	130 Moores Road	Mineral Bluff, GA	30559
Willow Creek, Macon	2738 Walden Road	Macon, GA	31216
Willow Gardens	16 Crestwood Drive	Toccoa, GA	30577
Willow Wood Personal Care Home	19818 Hartford Street	Edison, GA	39846
Wilsons Personal Care Home	1527 Dade Street	Augusta, GA	30904
Winthrop at Polk	131 Melissa Lane	Cedartown, GA	30125
Winthrop Court Assisted Living	10 Highway 411 East	Rome, GA	30161
Winthrop West Senior Living	279 Technology Parkway	Rome, GA	30165
Wise Choice Personal Care Home	318 Meadow Court	Martinez, GA	30907
Woodhaven Personal Care Home	6246 Highway 136	Trenton, GA	30752
Woodland Ridge	4005 South Cobb Drive	Smyrna, GA	30080
Woodstock Estates	1000 Professional Way	Woodstock, GA	30188
Yellow Brick House	6903 Main Street	Lithonia, GA	30058
Yellow Brick Road PCH	5063 Upper Elm Street	Atlanta, GA	30349

Appendix IX: Benjamin Rose Institute on Aging (BRI) Care Consultation; detailed research document on BRI Care Consultation, an evidence-based telephonic intervention program aimed at assisting Alzheimer's disease and related dementia patients and caregivers

BRI Care Consultation

AT-A-GLANCE

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Overview of the Research

BRI Care Consultation is the name of an evidence-based program that was developed through a series of local and national research projects conducted by the Margaret Blenkner Research Institute of the Benjamin Rose Institute on Aging. In collaboration with partner organizations such as the Alzheimer's Association and Department of Veteran Affairs, research on Care Consultation has involved nearly 4,000 families from 15 communities across the U.S. Caregiving families who participated in the studies were dealing with a variety of chronic health problems. Many were caring for older relatives with Alzheimer's disease or other dementias. Other families were caring for older relatives with depression or multiple physical health problems. Projects since 1997 have tested whether Care Consultation improved outcomes and is a practical intervention to implement in different types and sizes of organizations. The American Society on Aging has recognized Care Consultation with its national award for innovative practice, and Care Consultation also is recognized by the Administration on Aging and the Rosalynn Carter Institute for Caregiving as an evidenced-based program.

Benefits Found in Research Studies

- Improved Care
- Reduced Hospital Admissions
- Delayed Nursing Home Placement
- Fewer Emergency Department Visits
- Decreased Symptoms of Caregiver Depression and Strain
- Improved Quality of Life
  - Reduced Caregiver Stress and Burnout
  - Reduced Relationship Strain
  - Decreased Embarrassment and Isolation
- Improved Access to Information

Overview of the Service Model

Description

BRI Care Consultation is an information and coaching service delivered by telephone (supplemented by online communication). The service targets two main clients who are of equal importance: an adult with a chronic health condition (care receiver) and the family member or friend who helps the adult the most with daily activities, tasks, and/or health-related decisions (caregiver). Clients receive assistance with accessing health- and care-related information, organizing family and friends to help in better ways, arranging services and adjusting services over time, and coaching and support.

Key Features

- BRI Care Consultation empowers clients to manage care and decision-making more effectively.
- BRI Care Consultation finds simple and practical solutions that are not overwhelming or confusing.
- BRI Care Consultation helps clients find services and understand insurances.
- BRI Care Consultation facilitates effective communication with doctors and other health care providers.
- BRI Care Consultation sustains a long-term relationship with clients.
- BRI Care Consultation is both standardized and personalized.
- BRI Care Consultation focuses on preventing crises by helping clients prepare for change and plan for the future.

Four Types of Assistance

Care Consultation is designed to empower clients to take efficient and effective actions that match their care preferences. The Care Consultant is always a coach before he or she is a "player." In other words, Care Consultants refrain from doing tasks that clients can do for themselves. Care Consultants reinforce the autonomy of clients and their role in self-care. Greater involvement may be appropriate when clients cannot complete tasks on their own or when they encounter obstacles in getting needed assistance.

Four types of assistance are provided by Care Consultation:

- **Health- and Care-Related Information**
  - Giving references and tips for finding needed information
  - Providing information by mail, telephone, or computer
  - Searching online library resources and websites
  - Maintaining a repository of consumer-ready information produced by other sources

- **Family and Friend Involvement in Care**
  - Building consensus among the care receiver and caregivers in the network
  - Getting family members and friends to help in different ways
  - Involving family members and friends who are not currently helping
  - On rare occasions, serving as a telephone moderator on a conference call to help resolve minor family communication difficulties related to caregiving
  - Working with family members and friends to plan for future caregiving

- **Awareness and Use of Community Services**
  - Increasing awareness of available services
  - Providing information about how services help and what to expect from services
  - Explaining how to find and contact services
  - Giving referral information
  - Contacting service providers on behalf of clients
  - Monitoring service quality, adequacy, and benefits services based on clients' perceptions

- **Coaching and Support**
  - Validating the care situation
  - Being empathetic and a good listener
  - Reducing feelings of isolation
  - Maintaining an updated Action Plan that represents available approaches for care
  - Clarifying the appropriateness of concerns and feelings
  - Encouraging use of counseling or case management services, if needed

Components

Initial Assessment

Initial Assessment is designed to assist care receivers and family caregivers in identifying and communicating concerns they would like addressed by BRI Care Consultation.

The Assessment Tool has two main parts:

Triggers

Yes/No questions that alert the Care Consultant to areas of potential need. They are quick and easy to administer, saving time and avoiding unnecessary questions. Triggers cover a variety of problem areas:

- Arranging Services
- Benefits
- Capacity to Provide Care
- Depression and Anxiety
- Driving
- Dyadic Relationship Strain
- Emotional and Physical Health Strain
- Financial Concerns
- IADLS
- Legal Decision Making
- Medications
- Memory Problems Diagnosis
- Memory Problems and Difficult Behaviors
- Mobility and Balance
- Nutrition
- Personal and Home Safety
- Personal Care
- Quality of Informal Support
- Social Isolation

Table 1 display Trigger questions, their information source, and to whom the Trigger pertains: care receiver (CR) and/or caregiver (CG).

Table 1: Triggers			
Trigger Title	**Trigger Question**	**Info. Source**	**Pertains To**
Arranging Services	(Do you / Does your *relationship*) need any information or help with finding or arranging for any types of services related to health, personal care, or daily activities?	CR CG	CR CG
Benefits	(Do you / Does your *relationship*) need any help understanding health care benefits, such as Medicare and Medicaid?	CR CG	CR
Capacity to Provide Care	Do you often worry that you may be unable to continue helping or providing care for your (*relationship*)?	CG	CG
Depression and Anxiety	During the past four weeks, did *(you / your relationship)* often feel sad, depressed, nervous, worried, or frightened?	CR CG	CR CG
Driving	If still driving, do you have any concerns about (your / your *relationship's*) ability to drive safely?	CR CG	CR
Dyadic Relationship Strain	During the past four weeks, did you often feel your relationship with *(your relationship)* was strained or not as good as it used to be?	CR CG	CR CG
Emotional and Physical Health Strain	During the past four weeks, did you often feel your emotional or physical health was more strained because of helping your (*relationship*)?	CG	CG
Financial Concerns	(Do you / Does your *relationship*) need any information or help with finances, such as having enough money to pay for food, bills, health care, or services?	CR CG	CR
Health Care Concerns	(Do you / Does your *relationship*) experience difficulties with getting the right medical care, including from doctors?	CR CG	CR CG
IADLs	During the past four weeks, did *(you / your relationship)* have difficulty with daily activities such as shopping, paying bills, doing the laundry or house cleaning?	CR CG	CR
Legal Decision-Making	Are documents and plans in place (i.e., living will, power of attorney, etc.) for someone to make legal, medical, or financial decisions if (you are / your *relationship* is) unable to do so independently?	CR CG	CR
Medications	During the past four weeks, did *(you/your relationship)* often have difficulty taking medications in the correct amounts or at the correct times?	CR CG	CR
Memory Problems Diagnosis	Has a doctor or other health professional spoken to *(you/your relationship)* about memory problems?	CR CG	CR
Memory Problems and Other Difficult Behaviors	During the past four weeks, did *(your relationship)* have periods of confusion, problems remembering, or act in difficult ways such as being uncooperative, hard to handle, or wandering?	CG	CR
Mobility and Balance	Are you concerned about (your / your *relationship's*) safety because of difficulty with mobility or getting around the house, including difficulties using walkers, wheelchairs, handrails, or other devices?	CR CG	CR
Nutrition	During the past four weeks, did *(you / your relationship)* experience any changes in appetite, lose or gain weight, or have loose fitting clothes or dentures?	CR CG	CR
Personal and Home Safety	Are you concerned about (your / your *relationship's*) safety because of abuse, self-neglect, or harm living in an unsafe neighborhood, clutter, or inability to make repairs or home maintenance?	CR CG	CR
Personal Care	During the past four weeks, did *(you/your relationship)* have difficulty with personal care such as bathing, dressing, or toileting?	CR CG	CR
Quality of Informal Support	During the past four weeks, did (you / your *relationship*) often feel family members or friends could be helping more or in better ways?	CR CG	CR CG
Social Isolation	During the past four weeks, did (you / your *relationship*) often feel isolated from friends, family members, or others?	CR CG	CR CG

Detail Questions

Series of questions corresponding with each Trigger, asked only if more information is needed. These optional tools provide clues for Care Consultants when deciding how to best coach clients on possible solutions.

Triggers and Detail Questions in the Care Consultation Information System (CCIS)

Because care receivers and caregivers are clients of equal importance in BRI Care Consultation, Triggers and Detail Questions are used for each client. Some of the Triggers pertaining to the care receiver are displayed in the screen shot below (Triggers for caregivers are in a separate tab of the CCIS). Care Consultants place a check in the checkbox of each Trigger that is relevant to the client. Triggers may be revisited an unlimited number of times, and each reassessment is recorded in the CCIS to capture the history of discussion about the topic.

By clicking the title of each Trigger, such as "Quality of Informal Support," a popup of the Trigger question appears:

During the past four weeks, did (you/your relationship) often feel family members and friends could be helping (you/him/her) more or in better ways?

By clicking the question mark button next to each Trigger, a popup of Detail Questions appears. The questions shown below are a series that corresponds with the "Arranging Services" Trigger:

Arranging Services

1.	(Do/Does) (you/your relationship) need any further information or help with:	
1a.	Knowing which service providers to ask for different types of help?	YES / NO
1b.	Getting different service providers to work together?	YES / NO
1c.	Finding services that are needed?	YES / NO
1d.	Getting transportation to locations where services are provided?	YES / NO
1e.	Getting (you/your relationship) to accept help from service providers?	YES / NO
1f.	Finding services to help (you/your relationship) when family members are not available?	YES / NO
1g.	What to look for in an assisted living facility or a nursing home?	YES / NO
1h.	Paying for assisted living or nursing home care?	YES / NO
1i.	Finding an apartment or smaller house for (you/your relationship)?	YES / NO
1j.	Planning for (you/your relationship) to move into the home of a relative or friend?	YES / NO
2.	(Do/Does) (you/your relationship) need any more information about or help with issues related to arranging services?	YES / NO; If YES, go to 2a; If NO, go to Q3
2a.	What type of help or information is needed?	

Initial Assessment Fidelity Report in the CCIS

The Initial Assessment and Reassessment Fidelity Report tracks the completion of Initial Assessment (and Reassessment) for each Trigger within designated time frames. The example below shows yellow highlighted cells in areas that have not been assessed by the Care Consultant and are overdue. The first column shows that the Care Consultant still needs to address the following Triggers: Capacity to Provide Care, Depression and Anxiety for the Caregiver, Health Care Concerns, and Social Isolation of the Caregiver.

Initial Assessment and Reassessment Fidelity Report

selection criteria:

Primary care consultant	All cases
Case Status	All Cases
Days Enrolled	0 or more days
Site	All cases

Case ID	100951	Care consultant	Consultant 101, Care
Months enrolled	15.9	Relationship CR to CG	Mother
Case Status	Active		

Domain	Initial Assessment in First 4 Months	Initial Assessment Complete	Number of Reassessments Year 1	Number of Reassessments Year 2
Arranging Services	Yes	Yes	2	0
Arranging Services CG	Yes	Yes	1	0
Benefits	Yes	Yes	0	0
Capacity to Provide Care	No	Yes	1	0
Depression and Anxiety	Yes	Yes	0	0
Depression and Anxiety CG	No	Yes	1	0
Driving	Yes	Yes	1	0
Dyadic Relationship Strain	Yes	Yes	1	0
Dyadic Relationship Strain CG	Yes	Yes	1	0
Emotional and Physical Health Strain CG	Yes	Yes	1	0
Financial Concerns	Yes	Yes	1	0
Health Care Concerns	No	Yes	1	0
Health Care Concerns CG	Yes	Yes	1	0
IADLs	Yes	Yes	1	0
Legal Decision-Making	Yes	Yes	0	0
Medications	Yes	Yes	1	0
Memory Problems and Difficult Behaviors	Yes	Yes	1	0
Memory Problems Diagnosis	Yes	Yes	1	0
Mobility and Balance	Yes	Yes	1	0
Nutrition	Yes	Yes	0	0
Personal and Home Safety	Yes	Yes	0	0
Personal Care	Yes	Yes	0	0
Quality of Informal Support	Yes	Yes	1	0
Quality of Informal Support CG	Yes	Yes	1	0
Social Isolation	Yes	Yes	0	0
Social Isolation CG	No	Yes	1	0

Action Plan

The Action Plan is the key component of Care Consultation. The Action Plan develops a "one step at a time" roadmap of Action Steps—small, discrete tasks that gradually address unmet needs.

Effective Action Steps are:

- Comprised of one specific task or activity
- Assigned to one designated person
- Time sensitive (specified Date To Be Accomplished)
- Simple, direct, and easy to understand
- Realistic, practical and achievable
- Used as mechanisms to provide health and care-related information; involve family and friends in care; facilitate awareness and use of community services; and offer coaching and support
- Created in collaboration with clients, who set the priorities for the Action Plan

Please refer to Table 2. to view Action Step Examples.

Table 2: Action Step Examples
Health- and Care-Related Information
Read information from website
Call service provider to set up an appointment
Write down questions to ask your doctor
Attend an education program
Write down instructions for taking medications
Family and Friend Involvement in Care
Ask friend to help you with making meals for your mother
Ask family members for a time to hold weekly phone call to discuss updates on care receiver's condition
Review copy of Living Will with other family members
Lay out clothes each evening so care receiver can dress himself/herself the next morning
Try new approach to verbal cuing to encourage cooperation of care receiver with personal care tasks
Visit nursing home that accepts Medicaid to evaluate environment and standard of care
Awareness and Use of Community Services
Order directory of senior resources and services from Area Agency on Aging
Make referral to adult day service provider
Create an instruction sheet and give to home health aide to improve knowledge of care receiver's preferences
Coaching and Support
Discuss with care receiver the types of activities he/she might enjoy doing
Change time of day that personal care is performed
Move telephone so that it can be reached without getting out of bed
Lock ammunition in a separate place from firearms
Find an object or activity that provides comfort and security during personal care
Schedule appointment to talk to employer about taking unpaid leave
Suggest modifying activity the care receiver used to enjoy
Invite members from church to come to home for weekly gathering/religious study
Request flex-time from employer so you're able to take care receiver to appointments during normal work hours
Schedule breaks from caregiving to take care of personal matters
Review topics discussed at the caregiver support group
Discuss concerns with the Rabbi
Meet friend for coffee once per week

Action Steps in the CCIS

Below is an example of an Action Step assigned to a caregiver, which was accomplished on the targeted date for completion. Sometimes, however, clients encounter barriers when trying to complete Action Steps. Care Consultants record the barriers that clients face and work with them to find successful alternative approaches.

CR | CG | Enrollment | Other Contacts | Health Conditions | CR Triggers | CG Triggers | Goals | Protocol Tasks | Action Steps | Resources | Contact Log (View only

Action Steps | Add New Action Step | Preview Action Checklist

Meet with home care aide to learn more about her background and explore possibility of providing respite in the future.

Person Responsible: Jim
Role: Primary CG
Notes: 8/18/2010: CG mentioned that they would be meeting with aide who works for ABC agency but
Accomplished Date: 9/16/2010
Appear on Action Checklist

View All Action Step

Date Activated	Action Step Status	To Be Accomplished Date	Barrier1	Barrier 2
8/18/2010	To Be Accomplished	9/16/2010		
10/13/2010	Accomplished			
4/14/2011				

Record: 15 of 21 | No Filter | Search

Care Consultants can control which Action Steps appear in a report called the Action Checklist, designed to provide clients documentation of their tasks in progress and display the role that each person is playing in the process.

Below is an example of an Action Checklist that could be mailed or emailed to a client:

Care Consultation

Your Action Checklist

4/20/2011 Eleanor Lacey Jim Olson

Care Consultant(s)		Phone Number(s)
Primary	Stefanie Schroth	

	Action Step	Who will do?	By When?
1	Schedule in person meeting with Jennings Adult Day Program.	Jim	2/28/2011
2	Have conversation with Charlie about feelings of being overwhelmed with caregiving and to begin making future caregiving arrangements.	Pat	2/28/2011

Your next phone call is scheduled for Wednesday, May 04, 2011 at 10:00 AM

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A summary of all Action Steps in the Action Plan can be generated as a report:

Care Consultation

Action Plan

5/29/2012 Loretta Robins Isabella Montoni

Care Consultant(s)		Phone Number(s)
Primary	Mary McGrady	(952) 555-1623

	Action Step	Person Responsible	Date	Status
1	Read information packet on fall prevention, home safety, and home modifications.	Isabella	6/11/2011	Accomplished
2	Talk with Anthony about how he would like to proceed in communicating with parents about care concerns.	Isabella		Not Accomplished
3	Call Loretta to offer emotional support and talk about possibility of a professional coming to the home to help make sure it is safe.	Mary	6/27/2011	Accomplished
4	Ask Dr. Saeed about occupational therapist or other professional to do home assessment and make recommendations for improving safety and preventing falls.	Loretta	7/14/2011	Accomplished
5	Prepare list of questions for physical therapist and meet with physical therapist for home safety assessment.	Loretta	7/30/2011	Accomplished
6	Send information on Matter of Balance fall prevention program.	Mary	8/30/2011	Accomplished
7	Drive Loretta to Matter of Balance classes once per week.	Anthony	10/11/2011	Ongoing

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*Above names and phone number are fictitious and for illustrative purposes only.

Fidelity Monitoring Report for Action Steps in the CCIS

The example report below shows the number and percentage of Action Steps that were accomplished for an individual case. Action Steps are divided according to the person responsible for completion, including the Care Consultant, care receiver, and primary caregiver.

Fidelity Monitoring: Action Steps

Selection Criteria:

Primary Care Consultant	Schroth, Stefanie
Case Status	Active
Days Enrolled	180 or more days

CRID	18	Months Enrolled	20.7	Case Status	Active

Person Responsible for Action Step	Total Number of Action Steps	Number Accomplished	Percent Accomplished
Care Consultant	12	11	91.7%
Care Receiver	3	1	33.3%
Primary CG	11	7	63.6%
Total	26	19	73.1%

Maintenance and Support

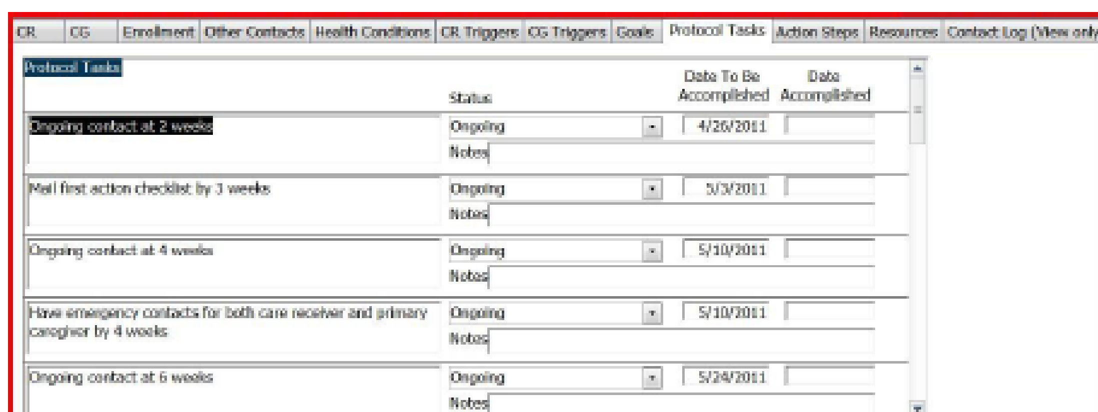
A distinctive feature of BRI Care Consultation, compared with other coaching interventions, is "Maintenance and Support" based on a long-term relationship with clients. This long-term relationship enables a focus on prevention, including reducing avoidable crises and unnecessary hospital and emergency department use, and continuing the preferred care arrangement for as long as possible. Maintenance and Support is accomplished in two ways: 1) Ongoing Contacts, and 2) Reassessment.

Ongoing Contacts

Ongoing Contacts are completed for every case at set intervals, following a standard schedule. These telephone contacts allow clients to provide less formal updates about how things are going and any changes in health or caregiving, even if considered minor. Some small changes may warrant attention in the Action Plan in order to prevent their escalating into more serious concerns. By keeping in touch with clients, even during periods of stability, Care Consultants maintain client rapport and familiarity with the current caregiving situation. The pattern for Ongoing Contacts is as follows: every 2 weeks for the first 2 months; once per month during months 3 through 6; every 3 months beginning in month 7 and through the remainder of service use.

Ongoing Contacts in the CCIS

The Care Consultation Information System keeps track of dates when Ongoing Contacts need to be completed for each case (in addition to other Protocol Tasks required for Care Consultation, such as mailing an Action Checklist within the first 3 weeks of enrollment). Reports in the CCIS notify the Care Consultant of all the Protocol Tasks that need to be completed within any specified time frame. When a Protocol Task is completed, the Care Consultant changes the Status from "Ongoing" to "Accomplished" and records the date.



Reassessment

Reassessment is the process of revisiting Triggers for the second time. Reassessment is required sometime between month 4 (after Initial Assessment has been completed) and month 12. Revisiting Triggers is necessary because changes in the care situation may prompt new Action Steps. For example, symptoms of the care receivers' health conditions may worsen and new Action Steps may be needed to respond to these changes. Reassessment uses the same Assessment Tools as the Initial Assessment.

Appendix X: Rowland Universal Dementia Assessment Scale (RUDAS) Report and Journal Article Abstracts; detailed information and abstracts related to RUDAS, a tool used to screen for memory loss by the ROAD program at the Rosalyn Carter Institute

RUDAS Report and Journal Article Abstracts

Rowland J, Conforti D, Basic D, Vrantsidis F, Hill K, LoGiudice D, Russel M, Haralambous B, Prowse R, Harry J and Lucero K. (2007) A study to validate the Rowland Universal Dementia Assessment Scale (RUDAS) in two populations outside the Sydney South West Area Health Service.

A report from South West Sydney Area Health Service and the National Ageing Research Institute to the Australian Government Department of Health and Ageing. This publication was supported by funding from the Australian Government Department of Health and Ageing, under the National Dementia Support Program.

Background: Over recent years there has been a recognised need for new cognitive screening tools to be developed and validated that address identified limitations of existing tools. Limitations have included that tools appear to be influenced by factors such as education level, cultural background and language, and that some important aspects of cognitive function such as frontal lobe function are not assessed. The Rowland Universal Dementia Assessment Scale (RUDAS) was developed to address some of these limitations. Initial results published in 2004 reported high reliability and good prediction accuracy for the RUDAS. A subsequent study in 2006 indicated the RUDAS compared favourably with a commonly used screening tool (the Mini Mental State Examination - MMSE), and indicated that unlike the MMSE the RUDAS did not appear to be influenced by language, education or gender. This project, funded by the Australian Government Department of Health and Ageing through Alzheimer's Australia, involves a further stage of validation for the RUDAS.

Method: The National Ageing Research Institute coordinated recruitment in Melbourne, and the Royal Adelaide Hospital and Alzheimer's Australia SA coordinated recruitment in Adelaide. The primary aim of the project was to validate the RUDAS in regions external to the initial studies (southwest Sydney) and in a broader sample population that included those with mild/moderate cognitive impairment (as earlier studies had samples with a high proportion of people with more severe cognitive impairment). A secondary aim was to compare the RUDAS with two existing cognitive screening tools (the MMSE and the General Practitioners Assessment of Cognition – GPCOG) in its utility and ability to accurately predict cognitive impairment. Ethics Committee approval was obtained for the project.

One hundred and fifty one people met the study inclusion criteria and completed the assessment process. Participants completed a series of cognitive assessments and measures of function and depression, in addition to the RUDAS, MMSE and GPCOG.

Results: Participants had an average age of 77 years, 70% were female, and 42% were from culturally and linguistically diverse (CALD) backgrounds. Forty percent of participants had normal cognition and 60% had some form of cognitive impairment. Based on the Cognitive Dementia Rating scale, 90% of participants with cognitive impairment were classified as having questionable or mild cognitive impairment. Average scores for the full sample on the RUDAS was 23, the MMSE 25, and the GPCOG (two stage process) 7. All three cognitive screening tools were highly correlated.

All three screening tools demonstrated a high level of accuracy in prediction of cognitive impairment against the gold standard classification (DSMIV –TR criteria), and there was no

1

significant differences between the tools. In analyses exploring the influence of a number of potential factors on the association between scores on the various tools and prediction of cognitive impairment, CALD status was shown to affect the MMSE score, and the participant's depression score was shown to affect the GPCOG score.

Conclusions: Results from this study provide further evidence to support the use of the RUDAS in screening people for cognitive impairment. In terms of the primary aims of the project, the RUDAS was found to have high predictive accuracy in a broader population sample, that included other settings (Melbourne and Adelaide) and a range of cognitive function (including mild to moderate cognitive impairment). In terms of the secondary aim of the project, similar prediction accuracy between the RUDAS, MMSE and GPCOG was demonstrated. However, the RUDAS was not substantially affected (confounded) by other factors in predicting cognitive status, whereas the MMSE and GPCOG were both influenced by other factors. The RUDAS has some advantages in its broad application, in that it does not require presence of an informant (in contrast to the GPCOG), and it does not include items that have potential to cause difficulties for some people with lower education levels or CALD background (in contrast to the MMSE).

Basic D, Khoo A, Conforti DA, Rowland JT, Vrantsidis F, LoGiudice D, Hill K, Harry J, Lucero K, Prowse RJ. (2009) Rowland Universal Dementia Assessment Scale, Mini-Mental State Examination and General Practitioner Assessment of Cognition in a multicultural cohort of community-dwelling older persons with early dementia. *Australian Psychologist*, 44: 40-53.

Early dementia can be difficult to diagnose in older persons from culturally and linguistically diverse (CALD) backgrounds. The Folstein Mini-Mental State Examination (MMSE), the General Practitioner Assessment of Cognition (GPCOG) and the Rowland Universal Dementia Assessment Scale (RUDAS) were compared in 151 older, community-dwelling persons. Receiver operating characteristic (ROC) curve analysis was used to evaluate diagnostic accuracy, while logistic regression was used to evaluate the influence of age, gender, CALD status and years of education. All three instruments were equally accurate in predicting dementia (ROC area under curve 0.92-0.97, $p > 0.05$ for all comparisons). At the recommended cut-offs, the RUDAS was best for ruling in dementia (positive $LR = 8.77$), while the GPCOG was best for ruling out dementia (negative $LR = 0.03$). All three instruments were influenced by concomitant depression. Whereas the MMSE was influenced by CALD status, the RUDAS and GPCOG were not. While the GPCOG combines participant and informant data, the RUDAS is a stand-alone measure specifically designed for, and validated in, multicultural populations.

Rowland JT, Basic D, Storey JE, Conforti DA. (2006) The Rowland Universal Dementia Assessment Scale (RUDAS) and the Folstein MMSE in a multicultural cohort of elderly persons. *International Psychogeriatrics*, 18:111-120.

Objective: To compare the accuracy of the Rowland Universal Dementia Assessment Scale (RUDAS) and the Folstein Mini-mental State Examination (MMSE) for diagnosis of dementia in a multicultural cohort of elderly persons.

Methods: A total of 129 community-dwelling persons were selected at random from a database of referrals to an aged-care team. Subjects were stratified according to language background and cognitive diagnosis, and matched for age and gender. The RUDAS and the MMSE were administered to each subject in random order. Within several days, a geriatrician assessed each subject for dementia (DSM-IV criteria) and disease severity (Clinical Dementia Rating Scale). All assessments were carried out independent and blind. The geriatrician also administered the Modified Barthel Index and the Lawton Instrumental Activities of Daily Living Scale, and screened all participants for non-cognitive disorders that might affect instrument scores.

Results: The area under the receiver operating characteristic curve (AUC) for the RUDAS [0.92, 95% confidence interval (95%CI) 0.85–0.96] was similar to the AUC for the MMSE (0.91, 95%CI 0.84–0.95). At the published cut-points (RUDAS < 23/30, MMSE < 25/30), the positive and negative likelihood ratios for the RUDAS were 19.4 and 0.2, and for the MMSE2.1 and 0.14, respectively. The MMSE, but not the RUDAS, scores were influenced by preferred language ($p = 0.015$), total years of education ($p = 0.016$) and gender ($p = 0.044$).

Conclusions: The RUDAS is at least as accurate as the MMSE, and does not appear to be influenced by language, education or gender. The high positive likelihood ratio for the RUDAS makes it particularly useful for ruling-in disease.

Storey JE, Rowland JT, Basic D, Conforti DA, Dickson HG. (2004) The Rowland Universal Dementia Assessment Scale (RUDAS): a multicultural cognitive assessment scale. *International Psychogeriatrics*, 16:13-31.

Objective: To develop and validate a simple method for detecting dementia that is valid across cultures, portable and easily administered by primary health care clinicians.

Design: Culture and Health Advisory Groups were used in Stage 1 to develop culturally fair cognitive items. In Stage 2, clinical testing of 42 items was conducted in a multicultural sample of consecutive new referrals to the geriatric medicine outpatient clinic at Liverpool Hospital, Sydney, Australia (n=166). In Stage 3, the predictive accuracy of items was assessed in a random sample of community-dwelling elderly persons stratified by language background and cognitive diagnosis and matched for sex and age (n=90).

Measurements: A research psychologist administered all cognitive items, using interpreters when needed. Each patient was comprehensively assessed by one of three geriatricians, who ordered relevant investigations, and implemented a standardized assessment of cognitive domains. The geriatricians also collected demographic information, and administered other functional and cognitive measures.DSM-IV criteria were used to assign cognitive diagnoses. Item validity and weights were assessed using frequency and logistic regression analyses. Receiver-operating characteristic (ROC) curve analysis was used to determine overall predictive accuracy of the RUDAS and the best cut-point for detecting cognitive impairment.

Results: The 6-item RUDAS assesses multiple cognitive domains including memory, praxis, language, judgement, drawing and body orientation. It appears not to be affected by gender, years of education, differential performance factors and preferred language.The area under the ROCcurve for the RUDAS was 0.94 (95% CI 0.87–0.98). At a cut-point of 23 (maximum score of 30), sensitivity and specificity were 89% and 98%, respectively. Inter-rater (0.99) and test-retest (0.98) reliabilities were very high.

Conclusions: The 6-item RUDAS is portable and tests multiple cognitive domains. It is easily interpreted to other languages, and appears to be culturally fair. However, further validation is needed in other settings, and in longitudinal studies to determine its sensitivity to change in cognitive function over time.

<u>Appendix XI: "Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms: Preliminary Findings from a Randomized Controlled Study"; published research article on TCARE®, an evidence-based program designed to enable care managers to more effectively support family caregivers</u>

Montgomery, R.J.V., Kwak, J., Kosloski, K., & O'Connell Valuch, K. (2011). Effects of the TCARE® intervention on caregiver burden and depressive symptoms: preliminary findings from a randomized controlled study. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 66(5), 640–647, doi:10.1093/geronb/gbr088

Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms: Preliminary Findings From a Randomized Controlled Study

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Objectives. We examined the effects of a manualized care management protocol specifically designed for care managers working with caregivers, the Tailored Caregiver Assessment and Referral® (TCARE®) protocol, on caregiver identity discrepancy, burden, and depressive symptoms.

Methods. Preliminary data from a longitudinal, randomized, controlled intervention study with 266 family caregivers served by 52 care managers in 4 states were analyzed using repeated measures random effects regression procedures. Caregivers in the intervention and control groups were repeatedly assessed for up to 9 months on caregiver identity discrepancy, 3 areas of caregiving burden—objective, relationship, and stress burdens; depression; and intention for nursing home placement.

Results. We found significant group by time interaction effects for caregiver identity discrepancy, relationship burden, stress burden, depression, and intention for nursing home placement. Caregivers in the intervention group experienced significant improvement on these measures, whereas caregivers in the control group worsened on these measures over time.

Discussion. The preliminary findings provide strong support for effectiveness of the TCARE® protocol on improving caregiver well-being and mental health outcomes.

Key Words: Caregiving—Caregiver identity theory—Care management—Intervention—TCARE®.

An estimated 65.7 million Americans provided unpaid care to one or more disabled or ill family members or friends in 2009 (National Alliance for Caregiving & AARP, 2009). This provision of care does not come without costs. An extensive body of literature documents the link between caregiving and a variety of negative mental and physical health outcomes (Schulz & Sherwood, 2008).

Over the past two decades, considerable efforts have been made to develop and test the effectiveness of a range of support services for family caregivers (Goy, Freeman, & Kansagara, 2010). These caregiver interventions have included respite services (Zarit, Stephens, Townsend, Greene, & Leitsch, 1999), psycho-educational skills training (Bourgeois, Schulz, Burgio, & Beach, 2002; Coon, Thompson, Steffen, Sorocco, & Gallagher-Thompson, 2003), cognitive behavioral therapy or family counseling (Gonyea, O'Connor, & Boyle, 2006; Mittelman, Haley, Clay, & Roth, 2006), or a combination of services (Belle et al., 2006). Two observations can be made about findings that have emerged from these studies. First, the most promising findings regarding the positive impact of support services on caregivers have emerged from studies that include a relatively comprehensive set of multiple support services (Belle et al., 2006). Second, it is clear that the programs are most effective for reducing caregiver burden when the services are provided in sufficient quantities and targeted to specific needs. Unfortunately, even with this information from numerous studies of caregiver interventions, few resources exist to help guide care managers or other family specialists to formulate decisions about the correct type of services and the most appropriate time for initiating service use. As a result, there is a tendency for service providers or care managers to offer caregivers the services that are available in their communities with little knowledge about which services are most needed and most likely to be used by and benefit the caregiver at that point in time. Unfortunately, this practice creates the circumstance that many caregiver services go unused, and/or they are provided at a point in time that is too late to fully benefit the caregiver or the care receiver (Montgomery, 2002).

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The Tailored Caregiver Assessment and Referral® (TCARE®) protocol is an efficient evidence-informed process that was developed to assist care managers and practitioners working with family caregivers to meet the unique needs of individual caregivers (Montgomery & Kwak, 2008). The protocol reflects current knowledge about caregivers and caregiver interventions and is grounded in the *Caregiver Identity Theory* articulated by Montgomery and Kosloski (2009). The major tenet of the *Caregiver Identity Theory* is that caregiver identity discrepancy, defined as a disparity between the care responsibilities that he or she is assuming and his or her identity standard, is a major source of caregivers' stress.

This conceptualization of the distress process builds upon the work of Burke (1991, 1996) and his colleagues who consider identity maintenance to be a continuous process in which identity standards are applied to the self in a social role. Identity standards are personal norms that serve as reference points for self-appraisal in a role. These personal norms are influenced by social, cultural, and familial norms. Consistency between an individual's identity standards and appraisal of behaviors maintains identity stability. An inconsistency between identity standards and behaviors challenges identity, resulting in stress and, at times, a transition to a different social role and new identity standard (Burke, 1991, 1996). Caregiver identity theory suggests that the caregiving role emerges out of a prior familial role, most often the role of child or spouse. As a caregiver assumes greater responsibilities for care he or she experiences an identity change in relation to the care recipient and a change in identity standards. This change process is dynamic and continues as the tasks and responsibilities of the caregiver change in response to the changing needs of the care recipient and care context. For most caregivers, the change in role identity is a slow insidious process that proceeds in stops and starts, ultimately resulting in a significant shift from one's initial role relationship to the care recipient. For example, a daughter may easily assist her mother who has some difficulty paying bills or shopping without experiencing stress. As the disease progresses, the needs of her mother and the resultant demands placed on the daughter increase. As this process unfolds, the daughter's activities gradually increase in intensity and become discrepant with the norms that the daughter has internalized with respect to her role as a daughter. Simply put, her activities are now discrepant with her previous role identity, that is, identity discrepancy.

This identity discrepancy can be manifested in at least three distinct areas of burden: objective burden, relationship burden, and stress burden, as well as depression (Savundranayagam & Montgomery, 2010). Reflecting these assumptions, the TCARE® protocol was designed to help caregivers by systematically targeting identity discrepancy, the three domains of burden, and depression (Montgomery & Kwak, 2008).

Essentially, TCARE® is a triaging mechanism that empowers family caregivers to make informed decisions by providing them with critical information about the care context, their own strengths and needs, and resources available to address their needs. The protocol outlines a six-step process for assessing the caregiving context and caregivers needs, creating a care plan and providing care managers with a set of tools to implement the process. The six steps are to (a) conduct an assessment using a 32-item standardized form; (b) transfer key information gained from the assessment process to a summary sheet that enables care managers to calculate scores for key measures and interpret them using distributions that have been established through previous studies; (c) follow a decision algorithm to identify goals, strategies, and resources that are targeted to the caregivers needs and preferences and record these on a care consultation worksheet; (d) consult with the caregiver to review and discuss the assessment results, suggested goals, strategies, and resources and mutually agree upon a care plan; (e) create a care plan that is a written record of decisions made during the care consultation and includes detailed information for implementing the plan; and (f) conduct a follow-up assessment at three-month intervals. A computer-assisted version of the protocol is available for care managers to use.

A key feature of the TCARE® protocol is the decision algorithm that enables care managers to integrate extensive information about the caregiver and care context to create a care plan tailored to the unique needs of the caregiver. The algorithm, which is grounded in the caregiver identity theory, leads to the identification of (a) an appropriate intervention goal, (b) strategies for reaching that goal, and (c) a generic list of services that is consistent with the identified strategies. The three possible goals for a caregiver are to (a) continue in his or her current identity as a caregiver by "stretching" that identity to include current caregiving activities, (b) reduce the caregiving aspects of his or her identity to bring his or her identity into line with what he or she is actually doing, or (c) further embrace an identity as a caregiver to bring his or her identity into line with what he or she is actually doing. For many caregivers, the algorithm also identifies a health goal, which is uniquely tied to the strategy of improving health and the recommendation of medical or behavioral health evaluation. The five possible strategies for achieving the selected goal include (a) changing the caregiver's personal norms or rules pertaining to care responsibilities and interactions with the care recipient, (b) reducing the workload, (c) enhancing positive self-appraisal, (d) reducing emotional stress, and (e) improve overall health.

The 44 pathways through the decision algorithm reflect various combinations of caregivers' scores on measures of three types of burden, intention to place, depression, and identity discrepancy. When appropriate, the algorithm also incorporates additional information about the care context to enable the care manager to make professional judgments regarding the capacity of the caregiver to provide necessary care in a safe manner.

Caregiver A	Caregiver B
Scores on Key Measures	
Depression = low; Objective Burden =high; Relationship Burden =low; Stress Burden =low; Identity Discrepancy =low; Intention to place care receiver given current condition =no	Depression =medium; Objective Burden =high; Relationship Burden =low; Stress Burden =high; Identity Discrepancy =high; Intention to place care receiver given current condition =no
Step 1: Identify map that includes algorithm for caregiver	
Map D is used when Objective Burden =medium or high and Relationship Burden =low; Intention to place =yes or no	
Step 2: Depression Medium or High?	
No *Go to Step 3*	Yes Goal: Improve Health Strategy E: Improve overall health Service: Medical/Behavioral Health Evaluation *Go to Step 3*
Step 3: Identity Discrepancy Medium or High?	
No Goal: Maintain Current Identity Strategy A: Change personal rules for care Service: Education to learn to respond to mood and behavior change Strategy B: Reduce or minimize work load Service: Education to learn to respond to mood and behavior change Service: In-home support service (e.g. chore services) *Go to Step 5*	Yes *Go to Step 4*
Step 4: Does caregiver accurately understand level of care receiver's need? (This is a professional judgment made by the care manager)	
	No, Care receiver has lower level of need than caregiver perceives. Goal: Reduce caregiver role Strategy A: Change personal rules for care Service: Education about disease process Service: Counseling for self care *Go to Step 5*
Step 5: Stress Burden Medium or High?	
No Develop care plan with local resources as outlined in Step 3	Yes Add counseling or education focused on coping skills to the care plan as outlined in Step 4
Initial Care Plan: The plan is tailored by identifying specific services for which the caregiver is eligible and providers in the caregiver's community.	
Goal: Maintain Current Identity Strategy A: Change personal rules for care Service: Education to learn to respond to mood and behavior changes Strategy B: Reduce or minimize work load Service: Education to learn to respond to mood and behavior changes Service: In-home support service (e.g. chore services)	Goal: Reduce Caregiver Role Strategy A: Change personal rules for care Service: Education about disease process Service: Counseling for self care Strategy E: Improve overall health Service: Medical/Behavioral Health Evalution

Figure 1. Example of decision algorithms and care plans for two caregivers.

A step-by-step illustration of the application of the decision algorithm for two caregivers with different combinations of scores is provided in Figure 1. The figure depicts the pathways for the two caregivers leading to the goals, strategies, and examples of the types of services that would be included on an initial care plan. The process starts on Map D, which includes the decision algorithms for caregivers who score medium or high on objective burden but low

on relationship burden. The second step is to examine the depression score. If a caregiver scores medium or high on the depression measure, as did Caregiver B, the goal to improve health is established. The third step in the process is to examine the caregivers' scores on the measure of identity discrepancy. Caregiver A has a low level of identity discrepancy and therefore the goal selected for her is to help her "maintain her current identity." Strategies and services are recommended that will help lower her level of objective burden by easing her workload. In contrast, Caregiver B has a high level of identity discrepancy, which stems from the fact that she inaccurately perceives the care receiver to be more dependent than he actually is. In this case, the caregiver is engaging in a level of care that is fostering overdependency on the part of the care receiver. Strategies and services are recommended to help her let go of caregiving tasks and thereby align her activities with an identity that is more in keeping with her primary role as a wife. The last step of the process for both caregivers is to examine stress burden to determine whether services are needed to help alleviate the caregiver's anxiety, which is the case for Caregiver B but not Caregiver A.

The generic service types listed in Figure 1 are drawn from the TCARE® *Guide for Selecting Services* which is a catalogue of over 90 types of resources grouped into 15 major categories that have been identified as potentially useful for supporting caregivers. The guide provides a cross walk between five strategies for supporting caregivers and each type of resource that could be used to support the strategy. Care managers hone and tailor the initial list of suggested services to reflect the caregiver's preferences and the availability of services within the community.

We report findings from preliminary data of the randomized controlled study of family caregivers that examined the effects of the TCARE® protocol on caregiver outcomes. We hypothesized that caregivers served by care managers using the TCARE® protocol would experience lower levels of identity discrepancy, objective burden, relationship burden, stress burden, and depressive symptoms over time when compared with caregivers served by care managers following their usual practices. We also hypothesized that there would be a difference between the two groups in the caregivers' expressed intention to place a relative in a nursing home facility.

Method

Participants

Caregivers.—The study sample included 266 family caregivers who contacted 20 social service organizations in Georgia, Michigan, Minnesota, and Washington for support services to care for their relatives with cognitive or functional impairment and met the eligibility criteria established for the study. A short standardized screening tool was used to identify potential participants. Caregivers were deemed eligible for the study if they (a) indicated that they "probably would" or "definitely would" place their care receivers in a different type of care setting for long-term placement given their relatives' current condition or (b) scored above the cut-off score on at least one of the following major outcome measures: caregiver identity discrepancy (Savundranayagam & Montgomery, 2010), objective burden, relationship burden, stress burden (Savundranayagam, Montgomery, & Kosloski, 2011), or depressive symptoms (Andresen, Malmgren, & Cater, 1994). Prior to this study, data from a sample of informal caregivers enrolled in a caregiver registry (n = 431) were analyzed to establish cut-off score for each measure, which was set to one standard deviation below the mean. Eligible caregivers were randomly assigned to the intervention or control group using a computer-generated algorithm and a standard protocol for transmitting randomization information to the participating organizations.

Care managers and organizations.—Fifty-two care managers from 20 social service organizations participated in the study. Twenty-three care managers were selected by their organizations to participate in a structured training process that included an initial two-day intensive TCARE® training session, a follow-up one-day session conducted one month later, and an in-person or web-based training session. To ensure fidelity with the protocol, all cases by intervention group care managers were submitted to the study team for review at baseline and six months. Twenty-nine care managers were assigned to the control group to serve caregivers following their normal customary practices. At least one care manager from each organization was assigned to the control group. We compared demographic and employment characteristics between the groups and found no significant differences except for mean age (53.04 [9.74] for the intervention vs. 46.55 [10.89] for control group, $p < .05$).

Procedures

This research project was approved by the University of Wisconsin-Milwaukee Institutional Review Board. Of the 626 caregivers who participated in the screening process, 481 caregivers were eligible for the study and randomly assigned to be served by a care manager in the intervention or the control group. At the initial meeting with their care managers, caregivers were informed about and invited to participate in the study. A total of 266 caregivers agreed to participate, 143 in the intervention group and 123 in the control group.

Data for caregivers in the intervention group were collected as part of the TCARE® protocol by care managers using the standardized TCARE® assessment form. Data for caregivers in the control group were collected by trained interviewers from the research team using the same

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TCARE® standardized assessment form. Up to three follow-up interviews were conducted with caregivers at intervals of approximately three months. Participants contributed data until they dropped out from the study. Follow-up interviews were discontinued for caregivers if the care receiver died during the study period ($n = 29$). We continued our follow-up data collection, however, for caregivers who placed the care recipient in a nursing home ($n = 34$). Of the 266 caregivers with baseline interviews, 185 (70%) individuals completed first follow-up (three-month) interviews, 138 (52%) individuals completed second (six-month) follow-up interviews, and 94 (39%) completed third (nine-month) follow-up interviews. The final analysis included a total of 680 observations from these caregivers.

Outcome Measures

Identity discrepancy.—Caregiver identity discrepancy is defined as the affective psychological state that accrues when there is a disparity between the care activities in which a caregiver is engaging and those activities that would be consistent with his or her identity standard (Montgomery & Kosloski, 2009). Identity discrepancy was measured using a 6-point six-item inventory with scores ranging 6–36 ($\alpha = .80$; Savundranayagam & Montgomery, 2010). For each statement, respondents indicated the extent to which they agreed using a response set that ranged from 1 (*strongly disagree*) to 6 (*strongly agree*). Example items are "the things I am responsible for do not fit very well with what I want to do" and "it is difficult for me to accept all the responsibility for my (care recipient)."

Caregiver burden.—Caregiver burden was measured using the modified Montgomery Borgatta Caregiver Burden Scale (Savundranayagam et al., 2011). The caregiver burden inventory measures three domains of caregiver burden (objective burden, relationship burden, and stress burden). For all items in the inventory, respondents were asked to use a 5-point response set ranging from 1 (*not at all*) to 5 (*a great deal*) to indicate the extent to which their caregiving responsibilities changed each aspect of their life. Objective burden is defined as a negative psychological state that results from the perception that caregiving activities and responsibilities are infringing on other aspects of the caregiver's life, such as time and energy to address other family obligations, leisure activities, and personal privacy. Scores for this measure, which comprised six items, ranged from 6 to 30 ($\alpha = .86$; e.g., Have your caregiving responsibilities decreased time you have to yourself?). Relationship burden, defined as demands for care and attention over and above the level that the caregiver perceives is warranted by the care receiver's condition, was measured with five questions (e.g., Have your caregiving responsibilities, caused conflicts with your care recipient?). Scores ranged from 5 to 25 ($\alpha = .84$). Stress burden is defined as a generalized form of negative affect that results from caregiving. Five items were included in this measure (e.g., Have your care responsibilities made you nervous?). Scores ranged from 5 to 25($\alpha = .87$).

Depressive symptoms.—Depressive symptoms were measured using a 10-item short version of the Center for Epidemiological Studies–Depression scale (Andresen et al., 1994). Scores ranged from 0 to 30 ($\alpha = .80$).

Intention to place.—Intention to place was defined as the caregiver's intention to place the care receiver in an alternate care setting now or in the future. The measure is the sum of responses to two questions that used a 4-point response set that ranged from *definitely not* to *definitely would*. The first item asked caregivers whether they would place the care receiver in a nursing home or other long-term care facility, given their relatives' current condition. The second item asked about the caregiver's intention to place the care receiver in an alternate setting if the care receiver's condition became worse. Scores ranged from 2 to 8, with a higher score indicating higher level of intention to place ($\alpha = .74$).

Statistical Analysis

We conducted repeated measures random effects regression analysis, which allowed the estimation of longitudinal trajectories for individual participants at one level with the intercepts and slopes of these person-specific longitudinal trajectories analyzed as the effects of between-subjects predictors at a higher order second level (Singer & Willett, 2003). To determine whether it was necessary to account for clustering at this higher level, we examined the size of the design effect for each outcome in the study. In accord with the recommendations of Muthen and Satorra (1995), the design effects were comfortably below 2.0 for every outcome, indicating that there would be no significant bias introduced by ignoring clustering at this higher level.

Predictor variables included in the analysis were *group* (intervention vs. control), *time* (measured in months from baseline interview), and a *group by time* interaction term indicating whether the groups differed from one another with respect to their trajectory of change. There was no evidence of skewness or kurtosis on any of the measured variables. Restricted maximum likelihood estimation as provided by the SAS Proc Mixed procedure was used to address missing data (Littell, Milliken, Stroup, & Wolfinger, 1996).

Results

Demographic characteristics and measures of outcome variables at baseline are shown in Table 1. Almost half of the caregivers were adult children (49.6%) and half (42.5%)

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Table 1. Caregiver Characteristics at Baseline (n = 266)[a]

	All (n = 266)	TCARE® (n = 143)	Control (n = 123)
		Percentage	
Gender			
Female	79.70	76.92	82.93
Male	20.30	23.08	17.07
Race			
White	75.67	73.76	77.87
Black or African American	19.39	23.40	14.75
Other[b]	4.94	2.84	7.38
Relationship to the care recipient			
Spouse/partner	42.48	43.36	41.46
Parent	49.62	47.55	52.03
Other[c]	7.90	9.09	5.51
Self-reported health			
Very poor/poor/fair	42.42	41.84	43.09
Good/very good	57.58	58.16	56.91
Care receiver memory problems			
No memory problem	9.51	9.22	9.84
Cognitive or memory problems suspected	16.35	19.15	13.11
Alzheimer's or other dementia suspected	15.97	15.60	16.39
Alzheimer's or other dementia diagnosed	58.17	56.03	60.66
Care receiver needs help with two or more ADLs	78.95	81.12	76.42
Care receiver needs help with two or more IADLs	100	100	100
		M (*SD*)	
Age in years	62.43 (13.02)	62.59 (14.04)	62.25 (11.80)
Identity discrepancy	20.77 (7.02)	20.53 (7.15)	21.04 (6.89)
Objective burden	21.52 (6.35)	21.50 (6.30)	21.54 (6.43)
Relationship burden	10.59 (4.82)	10.37 (5.25)	10.86 (4.25)
Stress burden	13.99 (5.27)	14.39 (5.56)	13.52 (4.89)
Depressive symptoms	12.10 (6.33)	12.23 (6.81)	11.95 (5.73)
Intention to place	4.50 (1.71)	4.43 (1.63)	4.58 (1.80)

Notes: No statistically significant difference between the two groups was found for any of the characteristics shown in the table. ADLs = activities of daily living; IADLs = instrumental activities of daily living.

[a]Thirty-four caregivers whose care recipients were institutionalized at some point during the study were included in the analysis because caregivers were still involved in caregiving for their care receivers.

[b]Other race refers to caregivers who did not identify as Caucasian or African American or who identified with two or more races or ethnicities.

[c]Other relationships to the care receiver include friends and other relatives.

were spouses. Seventy-six percent of caregivers were White and 19% were Black or African American. Most (79%) of the care receivers needed help with at least two activities of daily living and all needed assistance with two or more instrumental activities of daily living. The majority of care receivers also had memory or cognitive problems (90.5%). Independent samples t tests and chi-square tests indicated that there were no differences between the intervention and control groups in demographic characteristics or outcome variables at baseline.

Results of the repeated measures random effects regression analyses are shown in Table 2. We found statistically significant group by time interactions for identity discrepancy, relationship burden, stress burden, depressive symptoms, and intention to place. Over time, caregivers in the intervention group experienced a significant decrease in scores for these outcome measures, whereas the scores for caregivers in the control group increased. Of particular note is that caregivers in the intervention group experienced substantially lower levels of depressive symptoms compared with those in the control group over the nine-month period (see Figure 2).

Discussion

The study findings provide strong support for our main hypothesis that the use of the TCARE® protocol, which is designed to identify the unique needs of an individual caregiver and strategically recommend a set of services, will promote the well-being and mental health of caregivers. With the exception of objective burden, significant differences were found between the intervention and control groups for all of the key outcome measures, indicating that the protocol promoted the well-being of family caregivers. It is hypothesized that these differences can be attributed to more effective assessment of the caregivers' current circumstances and needs and the creation of a care plan that identifies goals, strategies, and resources specifically selected to alleviate or diminish identity discrepancy, depression, and any of three types of burden that a caregiver is experiencing. As described previously, an essential element of the TCARE® protocol is the selection of one of the three intervention goals aimed at minimizing identity discrepancy. Caregivers become distressed when their care activities and responsibilities are inconsistent with their own identity standards. Simply put, it is not what a caregiver is

Table 2. Random Intercept Regression Models of Caregiver Identity Discrepancy, Objective Burden, Relationship Burden, Stress Burden, Depressive Symptoms, and Intention to Place

	Identity discrepancy			Objective burden			Relationship burden			Stress burden			Depressive symptoms			Intention to place		
	Est.	SE	p Value	Est.	SE	p Value	Est.	SE	p Value	Est.	SE	p Value	Est.	SE	p Value	Est.	SE	p Value
Intercept	21.23	0.61	<.0001	21.35	0.56	<.0001	10.89	0.44	<.0001	13.66	0.47	<.0001	12.28	0.57	<.0001	4.59	0.15	<.0001
Group (0 = control, 1 = TCARE®)	−0.84	0.84	.317	0.14	0.77	.86	−0.51	0.60	.398	0.55	0.64	.396	−0.19	0.77	.8075	−0.19	0.21	.357
Time	0.11	0.11	.068	−0.06	0.06	.32	0.08	0.04	.068	0.06	0.05	.234	0.06	0.06	.3283	0.05	0.02	.04
Group × Time	−0.21	0.21	.012	−0.12	0.08	.1465	−0.18	0.06	.003	−0.26	0.07	<.0001	−0.24	0.09	.0051	−0.07	0.02	.002

Figure 2. Changes in depressive symptoms by group.

doing that creates stress but what a caregiver is doing relative to his or her personal norms or expectations. The TCARE® protocol leads to a care plan that helps caregivers align personal norms with care activities and responsibilities and, thereby, minimize identity discrepancy as a source of stress.

We also believe that the care consultation process is an educational process that helps caregivers understand the potential benefits of the services that have been offered and thereby promotes adherence to a mutually created plan. In short, the TCARE® process facilitates effective targeting of support services and compliance by caregivers with care plans tailored to their specific needs, hence improves caregiver outcomes. This interpretation is consistent with the results from a pilot study of TCARE® conducted in the state of Georgia in which we observed improved outcomes among caregivers served with the TCARE® protocol (Kwak, Montgomery, Kosloski, & Lang, 2011). In that study, we found that compared with the usual care group, care managers in the TCARE® group recommended a greater variety of services on care plans, several of which were used by a greater proportion of caregivers in the TCARE® group.

Additional insight can be gleaned from the absence of a difference between the intervention and control groups in the trajectory of objective burden scores in the current study. The types of services that the TCARE® protocol identifies as resources best aimed to reduce objective burden are adult day care and in-home homemaker or personal care services. These are also the types of services that are frequently made available to caregivers through usual care management practice. Hence, it is likely that there were few differences between the intervention and control group in the number of caregivers for whom these services were included on care plans or in the patterns of use of direct care services. Therefore, it would be understandable that no differences were observed between the intervention and control groups in their levels of objective burden.

Three aspects of this study should be noted when interpreting the results. First, the sample includes a small percentage of caregivers from racially/ethnically diverse backgrounds. Second, the attrition rate was relatively high, although this is not uncommon for a longitudinal study of caregivers. Third, we were only able to look at the intention to place rather than the actual placement due to the short observation window and small number of actual placements.

A more complete understanding of the pathways by which the TCARE® protocol affects caregiver outcomes will emerge when the final data from the study become available. Nevertheless, the present results provide initial support for the TCARE® protocol as an effective means to reduce multiple dimensions of caregiver burden and depression, which may also reduce the desire for institutionalization of care receivers.

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R. J. V. Montgomery, K. Kosloski, and J. Kwak participated in the planning of the study. J. Kwak conducted the analyses, interpreted the results, and wrote the article. R. J. V. Montgomery and K. Kosloski interpreted the results and wrote the article. K. O'Connell Valuch participated in collecting the data, interpreting the analysis, and revising the manuscript. All authors approved the final version of the manuscript.

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Appendix XII: CMS Partnership to Improve Dementia Care in Nursing Homes: Surveyor Checklist for Review of Care and Services for a Resident with Dementia; QIS Stage 1 Interview Tools: QIS Resident Interview Guidance

9/3/13

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Dear State Agency Survey Branch Managers:

This letter addresses two topics: the first is the National Partnership to Improve Dementia Care in Nursing Homes, and the second is the Quality Indicator Survey (QIS) Resident Interview Guidance.

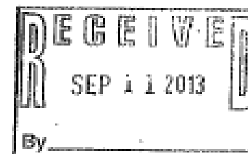
Partnership to Improve Dementia Care in Nursing Homes
On March 29, 2012, the Centers for Medicare & Medicaid Services (CMS) launched the National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes (this is now referred to as the Partnership to Improve Dementia Care in Nursing Homes). The goal of this Partnership is to optimize the quality of life and function of residents in America's nursing homes by improving approaches to meeting the health, psychosocial and behavioral health needs of all residents, especially those with dementia.[1]

The CMS has joined with various stakeholders to improve dementia care in nursing homes. We have done several things to support this work, including the production of surveyor training videos as well as updating Appendix P and Appendix PP of the State Operations Manual (SOM). A surveyor checklist that may be used in either the traditional or QIS process (modeled after the Critical Element pathways) has also been provided. However, this checklist is not part of the SOM.[1]

Our mission is to provide each surveyor with a laminated copy of this checklist. This tool was developed for the purpose of comprehensively reviewing the care and services that are being provided to residents with dementia. Specifically, to be used with the interpretative guidance found at F309. The focus of the checklist is on assessment, care planning, provision of care, and quality assurance. Although the use of this tool is not mandatory, CMS strongly encourages all surveyors to incorporate this resource within the survey process.

QIS Stage 1 Interview Tools
In recent months CMS has heard your concerns regarding the QIS stage 1 resident interview. As part of our ongoing efforts to improve the QIS, CMS is currently working with to refine all questions that make up the resident interview process. In the meantime the enclosed tools were developed by the CMS Central Office QIS team to help provide surveyors with guidance and clarification in this area.

[1] S&C Memo: 13-35-NH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In addition to the enclosed surveyor checklist you'll find two documents regarding the QIS resident interview. The first document, "Strategies for Surveyor Success with Resident Interviews", includes helpful instruction when conducting a resident interview. The second document, "QIS Resident Interview Guidance", contains guidance and clarification for each QIS stage 1 resident interview question.

The QIS resident interview documents have only been mailed to those states that are currently performing QIS surveys.

If you have any questions or concerns regarding the enclosed surveyor checklist, please contact the DNH Behavioral Health Team via email at dnh_behavioralhealth@cms.hhs.gov.

If you have any questions or concerns regarding the two enclosed resident interview tools, please contact Bonnie Reed via email at bonnie.reed@cms.hhs.gov.

Sincerely,

Thomas E. Hamilton
Director

Checklist

Review of Care and Services for a Resident with Dementia

(for use with the Interpretive Guidance at F309)

Assessment and Underlying Cause Identification

- ✓ Did staff describe behavior (onset, duration, intensity, possible precipitating events or environmental triggers, etc.) and related factors (appearance, alertness, etc.) in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible?
- ✓ If the behaviors represent a sudden change or worsening from baseline, did staff contact the attending physician/practitioner immediately for a medical evaluation, as appropriate?
- ✓ If medical causes are ruled out, did staff attempt to establish other root causes of the behavior using individualized knowledge about the person and when possible, information from the resident, family, previous caregivers and/or direct care staff?
- ✓ As part of the comprehensive assessment did facility staff evaluate:
  - The resident's usual and current cognitive patterns, mood and behavior, and whether these present a risk to the resident or others?
  - How the resident typically communicates a need such as pain, discomfort, hunger, thirst or frustration?
  - Prior life patterns and preferences, customary responses to triggers such as stress, anxiety or fatigue, as provided by family, caregivers, and others who are familiar with the resident before or after admission?
- ✓ Did staff, in collaboration with the practitioner, identify risk and causal/contributing factors for behaviors, such as:
  - Presence of co-existing medical or psychiatric conditions, or decline in cognitive function?
  - Adverse consequences related to the resident's current medications?

1. ***If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the physical, mental and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes (to the extent possible) of the resident's behavioral and/or mental or psychosocial symptoms, needed adaptations, and the impact upon the resident's function, mood and cognition?***
   If No, cite F272

Care Planning

- ✓ Was the resident and/or family/representative involved (to the extent possible) in discussions about the potential use of any interventions, and was this documented in the medical record?
- ✓ Does the care plan reflect an individualized approach with measureable goals, timetables and specific interventions for the management of behavioral and psychological symptoms?
- ✓ Does the care plan include:
  - Involvement of the resident/representative to the extent possible?
  - A description of and how to prevent targeted behaviors?
  - Why behaviors should be prevented or otherwise addressed (e.g., severely distressing to resident)?
  - Monitoring of the effectiveness of any/all interventions?
- ✓ If the resident or family/representative refused a recommended treatment or approach, was counseling on consequences and alternative approaches to address behavioral symptoms provided?

Note: If the resident lacks decisional capacity and lacks effective family/representative support, contact the facility social worker to determine what type of social services or referrals have been attempted to assist the resident.

2. ***Did the facility develop a plan of care with measurable goals and interventions to address the care and treatment for a resident with dementia related to the behavioral and/or mental/psychosocial symptoms, in accordance with the assessment, resident's wishes and current standards of practice? If No, cite F279***

Implementation of the Care Plan

Did staff:

Identify, document and communicate specific targeted behaviors and expressions of distress as well as desired outcomes?

- ✓ Implement individualized, person-centered interventions by qualified persons and document the results?
- ✓ Communicate and consistently implement the care plan, over time and across various shifts?
- ✓ If there is a sudden change in the resident's condition and medical causes of behavior or other symptoms (e.g., delirium or infection) are suspected, is the physician contacted immediately and treatment initiated?
- ✓ Is there a sufficient number of staff to consistently implement the care plan? (*Surveyors should focus on observations of staff interactions with residents who have dementia to determine whether staff consistently applies basic dementia care principles in the care of those individuals*).

3. ***Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care? If No, cite F282***

Note: If during the survey a concern is identified that an antipsychotic medication is given by staff for purposes of discipline or convenience and not required to treat the resident's medical symptoms, review F222 – §483.13(a).

Care Plan Revision/Monitoring and Follow up

- ✓ Does staff, in collaboration with the practitioner, adjust the interventions based on the impact on behavior or other symptoms as well as any adverse consequences related to treatment?
- ✓ When concerns related to the effectiveness or adverse consequences of a resident's treatment regimen are identified:
  - Does staff modify the care plan and, if appropriate, notify the physician and does the physician respond and initiate a change to the resident's care as necessary?

4. ***Did the facility reassess the effectiveness of the interventions and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident with dementia? If No, cite F280***

  - If the physician does not respond to the notification, does staff contact the medical director for further review? If the medical director was contacted, does he/she respond and intervene as needed?

5. ***Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care? If No, cite F309***

Quality Assessment and Assurance

Note: *Please refer to F520 Quality Assessment and Assurance for guidance regarding the information that may be obtained from the QAA committee.*

- ✓ Do resident care policies and procedures clearly outline a systematic process for the care of residents with dementia?
- ✓ Does the QAA Committee monitor for consistent implementation of the policies and procedures for the care of residents with dementia?
- ✓ Has the QAA committee corrected any identified quality deficiencies related to the care of residents with dementia?
- ✓ Has the QAA committee provided monitoring and oversight for the care and services for a resident with dementia?

Strategies for Surveyor Success with Resident Interviews

Interviewing helps residents fulfill their choices over aspects of their lives and serves as a valuable tool for surveyors to identify potential areas of concern related to resident rights, quality of care and life, and more. This document contains strategies to enhance resident understanding and resident participation in the interview process and has been developed with input from surveyors around the country who report success with the QIS Resident Interviews.

Making an Initial Contact

- Introduce yourself to the resident and explain the purpose of your visit
- Screen the Census Sample resident to assess the interview status listed on the Census Sample report
- Determine if the resident requires an interpreter
- Show genuine interest in the resident's responses
- Sample language to use:
  - "During the first two days of our visit to the facility, my colleagues and I will be meeting with several residents to ask some questions to find out what it is like to live in this facility. I would like to meet with you if you would be willing to do so; would that be okay?"
- If the resident is willing to be interviewed and is available immediately proceed with the interview
- If the resident is **not** able to be interviewed immediately you should schedule a time and location to meet with the resident and complete the interview
- Use good time management when scheduling your resident interviews to allow for the opportunity to complete all of your Stage 1 activities
- Make the resident aware the interview will take about 20 minutes

Beginning the Interview

- Re-introduce yourself
- Explain the reason for your visit to the resident, if necessary
- Respect the resident's privacy by seeking a quiet / private area to talk
  Make sure he/she is comfortable & that you can establish eye-contact (e.g., sit down to conduct the interview after asking permission)

Establishing Rapport and Respect

- Offer the resident the opportunity to ask questions
- Show the resident the laptop or tablet so they can see what you are doing
- Explain that you have several questions that require a yes or no response
- Ensure they understand their privacy will be protected
- Engage the resident in general conversation to help establish rapport

Nonverbal Communication

- Nonverbal communication sends a powerful message about your level of interest in what the resident has to say (e.g., don't act disinterested in what the resident is saying, don't act bothered by computer issues or distracted with computer issues)
- Take your time; do not rush
- Maintain eye contact with the resident

Maintaining the Intent of the Question

CMS recognizes that every surveyor applies his or her unique assessment skills, including those related to interviews. During the survey process it is critical that the intent of the interview questions be maintained. Some residents, especially those speaking English as a second language, with cognitive deficits or with strong regional dialects, may require the question be rephrased. Some questions have additional guidance to help clarify a question during an interview. If an interpreter is used during resident interviews, it is important that he or she understand to maintain the intent of the questions.
(e.g., if a question cannot be translated verbatim)

- Break the question apart for easier understanding if the resident requests clarification or seems hesitant to answer
- CMS recognizes it may be difficult to obtain a yes or no response from the resident.
- Vague responses such as "maybe", "sometimes" or "not all the time", "most of the time" should be recorded as a negative response along with pertinent Relevant Findings

(CMS has provided guidance regarding rephrasing questions and probing for more information in the document titled QIS Resident Interview Guidance.)

Keeping Focused

- If the resident begins to discuss information outside of the structured interview questions, be sure to:
  - acknowledge the concern
  - make notes, as appropriate, in Relevant Findings
  - try to redirect the conversation to the prior sequence of interview questions
- It is also possible that the resident's discussion regarding one question may provide an answer to a question yet to come

  Consider the following example: a resident replied positively to the question "Can you have visitors anytime during the day or night?" by saying that visitors are always welcome. The resident then proceeded to describe that although her family is always welcome that there is nowhere in the facility to visit without being overheard. This second bit of information answers a question appearing much later in the interview. In such a case, it would be appropriate to move out of sequence to the question "If you would have a visitor, do you have a private place to meet?" which appears several sections later in the interview. Using echoing techniques, the negative response to the question could be confirmed and then any pertinent additional information would be documented in Relevant Findings. After addressing this issue, the interviewer would return back to where he or she left off when the resident directed the conversation to the later question. In other words, the surveyor has flexibility to address questions out of order if the resident is directing this through conversation.

- If a resident interview is interrupted and it is not possible to complete it prior to the end of Stage 1 the responses entered during the partial interview should be retained.
  (see the note section at checklist Step #27)

Documenting the Results

- Document responses to all questions directly into ASE-Q without disrupting the ongoing interview with the resident
  Document Relevant Findings for all negative responses to ensure accuracy by including the date, time source of information
  (Record the resident's response not your interpretation of their response)
- Record the resident's response even if it is inconsistent with information gathered from another data source

Closing the Interview

- At the end of formal interview let the resident know that you and the team will be on-site for several more days and are available should they want to follow up with you
- Share with the resident that as part of information gathering over the next several days that you may be back to talk with them further
- Explain to the resident, that with their permission, you will be following up with the facility regarding any concerns voiced during the interview
- Thank the resident for taking the time with you and validate the importance of the information that they have provided

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Stage 1 Resident Interview Questions from ASE-Q	Additional CMS Central Office Guidance for Surveyors
Ask screening questions similar to the following: 1. Are you from around here, the area, etc.? 2. Tell me a little about yourself. 3. How long have you been here? 4. What is the food like here? **Proceed with the interview questions below if you are comfortable that the resident is interviewable.**	*There is no need to ask these particular questions as written. These are suggested screening questions to:* • *Determine the resident's cognitive ability to participate in the interview process, and* • *Initiate conversation and begin to build report with the resident.*
A. Cognitive Status	
1) **Is the resident able to be interviewed?** ☐ Not Interviewable ☐ Interviewable ☐ Resident refused interview ☐ Resident is unavailable for an interview **If the resident is interviewable, proceed to the Resident Interview section on the following page. If the resident is not interviewable, refuses, or is unavailable (after repeated attempts to interview) proceed to the Resident Observation section on the following page (the resident is excluded from the resident interview).**	*If the resident refuses to participate in the interview do not attempt to interview a second time. Surveyors should be cognizant of the fact that they are visitors in the resident's home.* *When first meeting the resident, if the surveyor is able to interview the resident at that time, he or she should proceed. If the resident is not available, the surveyor should ask the resident when a good time to conduct the interview would be. If the resident is otherwise occupied or has other obligations, a specific future appointment with the resident should be made if possible [keeping in mind the date/time that the Team Coordinator (TC) has scheduled for transition into Stage 2].*

<table>
<tr><th>B. Choices QP234</th><th></th></tr>
<tr><td>1) Do you choose when to get up in the morning? If No: What time do you get up? What time would you like to get up in the morning?
☐ No
☐ Yes
☐ N/A, the resident is independent with ADLs*

2) Do you choose when to go to bed at night? If No: What time do you go to bed? What time would you like to go to bed?
☐ No
☐ Yes
☐ N/A, the resident is independent with ADLs

3) Do you choose how many times a week you take a bath or shower? If No: How many times a week do you get a bath or shower? How many times a week would you like to bathe?
☐ No
☐ Yes
☐ N/A, the resident is independent with ADLs

4) Do you choose whether you take a shower, tub, or bed bath? If No: what type of bathing are you receiving? What would you like to receive?
☐ No
☐ Yes
☐ N/A, the resident is independent with ADLs

5) Can you have visitors anytime during the day or night? If No: what are the visiting restrictions?
☐ No
☐ Yes</td><td>The second part of each of the questions in Section B: Choices is intended to probe for additional information when a resident responds negatively to the initial portion of the question. The surveyor may find there are additional probing questions that need to be asked to obtain appropriate information to start an investigation in Stage 2, should one be required</td></tr>
</table>

C. Dignity QP212	
1) Do staff treat you with respect and dignity? If No, tell me some examples about when staff did not treat you with respect and dignity. The focus of this question is how well staff interacts with the resident. ☐ No ☐ Yes	*The second part of the question in Section C: Dignity is to probe for additional information if a resident responds negatively. The surveyor may find there are additional probing questions that are needed to obtain adequate information to start an investigation in Stage 2, should one be required.*
D. Activities QP208	
1) Do you participate in the activity programs here? If No, ask why he/she doesn't participate. ☐ No ☐ Yes ☐ N/A Does not wish to participate **(Skip to 4)** **2) Do the activities meet your interests?** ☐ No ☐ Yes **3) Are the activities provided as often as you would like, including on weekends and evenings?** ☐ No ☐ Yes **4) Does staff provide items so you can do activities on your own, like books or cards?** ☐ No ☐ Yes ☐ N/A, family provides	*If the resident responds "No" to the first question in Section D: Activities, the surveyor then asks why the resident doesn't participate. The intent of asking this is to determine if the resident does not wish to participate (in which case "N/A" is marked and the surveyor skips to question 4) or if the resident doesn't participate for another reason (in which case the surveyor proceeds through the remaining questions). Examples of other reasons that a resident doesn't participate include (but are not limited to) the activities not meeting the resident's interest, programming is offered at days or times that don't meet the resident's needs or preferences, or staff does not provide assistance to attend activities.* *Examples of resident who may respond "No" which would result in the surveyor marking "N/A" include a short-stay resident who has no interest in the activities or a LTC resident who also doesn't have any interest in the activities. If the resident does not wish to participate in the activities program, the surveyor does NOT ask questions 2 and 3.* *Remember, when the surveyor receives a negative response the surveyor should probe for additional information that will be helpful if a Stage 2 investigation is needed. The surveyor should obtain enough pertinent information to begin an investigation in Stage 2, should one be required.*

E. Building and Environment QP201	
1) Is the building clean? ☐ No ☐ Yes **2) Do you have any problems with the temperature, lighting, noise or anything else in the building that affects your comfort?** ☐ Temperature QP272 ☐ Lighting QP273 ☐ Noise QP274 ☐ Other identified issues QP275* ☐ None of the above	*The intent of question 2 is to determine if the resident has any concerns regarding their living environment. The surveyor should probe and document the resident's specific concerns in Relevant Findings.* **An example of "other identified issues" would be if the resident stated during the interview they could not get to the bathroom due to the roommate's cluttered side of the room.*

F. Participation in Care Plan QP210	
1) Have you been involved in decisions about your daily care? ☐ No ☐ Yes	*The surveyor should provide guidance for the resident, as needed, in order to confirm that the resident is afforded the opportunity to choose between alternative treatments, both initially and with changes to the plan of care. The surveyor may find the following probing questions helpful in assisting the resident to understand the intent of the question in Section F: Participation in Care Plan:* ∘ *If the physician orders a change in your medications, are you made aware of the change?* ∘ *If the physician is contacted about you, are you made aware of the results of the contact and given treatment options?* ∘ *Does staff tell you the results of tests like lab work or x-rays?* ∘ *If you need to have an appointment scheduled (for instance with an outside physician), are you informed of the appointment and why it is being recommended?* ∘ *Have you brought questions or concerns about your care to the attention of facility's staff? If so, what happened as a result?*

G. Abuse QP253	
1) Has staff, a resident or anyone else here abused you - this includes verbal, physical or sexual abuse? ☐ No (skip to 3) ☐ Yes If "Yes", ask who the abuser was, what happened, when it occurred, where it happened and how often. **2) Did you tell staff?** ☐ No ☐ Yes If "Yes", ask who the resident told. If "No", report immediately to the administrator. If you have concerns with how the facility handles the investigation after you report it, consider initiating abuse. **3) Have you seen any resident here being abused?** ☐ No (skip to H) ☐ Yes If "Yes", ask who the abuser was, what happened, when it occurred, where it happened, and how often. **4) Did you tell staff?** ☐ No ☐ Yes If "Yes", ask who the resident told. If "No", report immediately to the administrator if you have concerns with how the facility handles the investigation after you report it, consider initiating abuse.	*Remember, when the surveyor receives a negative response he or she should probe for additional information that will be helpful if a Stage 2 investigation is needed. The surveyor will want to obtain enough pertinent information to begin an investigation in Stage 2, should one be required.*

H. Interaction with Others QP246	
1) Have there been any concerns or problems with a roommate or any other resident? ☐ No (skip to I) ☐ Yes **2) Has the staff addressed the concern(s) to your satisfaction?** ☐ No ☐ Yes	*Remember, when the surveyor receives a negative response he or she should probe for additional information that will be helpful if a Stage 2 investigation is needed. The surveyor will want to obtain enough pertinent information to begin an investigation in Stage 2, should one be required.*
I. Personal Property QP194	
1) Were you encouraged by staff to bring in any personal items? If No, Do you wish to have items brought in? ☐ No ☐ Yes ☐ N/A, the resident is a short-stay resident **2) Have you had any missing personal items?** If Yes, what is still missing and how long has it been missing? ☐ No ☐ Yes **3) Did you tell staff about the missing items(s)?** If Yes, Who did you tell about the missing item? If ☐ No (skip to J) ☐ Yes **4) Has staff told you they are looking for your missing item(s)?** If No, do you know who or which department is supposed to be looking for your missing item? ☐ No ☐ Yes	*The intent of question 1 is to determine if the facility allows the resident to bring in personal items. In the event that the resident says "No" yet the surveyor observes personal items in the resident's room, the surveyor should probe to ensure the resident understands the intent of the question. Suggested probes includes:* ∘ *I see you have some personal things here in your room, were there other things that you wanted to bring in that the facility staff discouraged you from bringing in?* ∘ *It looks like there are personal items in your room yet you said that you weren't encouraged to bring in personal items, what I am trying to determine is if you are allowed to bring in the personal items that you wish to have here in the facility. Are you allowed to bring in the things that you wish to have here?* *Remember, when the surveyor receives a negative response he or she should probe for additional information that will be helpful if a Stage 2 investigation is needed. The surveyor will want to obtain enough pertinent information to begin an investigation in Stage 2, should one be required.*

J. Pain QP255	
1) Do you have any discomfort now or have you been having discomfort such as pain, heaviness, burning, or hurting with no relief? ☐ No ☐ Yes	*The intent of this question is to determine if the resident has pain for which the facility has not attempted to relieve with interventions including medication or non-pharmacological measures. The key words are "with no relief".* *As always, it is appropriate to break up questions into segments if the resident is better able to understand the question.*
K. Food Quality QP249	
1) Does the food taste good and look appetizing? ☐ No ☐ Yes **2) Is the food served at the proper temperature?** ☐ No ☐ Yes	*If the resident has concerns related to food quality probe for additional information by asking questions such as:* ∘ *Is there a particular food item or meal that is not appetizing or doesn't taste good to you?* ∘ *Is the food served too hot or too cold?* ∘ *Is there a certain meal such as breakfast, lunch or supper or snack that is consistently served to you that is of poor quality or not at the proper temperature?* ∘ *Where are your meals served? Do you eat your meals in the dining room, in your room, or in another location?*
L. Hydration QP258	
1) Do you receive the fluids you want between meals? ☐ No ☐ Yes ☐ N/A, does not take fluids orally	*The intent of this question is not only to determine if the resident receives fresh water. The surveyor should also determine if the resident receives the fluids they want between meals which may include water, coffee, juice, soda, etc.*
M. Sufficient Staff QP232	
1) Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time? ☐ No ☐ Yes	*If the resident has a negative response to this question, surveyors should probe for as many specific concerns as possible to aid in the Stage 2 investigations. Should they be required. Consider asking questions such as:* ∘ *When was the last time you had to wait for assistance?* ∘ *Does this routinely happen at a specific time of the day?*

N. Oral Health QP204	
1) Do you have mouth/facial pain with no relief? ☐ No ☐ Yes	*The focus of question #1 is dental pain.*
2) Do you have any chewing or eating problems (could be due to: no teeth, missing teeth, oral lesions, broken or loose teeth)? ☐ No ☐ Yes	*The focus of question #2 is chewing or eating problems related to dental issues. Swallowing problems should not be addressed here.*
3) Do you have tooth problems, gum problems mouth sores, or denture problems? ☐ No ☐ Yes	*The focus of question #3 is identifying concerns with teeth, gums, dentures or any sores which may be located in the resident's oral cavity.*
4) Does staff help you as necessary to clean your teeth? ☐ No ☐ Yes ☐ N/A, do not need assistance (skip to O)	*When asking question #4, If the resident does not require assistance from staff to perform any oral health activities, the surveyor should check "N/A" and skip to Section O.*
5) How often are your teeth/dentures/mouth cleaned (routine oral hygiene)? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never	*A response of "weekly", "monthly" or "never" are considered negative responses to question #5 and the surveyor should probe for any additional information to begin an investigation in Stage 2, should one be required.*
O. Privacy QP204	
1) Does staff provide you privacy when they work with you, changing your clothes, providing treatment? ☐ No ☐ Yes	*Remember, when the surveyor receives a negative response he or she should probe for additional information that will be helpful if a Stage 2 investigation is needed. The surveyor will want to obtain enough pertinent information to begin an investigation in Stage 2, should one be required.*

P. Exercise of Rights QP250	
1) Have you been moved to a different room or had a roommate change in the last nine months? ☐ No (skip to Q) ☐ Yes **2) Were you given notice before a room change or a change in roommate?** ☐ No ☐ Yes	*Remember, when the surveyor receives a negative response he or she should probe for additional information that will be helpful if a Stage 2 investigation is needed. The surveyor will want to obtain enough pertinent information to begin an investigation in Stage 2, should one be required.*
Q. Personal Funds QP199	
1) Do you have a personal funds account with the facility? ☐ No (skip 2 & 3) ☐ Yes ☐ Do Not Know (skip 2 & 3) **2) Does the facility let you know how much money you have in your account?** ☐ No ☐ Yes ☐ Do Not Know **3) Can you get your money when you need it, including on weekends?** ☐ No ☐ Yes ☐ Do Not Know	*The surveyor may need to ask probing questions to help determine if the resident understands the difference between a commercial bank account and the facility's resident funds account.* *Remember, when the surveyor receives a negative response he or she should probe for additional information that will be helpful if a Stage 2 investigation is needed. The surveyor will want to obtain enough pertinent information to begin an investigation in Stage 2, should one be required.*

Appendix XIII: Fact Sheet on The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013-2018, including Road Map Action Item which are key to implementing the State Plan and establishing Georgia's readiness to accept National Plan funding and allow stronger tandem work

factsheet

JULY 2013 alz.org

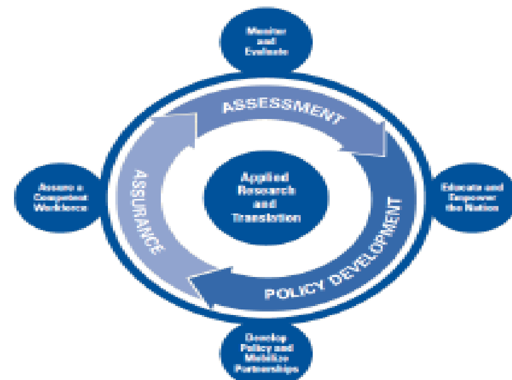
The Public Health Road Map

What is the *Public Health Road Map*?

- The Alzheimer's Association and the Centers for Disease Control and Prevention's (CDC) Healthy Aging Program have developed the second in a series of road maps – *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013-2018* – to advance cognitive health as a vital, integral component of public health.
- The document, which was developed with input from more than 280 experts in the field, outlines how state and local public health agencies and their partners can promote cognitive functioning, address cognitive impairment, and help meet the needs of caregivers.

Why is the *Road Map* important?

- The *Road Map* provides a foundation for the public health community to address the growing Alzheimer's crisis through the traditional tools of public health.
- While the federal government plays a critical role in leading and funding efforts to address Alzheimer's disease, state and local agencies organize and provide public health services at the community level.
- By strengthening the capacity of public health agencies to address healthy aging and leveraging strong state and national partnerships, cognitive health can be incorporated into ongoing public health efforts.



What does the *Road Map* include?

- The *Road Map* contains 35 specific action items that public health agencies and their partners can do over the next five years to address cognitive health and to meet the needs of caregivers.
- These action items align with the Essential Services of Public Health: monitor and evaluate; develop policy and mobilize partnerships; assure a competent workforce; and educate and empower the nation.

This Fact Sheet is supported by Cooperative Agreement #5U58DP002946-03 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the Alzheimer's Association and do not necessarily represent the official views of the CDC.

What are some *Monitor and Evaluate* action items that public health officials can undertake?

- Define the needs of caregivers and individuals with dementia, including Alzheimer's disease and those with younger-onset, as they relate to employment and employers.
- Support needs assessments to identify racial/ ethnic; lesbian, gay, bisexual, and transgender; socioeconomic; and geographic disparities related to cognitive health and impairment.
- Implement the Behavioral Risk Factor Surveillance System's cognitive and caregiver modules.

What are some examples for *Develop Policies and Mobilize Partnerships*?

- Collaborate in the development, implementation and maintenance of state Alzheimer's plans.
- Integrate cognitive health and impairment into state and local government plans (such as aging, coordinated chronic disease, preparedness, falls and transportation plans).
- Integrate *Healthy People 2020* objectives on "Older Adults" and "Dementias, including Alzheimer's disease" into state-based plans.

What can public health agencies do to *Assure a Competent Workforce*?

- Support continuing education efforts that improve health care providers' ability to recognize early signs of dementia and to offer counseling to individuals and their care partners.
- Educate health care providers about validated cognitive assessment tools.

What are some ways to *Educate and Empower the Nation*?

- Promote advance care planning and advance financial planning to care partners, families and individuals with dementia in the early stages before function declines.
- Identify and promote culturally-appropriate strategies designed to increase public awareness about dementia, including Alzheimer's disease, to reduce conflicting messages, decrease stigma and promote early diagnosis.
- Promote appropriate partnerships and strategies to educate and increase local participation in clinical trials and studies on cognitive health and impairment.
- Develop strategies to promote the availability of services for people with younger-onset dementia, including Alzheimer's disease.

What must be done to successfully implement the *Road Map*?

- Effective implementation of the *Road Map* requires participation by, and partnerships between, private, non-profit and governmental partners at the national, state and local levels.
- State and local public health agencies must use the *Road Map* as a guide in incorporating cognitive health into their work; identify those action items that best fit their missions, needs, interests and capabilities; and leverage partnerships to implement those specific items.

For More Information

To read a copy of the complete *Road Map*, examine all 35 action items and find out how you can help implement the *Road Map*, visit alz.org/publichealth.

Appendix XIV: Senate Bill 14, establishing the Alzheimer's and Related Dementias State Plan Task Force and authorizing its creation of a Georgia Alzheimer's and Related Dementias State Plan

13 SB 14/AP

Senate Bill 14 By: Senators Unterman of the 45th, Wilkinson of the 50th, Crosby of the 13th, Hill of the 4th and Orrock of the 36th

A BILL TO BE ENTITLED AN ACT

AS PASSED

1 To amend Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to

2 indigent and elderly patients, so as to create a Georgia Alzheimer's and Related Dementias

3 State Plan Task Force; to provide for legislative intent; to provide for its members and

4 vacancies; to provide for duties and responsibilities; to provide for a chairperson; to provide

5 for a quorum for the transaction of business; to provide for a final report; to provide for

6 related matters; to provide an effective date; to provide for automatic repeal; to repeal

7 conflicting laws; and for other purposes.

8 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

9 **SECTION 1.**

10 Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to indigent and

11 elderly patients, is amended by adding a new article to read as follows:

12 "ARTICLE 9

13 31-8-300.
14 The General Assembly finds and declares that Alzheimer's disease is a looming national

15 public health crisis and impacts every state. It is important for Georgia to assess its ability

16 to provide appropriate and necessary programs and services to Georgia's citizens living

17 with Alzheimer's disease and related dementias, and determine where Georgia is, where

18 Georgia is doing well, where gaps may exist, and where the private sector, public sector,

19 nonprofit and faith-based communities' resources may be leveraged to ensure that Georgia

20 grows to be fully dementia capable. The General Assembly further finds that access to

21 quality health care for Alzheimer's and related dementias and the rising cost of such care

22 are vitally important to the citizens of Georgia. Therefore, the General Assembly has

23 determined that it is in the best interests of the state and its citizenry to address this issue

24 31-8-301.

25 There is created the Georgia Alzheimer's and Related Dementias State Plan Task Force

26 for the purpose of studying and collecting information and data to assess the current and

27 future impact of Alzheimer's disease on Georgia's citizens; to examine the existing

28 industries, services, and resources addressing the needs of persons with Alzheimer's

29 disease, their families, and caregivers; to review the National Alzheimer's Disease Plan

30 currently under development by the federal Department of Health and Human Services;

31 and to develop a strategy to mobilize a state response to Alzheimer's and related dementias

32 as a public health crisis by creating a state plan.

33 31-8-302.

34 (a) The Georgia Alzheimer's and Related Dementias State Plan Task Force shall be

35 composed of six members and shall include the director of the Division of Aging Services

36 within the Department of Human Services, the commissioner of community health or his

37 or her designee, the state health officer or his or her designee, the chairperson of the House

38 Committee on the Health and Human Services, the chairperson of the Senate Health and

39 Human Services Committee, and the chairperson of the House Committee on Human

40 Relations and Aging.

41 (b) The director of the Division of Aging Services within the Department of Human

42 Services shall serve as the chairperson of the task force. The task force may elect other

43 officers as deemed necessary. The chairperson of the task force may designate and appoint

44 committees from among the membership of the task force as well as appoint other persons

45 to perform such functions as he or she may determine to be necessary as relevant to and

46 consistent with this article. The chairperson shall only vote to break a tie.

47 (c) The task force shall invite other advisory members to assist the committee and may

48 consider the following in making its selection: a person with Alzheimer's disease; a person

49 with Alzheimer's related dementia; such person's caregiver; a representative of the nursing

50 facility industry; a representative from the adult daycare services industry; a representative

51 of the home health industry; a representative of the personal care home industry; a

52 physician; a consultant pharmacist; an Alzheimer's disease and related dementias

53 researcher; law enforcement personnel; and other stakeholders from the public private and

54 nonprofit sectors, voluntary health organizations, and the faith-based community.

55 31-8-303.

56 (a) The task force shall hold meetings at the call of the chairperson.

57 (b) A quorum for transacting business shall be a majority of the members of the task force.

58 (c) The members of the task force shall serve without compensation.

59 (d) The Division of Aging Services within the Department of Human Services shall

60 provide administrative support to the task force.

61 (e) Each legislative member of the task force shall receive the allowances provided for in

62 Code Section 28-1-8. Citizen members shall receive a daily expense allowance in the

63 amount specified in subsection (b) of Code Section 45-7-21 as well as the mileage or

64 transportation allowance authorized for state employees. Any members of the task force

65 who are state officials, other than legislative members, and state employees shall receive

66 no compensation for their services on the task force, but they shall be reimbursed for

67 expenses incurred by them in the performance of their duties as members of the task force

68 in the same manner as they are reimbursed for expenses in their capacities as state officials

69 or employees. The funds necessary for the reimbursement of the expenses of state

70 officials, other than legislative members, and state employees shall come from funds

71 appropriated to or otherwise available to their respective departments. All other funds

72 necessary to carry out the provisions of this article shall come from funds appropriated to

73 the House of Representatives and the Senate.

74 31-8-304.

75 (a) The purpose of the task force shall be to create a comprehensive state plan for Georgia

76 to address Alzheimer's and related dementias and shall include, at a minimum:

77 (1) Trends in state Alzheimer's and related dementias population and needs, including

78 the changing population with dementia, including, but not limited to:

79 (A) State role in long-term care, family caregiver support, and assistance to persons

80 with early stage and early onset Alzheimer's disease;

81 (B) State policy regarding persons with Alzheimer's disease and developmental

82 disabilities; and

83 (C) Ongoing periodic surveillance of persons with Alzheimer's disease for purposes

84 of having proper estimates of the number of persons in the state with Alzheimer's

85 disease, and for the development of a response to this chronic condition that has risen

86 to the level of a public health crisis;

87 (2) Existing services, resources, and capacity, including but not limited to the:

88 (A) Type, cost, and availability of dementia services;

89 (B) Dementia-specific training requirements for long-term care staff;

90 (C) Quality care measures for long-term care facilities;

91 (D) Capacity of public safety and law enforcement to respond to persons with

92 Alzheimer's disease;

93 (E) Availability of home- and community-based resources for persons with

94 Alzheimer's disease and respite care to assist families;

95 (F) Inventory of long-term care dementia care units;

96 (G) Adequacy and appropriateness of geriatric-psychiatric units for persons with

97 behavior disorders associated with Alzheimer's disease and related dementias;

98 (H) Assisted living residential options for persons with dementia;

99 (I) State support of Alzheimer's disease research through Georgia universities and other

100 resources;

101 (J) Medical education, content, and quality of course offerings and requirements for

102 dementia training provided to students in medical education programs at all levels of

103 education within both state and private programs from emergency medical technician

104 and nursing assistant programs through advanced medical specialties and medical

105 continuingeducation;

106 (K) Inventory of federal agencies who provide funding, services, programs, or

107 resources for individuals with Alzheimer's disease or a related dementia, caregivers,

108 medical professionals, or professional care providers; and

109 (L)Gaps in services;

110 Needed state policies or responses, including but not limited to directions for

111 the provision of clear and coordinated services and support to persons and families 112 living with Alzheimer's disease and related disorders and strategies to address any

113 identified gaps in services;

114 (4) Ways in which state and local agencies, private sector, quasi-governmental,

115 voluntary health organizations, the faith community, and nonprofit organizations can

116 collaborate and work together to form a seamless network of education, support, and 117 other needed services to those living with Alzheimer's disease and related dementias and 118 their families; and

119 (5) Specific areas to address,

120 including:

121 (A) Increasing awareness of Alzheimer's disease among the public;

122 (B) Encouraging increased detection and diagnosis of Alzheimer's disease;

123 (C) Improving the individual health care that those with Alzheimer's disease receive;

124 (D) Improving the quality of the health care system in serving people with Alzheimer's

125 disease;

126 (E) Expanding the capacity of the health care system to meet the growing number and

127 needs of those with Alzheimer's disease;

128 (F) Training and better equipping health care professionals and others to deal with

129 individuals with Alzheimer's disease;

130 (G)Workforce development by increasing the number of health care professionals that will be necessary to treat the growing aging and Alzheimer's populations;

131 (H) Improving services provided in the home and community to delay and

132 decrease the need for institutionalized care;

133 (I) Improving access to long-term care, including assisted living, for those

134 with Alzheimer's disease;

135 (J) Assisting unpaid Alzheimer's

136 caregivers; (K) Increasing research on

137 Alzheimer's disease;

138 (L) Promoting activities that would maintain and improve brain

139 health;

140 (M) Creating a better system of data collection regarding Alzheimer's disease

141 and its public health burden;

142 Public safety and addressing the safety related needs of those with

143 Alzheimer's disease, including in-home safety for those living at home, Mattie's

Call

144 and safety of those who wander or are found wandering but who need supervision

145 until they can be reunited with their family or professional caregiver and driving

146 safety, including assessments and taking the license away when a person with

147 dementia is no longer capable of driving safely;

148 (O) Addressing legal protections for, and legal issues faced by, individuals with

149 Alzheimer's disease; and

150 (P) Improving how state government evaluates and adopts policies to help people

151 with Alzheimer's disease and their families; determination of which department of

152 state government is the most appropriate agency to house the ongoing work of the

153 Georgia Alzheimer's and Related Dementias State Plan Task Force as it convenes

154 annually to ensure track and report progress as Georgia becomes a more dementia-

155 capable state.

156 (b) The task force shall have the following powers:

157 (1) To hold public meetings and utilize technological means, such as webcasts, to

gather

158 feedback on the recommendations from persons and families affected by

Alzheimer's

159 disease and related dementias and from the general public;

160 (2) To request and receive data from and review the records of appropriate

agencies

161 and health care facilities to the greatest extent allowed by state and federal law;

162 (3) To accept public or private grants, devises, and bequests; and

164 (4) To enter into all contracts or agreements necessary or incidental to the performance

165 of its duties.

166(c) Prior to the final report required in subsection (d) of this Code section, the task force may advise on legislation and other recommended changes to the Governor and the General Assembly.

167 31-8-305.

168 (a) Upon the abolishment of the task force as provided by this article, there shall be

169 created the Georgia Alzheimer's and Related Dementias Advisory Council.

170 (b) The advisory council membership shall include the same membership as the

171 original task force as provided for in this article.

172 (c)The advisory council shall meet at least annually to review the progress of the state

173 plan and to make any recommendations for changes, as well as recommend any legislation

174 needed to implement the plan.

175 31-8-306.

176 The task force shall stand abolished on March 31, 2014."

177 SECTION 2.

178 This Act shall become effective upon its approval by the Governor or upon its becoming law

179 without such approval.

180 SECTION 3.

181 All laws and parts of laws in conflict with this Act are repealed.

Appendix XV: National Dementia Organizations

National Dementia Organizations

Alzheimer's Disease Education and Referral Center (ADEAR)
National Institute on Aging
P.O. Box 8250
Silver Spring, MD 20907-8250
adear@nia.nih.gov
http://www.nia.nih.gov/alzheimers
Tel: 1-800-438-4380 / Fax: 301-495-3334

Alzheimer's Association
225 North Michigan Avenue
Floor 17
Chicago, IL 60601-7633
info@alz.org
http://www.alz.org
Tel: 312-335-8700 1-800-272-3900 (24-hour helpline)
TDD: 312-335-5886 / Fax: 866.699.1246

Alzheimer's Foundation of America
322 Eighth Avenue
7th Floor
New York, NY 10001
info@alzfdn.org
http://www.alzfdn.org
Tel: 866-AFA-8484 (232-8484) /
Fax: 646-638-1546

Alzheimer's Drug Discovery Foundation
57 West 57th Street
Suite 904
New York, NY 10019
info@alzdiscovery.org
http://www.alzdiscovery.org
Tel: 212-901-8000 / Fax: 212-901-8010

Association for Frontotemporal Degeneration (AFTD)
Radnor Station Building #2 Suite 320
290 King of Prussia Road
Radnor, PA 19087
info@theaftd.org
http://www.theaftd.org
Tel: 267-514-7221 / 866-507-7222

BrightFocus Foundation
22512 Gateway Center Drive
Clarksburg, MD 20871
info@brightfocus.org
http://www.brightfocus.org/alzheimers/
Tel: 1- 800-437-2423 / Fax: 301-258-9454

John Douglas French Alzheimer's Foundation
11620 Wilshire Blvd.
Suite 270
Los Angeles, CA 90025
http://www.jdfaf.org
Tel: 310-445-4650 / Fax: 310-479-0516

Lewy Body Dementia Association
912 Killian Hill Road, S.W.
Lilburn, GA 30047
lbda@lbda.org
http://www.lbda.org
Tel: Telephone: 404-935-6444 LBD Caregiver Link: 800-539-9767
Fax: 480-422-5434

National Institute of Mental Health (NIMH)
National Institutes of Health, DHHS
6001 Executive Blvd. Rm. 8184, MSC 9663
Bethesda, MD 20892-9663
nimhinfo@nih.gov
http://www.nimh.nih.gov
Tel: 301-443-4513/866-415-8051 301-443-8431 (TTY) / Fax: 301-443-4279

National Organization for Rare Disorders (NORD)
55 Kenosia Avenue
Danbury, CT 06810
orphan@rarediseases.org
http://www.rarediseases.org
Tel: 203-744-0100 Voice Mail 800-999-NORD (6673)
Fax: 203-798-2291

American Parkinson Disease Association
135 Parkinson Ave.
Staten Island, NY 10305
Tel: 800-223-2732 / Fax: 718-981-4399
http://www.apdaparkinson.org/
apda@apdaparkinson.org

Glossary

GEORGIA ALZHEIMER'S AND RELATED DEMENTIAS STATE PLAN GLOSSARY OF TERMS AS THEY RELATE TO ALZHEIMER'S AND RELATED DEMENTIAS WITHIN THIS STATE PLAN

Aging and Disability Resource Connection (ADRC) – This statewide coordinated system of partnering organizations is managed by the DHS Division of Aging Services. ADRC provides information about publically and privately financed long-term supports and services, offers a consumer-oriented approach to learning about the availability of services in the home and community, alleviates the need for multiple calls and/or visits to receive services, and supports individuals and family members who are aging or living with a disability, including those living with Alzheimer's and those who care for them.

Alzheimer's Disease Research Center (ADRC) — Funded by the National Institute on Aging (NIA), the Emory Alzheimer's Disease Research Center is a medical facility that treats those with Alzheimer's and Related Dementias and conducts research into the disease. It serves the state.

ADRD — ADRD is an acronym for Alzheimer's and Related Dementias.

Alzheimer's — Alzheimer's (AHLZ-high-merz) is a disease of the brain that causes problems with memory, thinking and behavior. It is not a normal part of aging. Alzheimer's gets worse over time. Although symptoms can vary widely, the first problem many people notice is forgetfulness severe enough to affect their ability to function at home or at work, or to enjoy lifelong hobbies. The disease may cause a person to become confused, lost in familiar places, misplace things or have trouble with language.

> ***Alzheimer's* is a type of dementia that causes problems with memory, thinking and behavior.** Symptoms usually develop slowly and get worse over time, becoming severe enough to interfere with daily tasks.
>
> ***Alzheimer's* is the most common form of dementia**, a general term for memory loss and other intellectual abilities serious enough to interfere with daily life. Alzheimer's disease accounts for 50 to 80 percent of dementia cases.

Assisted Technology — As it applies to those with Alzheimer's or a related dementia, assisted technology is person-specific to help the individual with activities of daily living, to trigger memory, or to perform routine tasks.

Centers for Disease Control and Prevention (CDC) — In the Fall of 2005, the Centers for Disease Control and Prevention and the Alzheimer's Association formed a new partnership to examine how best to bring a public health perspective to the promotion of cognitive health. The first publication,

The Healthy Brain Initiative: A National Public Health Road Map to Maintaining Cognitive Health, was published in 2007.

The Alzheimer's Association and the Centers for Disease Control and Prevention's (CDC) Healthy Aging Program have developed the second in a series of road maps to advance cognitive health as a vital, integral component of public health. ***The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013 – 2018***, outlines how state and local public health agencies and their partners can promote cognitive functioning to address cognitive impairment for individuals living in the community and help meet the needs of care partners. Specific actions are addressed in four traditional domains of public health: monitor and evaluate, educate and empower the nation, develop policy and mobilize partnerships, and assure a competent workforce. Public health agencies and private, non-profit, and governmental partners at the national, state, and local levels are encouraged to work together on those actions that best fit their missions, needs, interests, and capabilities.

Some of the specific recommendations contained in the State Plan come as a result of ***The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013 – 2018.***

Division of Aging Services (DAS) – This division of the Georgia Department of Human Services is the State Unit on Aging for Georgia which carries out service planning functions as detailed in the Older Americans Act of 1965 as amended. DAS performs this function in collaboration with other members of Georgia's aging network – namely 12 Area Agencies on Aging and numerous service providers throughout the state. As it relates to Alzheimer's and Related Dementias, the Georgia Alzheimer's and Related Dementias State Plan will be managed by the Division of Aging Services.

Georgia Department of Community Health (DCH) — As it relates to Alzheimer's and Related Dementias, this agency of state government provides rules, regulations, and guidelines for facilities and programs serving a wide array of individuals, including those with dementia. Such facilities and programs include adult day programs, assisted living communities, nursing homes, and home health agencies.

Dementia — Dementia is a general term for a decline in mental ability severe enough to interfere with daily life. Memory loss is an example. Alzheimer's is the most common type of dementia. **Dementia is not a specific disease. It's an overall term that describes a wide range of symptoms** associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities.

All types of dementia involve mental decline that:
- occurred from a higher level (for example, the person didn't always have a poor memory)
- is severe enough to interfere with usual activities and daily life
- affects more than one of the following four core mental abilities
    - recent memory (the ability to learn and recall new information)

• language (the ability to write or speak, or to understand written or spoken words)
• visuospatial function (the ability to understand and use symbols, maps, etc., and the
brain's ability to translate visual signals into a correct impression of where objects are in space)
• executive function (the ability to plan, reason, solve problems and focus on a task)

Dementia-Capable — Dementia-capable means that the program, service, system is designed such that it provides quality care, supports, information, and education, to ensure that current systems as well as the development of future systems at the government, private, non-profit, healthcare community, long-term care community, home health community, voluntary health organization, and faith-based sectors will be fully able to seamlessly serve those living with dementia, providing a level of service that appropriately meets the needs of the individual and the population.

Georgia Department of Public Health (DPH) — Alzheimer's is the most under-recognized public health crisis of the 21st century. It affects Americans across all walks of life and all regions of the country. As it relates to Alzheimer's and Related Dementias, the Georgia Department of Public Health is the lead agency in Health Promotion and Disease Prevention, Epidemiology, and Chronic Disease Management. Alzheimer's is a chronic disease. The Department of Public Health can help raise awareness and provide education regarding Alzheimer's and Related Dementias. The Public Health Districts can use assessment tools such as an algorithm to help assess individuals who visit local health departments for care. The Epidemiology Section conducts the Behavioral Risk Factor Surveillance System—including the Cognitive Impairment and Caregiver Modules, providing Georgia agencies and other stakeholders with key information to help shape policy and service to those living with Alzheimer's and related dementias.

Down Syndrome — Down syndrome is a condition in which a person is born with extra genetic material from chromosome 21, one of the 23 human chromosomes. Most people with Down syndrome have a full extra copy of chromosome 21, so they have three copies instead of the usual two. In ways that scientists don't yet understand, the extra copies of genes present in Down syndrome cause developmental problems and health issues. Scientists think that the increased risk of dementia in individuals with Down syndrome may also result from the extra gene.

As with all adults, advancing age also increases the chances a person with Down syndrome will develop Alzheimer's disease. Because people with Down syndrome live, on average, 55 to 60 years, they are more likely to develop younger onset Alzheimer's (Alzheimer's occurring before age 65) than older-onset Alzheimer's (Alzheimer's occurring at age 65 or older).

Early Stage Alzheimer's —"Generally, people with early stage Alzheimer's disease are those of any age who have only mild impairment." (from *Counseling People with Early-Stage Alzheimer's Disease: A Powerful Process of Transformation,* by Robyn Yale). It is also referred to as Mild/Moderate cognitive decline.

At this point, a careful medical interview should be able to detect clear-cut symptoms in several areas:

- Forgetfulness of recent events
- Impaired ability to perform challenging mental arithmetic — for example, counting backward from 100 by 7s
- Greater difficulty performing complex tasks, such as planning dinner for guests, paying bills or managing finances
- Forgetfulness about one's own personal history
- Becoming moody or withdrawn, especially in socially or mentally challenging situations.

Mild cognitive decline (Early-stage Alzheimer's can be diagnosed in some, but not all, individuals with these symptoms.)
Friends, family or co-workers begin to notice difficulties. During a detailed medical interview, doctors may be able to detect problems in memory or concentration. Common stage 3 difficulties include:

- Noticeable problems coming up with the right word or name
- Trouble remembering names when introduced to new people
- Having noticeably greater difficulty performing tasks in social or work settings
- Forgetting material that one has just read
- Losing or misplacing a valuable object
- Increasing trouble with planning or organizing.

Early/Younger Onset — Younger-onset (also known as early-onset) Alzheimer's affects people younger than age 65. Nearly 4 percent of the more than 5 million Americans with Alzheimer's have younger-onset.

Many people with early onset are in their 40s and 50s. They have families, careers or are even caregivers themselves when Alzheimer's disease strikes. In the United States, it is estimated that more than 200,000 people have early onset.

GARD — This acronym for the Georgia Alzheimer's and Related Dementias State Plan Task Force and the State Plan itself was coined by staff in the Division of Aging Services.

Home and Community-Based Services (HCBS) — These services enable older adults and people with disabilities, including individuals with Alzheimer's and related dementias, to continue to live at home, rather than be institutionalized at a greater cost to taxpayers.

Healthy Brain Initiative —- See the entry for CDC (Centers for Disease Control).

Long-Term Services and Supports (LTSS) -- Long-term services and supports (LTSS) help older adults and people with disabilities accomplish everyday tasks that many of us take for granted. Tasks include those such as bathing, getting dressed, fixing meals, and managing a home. .As our population ages, the number of individuals needing this kind of help is projected to double. Long-term services and supports allow millions of individuals to lead healthy, secure, and independent lives.

Mattie's Call — Mattie's Call is a safety alert program, first established by the City of Atlanta, then subsequently adopted across the country as the Silver Alert. It is named after Mattie Moore, an Atlanta resident living with dementia who wandered from her home who, after exhaustive searches and a major media blitz, was found only 500 feet from her home, deceased. Mattie's Call is an emergency alert system in Georgia, initiated by a local public safety agency through the GBI (Georgia Bureau of Investigation)/GSP (Georgia State Patrol) that sends out media alerts and alerts through "A Child Is Missing" to seek community assistance in finding a disabled missing adult who has wandered from a caregiver or eloped from a care facility. Its goal is to return the individual safely to his or her family or caregiver. It was signed into law by the Governor in 2006.

Older Americans Act (OAA) — The Older Americans Act (OAA) of 1965 as amended calls for a range of programs that offer services and opportunities for older Americans, especially those at risk of losing their independence. The Older Americans Act focuses on improving the lives of older people in areas of income, housing, health, employment, retirement and community services. Individuals with Alzheimer's and Related Dementias benefit from many of these services targeted at keeping individuals in their communities longer.

Person-Centered — This concept puts the person receiving services at the center of planning and service delivery. Plans and services are developed with attention to each person's unique preferences, skills and abilities, and needs.

Related/Other Dementias—

Creutzfeldt-Jakob disease (CJD) — Creutzfeldt-Jakob disease (pronounced CROYZ-felt YAH-cob) is a rare, rapidly fatal disorder affecting about 1 in a million people per year worldwide. It usually affects individuals older than 60. CJD is one of the prion (PREE-awn) diseases. These disorders occur when prion protein, a protein normally present in the brain, begins to fold into an abnormal three-dimensional shape. This shape gradually triggers the protein throughout the brain to fold into the same abnormal shape, leading to increasing damage and destruction of brain cells.

Recently, "variant Creutzfeldt-Jakob disease" (vCJD) was identified as the human disorder believed to be caused by eating meat from cattle affected by "mad cow disease." It tends to occur in much younger individuals, in some cases as early as their teens.

The first symptoms of CJD may involve impairment in memory, thinking and reasoning or changes in personality and behavior. Depression or agitation also tends to occur early. Problems with movement may be present from the beginning or appear shortly after the other symptoms. CJD progresses rapidly and is usually fatal within a year.

Dementia with Lewy bodies (DLB) — In Dementia with Lewy bodies, abnormal deposits of protein called alpha-synuclein form inside the brain's nerve cells. These deposits are called "Lewy bodies" after the scientist who first described them. Lewy bodies have been found in several brain disorders, including dementia with Lewy bodies, Parkinson's disease and some causes of Alzheimer's.

Frontotemporal dementia (FTD) — FTD is a rare disorder chiefly affecting the front and sides of the brain. Because these regions often, but not always, shrink, brain imaging can help in diagnosis. There is no specific abnormality found in the brain in FTD. In one type called Pick's disease, there are sometimes (but not always) abnormal microscopic deposits called Pick bodies.

FTD progresses more quickly than Alzheimer's disease and tends to occur at a younger age. The first symptoms often involve changes in personality, judgment, planning and social skills. Individuals may make rude or off-color remarks to family or strangers, or make unwise decisions about finances or personal matters. They may show feelings disconnected from the situation, such as indifference or excessive excitement. They may have an unusually strong urge to eat and gain weight as a result.

Huntington's disease (HD) -- HD is a fatal brain disorder caused by inherited changes in a single gene. These changes lead to destruction of nerve cells in certain brain regions. Anyone with a parent with Huntington's has a 50 percent chance of inheriting the gene, and everyone who inherits it will eventually develop the disorder. In about 1 to 3 percent of cases, no history of the disease can be found in other family members. The age when symptoms develop and the rate of progression vary.

Symptoms of Huntington's disease include twitches, spasms, and other involuntary movements; problems with balance and coordination; personality changes; and trouble with memory, concentration or making decisions.

Mild Cognitive Impairment (MCI) — In mild cognitive impairment, a person has problems with memory or one of the other core functions affected by dementia. These problems are severe enough to be noticeable to other people and to show up on tests of mental function, but not serious enough to interfere with daily life. When symptoms do not disrupt daily activities, a person does not meet criteria for being diagnosed with dementia.

Individuals with MCI have an increased risk of developing Alzheimer's disease over the next few years, especially when their main problem involves memory. However, not everyone with MCI progresses to Alzheimer's or another kind of dementia.

Mixed dementia — In mixed dementia, Alzheimer's disease and vascular dementia occur at the same time. Many experts believe mixed dementia develops more often than was previously realized and that it may become increasingly

common as people age. This belief is based upon autopsies showing that the brains of up to 45 percent of people with dementia have signs of both Alzheimer's and vascular dementia.

Normal pressure hydrocephalus (NPH) — Normal pressure hydrocephalus (high-droh-CEFF-a-luss) is another rare disorder in which fluid surrounding the brain and spinal cord is unable to drain normally. The fluid builds up, enlarging the ventricles (fluid-filled chambers) inside the brain. As the chambers expand, they can compress and damage nearby tissue. "Normal pressure" refers to the fact that the spinal fluid pressure often, although not always, falls within the normal range on a spinal tap.

The three chief symptoms of NPH are (1) difficulty walking, (2) loss of bladder control and (3) mental decline, usually involving an overall slowing in understanding and reacting to information. A person's responses are delayed, but they tend to be accurate and appropriate to the situation when they finally come.

Parkinson's disease (PD) -- Parkinson's is another disease involving Lewy bodies. The cells that are damaged and destroyed are chiefly in a brain area important in controlling movement. Symptoms include tremors and shakiness; stiffness; difficulty with walking, muscle control, and balance; lack of facial expression; and impaired speech. Many individuals with Parkinson's develop dementia in later stages of the disease.

Vascular Dementia (VaD) — Previously known as multi-infact or post-stroke dementia, vascular dementia is the second most common cause of dementia after Alzheimer's disease.

Wernicke-Korsakoff syndrome -- Wernicke-Korsakoff syndrome is a two-stage disorder caused by a deficiency of thiamine (vitamin B-1). Thiamine helps brain cells produce energy from sugar. When levels of the vitamin fall too low, cells are unable to generate enough energy to function properly. Wernicke encephalopathy is the first, acute phase, and Korsakoff psychosis is the long-lasting, chronic stage.

The most common cause is alcoholism. Symptoms of Wernicke-Korsakoff syndrome include:

- confusion, permanent gaps in memory and problems with learning new information
- a tendency to "confabulate," or make up information individuals can't remember
- unsteadiness, weakness and lack of coordination.

If the condition is caught early and drinking stops, treatment with high-dose thiamine may reverse some, but usually not all, of the damage. In later stages, damage is more severe and does not respond to treatment.

Georgia Department of Human Services
Division of Aging Services

Update: Georgia Memory Net

Abby Cox
Director

stronger families

FOR A STRONGER GEORGIA

Division Vision and Mission

Vision

Living longer, Living safely, Living well

Mission

The Georgia Department of Human Services (DHS) Division of Aging Services (DAS) supports the larger goals of DHS by assisting older individuals, at-risk adults, persons with disabilities and their families and caregivers to achieve safe, healthy, independent and self-reliant lives.

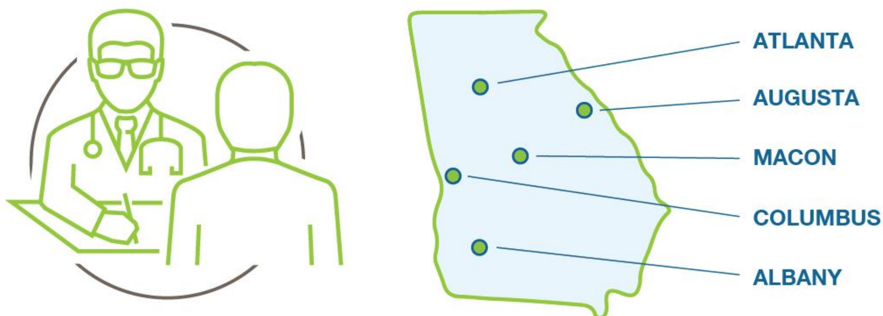
Georgia Memory Net
Progress Update

Goal

- Improve screening and care for dementia, such as Alzheimer's disease
  - Training and education for primary care providers
  - Five Memory Assessment Clinics (MACs)
  - Community resource partnerships to provide services to patients and families
  - Data collection, oversight, and evaluation

Memory Assessment Clinics

- Augusta: Augusta University (Medical College of Georgia)
  - Initiation in August 2017
- Atlanta: Grady Health (Morehouse School of Medicine)
  - Initiation in November 2017
- Macon: Navicent Health (Mercer University School of Medicine)
  - Initiation in October 2017
- Columbus: Columbus Piedmont Regional (Mercer University School of Medicine)
  - Initiation in December 2017
- Albany: Phoebe Putney Health (Medical College of Georgia)
  - Initiation in March 2018



Model

- Primary Care Providers
  - Annual Wellness Visit
  - Referral to MAC
- MAC Visit: two visits
  - Testing and assessments
  - Delivery of diagnosis
  - Community Services Educator (CSE)
    - Referrals & care plans sent
  - Care plan sent to PCP
- Returns to PCP to manage care

Model

PCP
provides annual wellness visit (AWV) & screen for cognitive decline

PCP
refers patient to regional MAC

MAC Visit 1
Comprehensive evaluation at MAC

MAC Visit 2
Establish specific diagnosis and care plan (clinician + CSE)

Handoff
Warm hand-off from MAC to PCP

Continued care
with PCP and support through community services

Partnerships for Community Resources

- Alzheimer’s Association, Georgia Chapter
  - Resources, training for CSEs, referrals
- Aging & Disability Resource Connection (ADRC) through the Area Agencies on Aging (AAA)
  - Referrals, collaborative models
- Rosalynn Carter Institute (RCI)
  - Training, resources for caregivers

Georgia Memory Net Summit

- 76 attendees
  - MAC providers/staff
  - Representatives from all AAAs, RCI, and Alzheimer's Association
  - Emory
  - DHS
- Two "tracks": Community Resources/Care Planning & Clinical
- Best practices, case studies, legislative panel, media/public messaging

What's Ahead in SFY19

- Further piloting of workflow in each MAC; increase in patient referrals
- Advisory Boards for each MAC service area
- Increase in public messaging and outreach
- Data collection to track outcomes and trends
- Advancements in IT infrastructure including data repository

Questions?

STATE OF GEORGIA

Older Adults Cabinet

2017 ANNUAL REPORT

CHAIRWOMEN

Sandra Deal | First Lady, State of Georgia

Robyn A. Crittenden | Commissioner, Department of Human Services

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ABOUT

In 2017, Gov. Nathan Deal announced the creation of Georgia's Older Adults Cabinet, a committee working to enhance the state's capacity to serve older adults. The Older Adults Cabinet seeks to identify ways for Georgia to improve the well-being of its older residents by bringing together state agency heads whose work supports older Georgians, as well as stakeholders in the business, philanthropic and education communities.

Co-chaired by First Lady Sandra Deal and Georgia Department of Human Services (DHS) Commissioner Robyn A. Crittenden, the Cabinet examines and assesses issues impacting older Georgians such as: healthcare, nutrition, transportation, housing, safety, abuse, neglect and exploitation, well-being, workforce development and economic security. The Cabinet held its first meeting on January 26, 2017.

The Cabinet's executive committee comprises leaders representing DHS, Behavioral Health and Developmental Disabilities, Community Affairs, Community Health, Public Health, Transportation, Early Care and Learning, the Technical College System of Georgia, Family and Children Services and Bureau of Investigation agencies. The larger committee includes partners from the University System of Georgia, providers of health care and community-based nutrition programs, advocacy organizations and members of the Georgia General Assembly. The Cabinet's purpose is to provide a place for policymakers and state agencies to work with stakeholders to develop strategic planning focused on improving the well-being of Georgia's aging population.

Vision

Living Longer, Living Safely, Living Well

Goals

- Analyze existing programs and services for older Georgians.
- Enhance the state's capacity to provide services to older and vulnerable adults.
- Commit to collaborative approaches that allow older adults to safely remain in their homes and communities.

Priorities

- Abuse, Neglect and Exploitation
- Workforce Development
- Access to Services

Abuse, Neglect and Exploitation (ANE)
The ANE priority area centers on increasing awareness of the abuse, neglect and exploitation of older adults. This priority area also encourages collaborative approaches to protecting Georgia's aging population and individuals with Alzheimer's or related dementias in communities and long-term care facilities across the state.

Workforce Development
The Workforce Development priority area includes a focus on developing practical strategies to enhance workforce development to better serve the aging population. These efforts include providing career opportunities in the aging and other related fields, recruiting and retaining staff and providing more specific training for staff who work in the aging field.

Access to Services
The third priority area, Access to Services, underscores the importance of educating Georgia's older adults and the public about the helpful resources that exist to serve older adults. It also focuses on exploring barriers to accessing key resources such a transportation, housing, and healthcare.

O U T C O M E S

1. Analyze existing programs and services for older Georgians.

The Aging and Disability Resource Connection (ADRC)

The ADRC is a coordinated system of partnering organizations that are dedicated to serving older individuals, individuals with disabilities of all ages, families, caregivers and professionals. Georgia's ADRC currently serves all 159 counties and is critical in providing access to services to older Georgians. Increasing public knowledge of this invaluable resource is key in meeting the needs of Georgia's seniors.

At-Risk Adult Crime Tactics (ACT) Specialist Certification course

The Division of Aging Services Forensic Special Initiatives Unit (FSIU) conducts a two-day ACT training which is open to primary and secondary responders including law enforcement, prosecutors, judges, EMS, employees of financial institutions, regulatory/social/victim service agencies, key healthcare providers, coroners, medical examiners and other professions who respond to the abuse, neglect, and exploitation of at-risk adults (the elderly and persons age 18+ with disabilities). Topics covered in the ACT Certification class include Georgia Law, types and indicators of abuse, neglect, and exploitation, financial crimes targeting older adults and adults with disabilities, undue influence, Power of Attorney, guardianship, conservatorship, investigations, suspicious deaths, human trafficking, and crimes in facilities.

Rosalynn Carter Institute for Caregiving Dealing with Dementia Workshop

Developed by the Rosalynn Carter Institute for Caregiving (RCI), the Dealing with Dementia program provides tips and strategies for caregivers on best practices for caring for their loved ones and themselves. The goal is for Alzheimer's and dementia family caregivers to gain a better understanding of dementia, utilize strategies to effectively manage problem behaviors, and handle caregiver stress and burnout.

Gwinnett Technical College Nursing Program

Gwinnett Technical College incorporates the aging population in many of its degree programs including the Associate Degree Nursing Program, Medical Assisting Program, Patient Care Assisting Program (A-NF). Students gain critical knowledge of gerontology through simulations focused on older adults, clinical placements in nursing homes, home health facilities and hospices, and other workforce development opportunities. Collegiate programs like this one enable more specific and expansive workforce readiness training for individuals interested in careers related to aging.

2. Enhance the state's capacity to provide services to older and vulnerable adults.

WSB-TV Highlights new Power of Attorney Law

In December 2017, State Rep. Chuck Efstration spoke with WSB-TV's Jocelyn Dorsey about the Power of Attorney Bill. In the interview, he discussed the importance of the law in preventing financial exploitation of Georgia's older adults and individuals with disabilities.

Attorney General Chris Carr to participate in national effort to combat elder abuse

In August of 2017, Attorney General Chris Carr announced his participation in an effort led by the National Association of Attorneys General (NAAG) which will focus on strengthening nationwide actions to combat elder abuse. NAAG President and Kansas Attorney General Derek Schmidt will lead the bipartisan working group.

The Georgia Alzheimer's Project (GAP)

DHS received $4.12 million for the Georgia Alzheimer's Project (GAP) during the 2017 legislative session. Emory University will the "hub" of GAP. Emory University is the state of Georgia's only National Institutes of Health (NIH) designated Alzheimer's Disease Research Center.

The Georgia Alzheimer's Project will create a network of Memory Assessment Centers (MACs) to improve care and accessibility of care for Georgians living with dementias as well as their caregivers. This project addresses current gaps in links to community resources. GAP leaders will partner with academic, community and professional organizations to:

- Improve primary care clinician screenings, referrals to specialized services, and care of Georgian's living with dementia and their caregivers through education and training.
- Establish MACs around the state to improve access to early and accurate diagnosis of dementias as well as improve long-term outcomes for people living with dementia and their caregivers, which will include community resources.
- Establish an oversight and ongoing evaluation plan to monitor and access project success.

3. Commit to collaborative approaches that allow older adults to safely remain in their homes and communities.

Georgia Bureau of Investigation (GBI), Division of Aging Services (DAS) and Alzheimer's Association collaboration
In August of 2017, GBI hosted a Symposium on Alzheimer's and Related Dementias in collaboration with DAS and the Alzheimer's Association. This symposium was specifically targeted to provide education on understanding the disease, responding effectively in various settings, search and rescue, and resources available in Georgia to assist law enforcement. Governor Nathan Deal, First Lady Sandra Deal, Georgia Attorney General Chris Carr, and DHS Commissioner Robyn Crittenden delivered special remarks.

GBI's At-Risk Adult ANE Work Group
GBI formed the At-Risk Adult ANE work group in 2012 to focus on identifying obstacles, make recommendations, create initiatives and evaluate legislation as it pertains to the abuse, neglect and exploitation of at-risk adults. The work group is comprised of members from various federal, state and local agencies and meets regularly to discuss ANE-related topics.

HOPE Career Grant
The Hope Career Grant is an opportunity for technical school students of any age to pursue careers specifically aligned with one of 12 industries in which there are more jobs available in Georgia than there are skilled workers to fill them. The HOPE Career Grant is formerly known as the Strategic Industries Workforce Development Grant and involves industries that have been identified as strategically important to the state's economic growth, many of which directly intersect with careers in aging. The HOPE Career Grants provides a unique workforce development opportunity that stakeholders in the business, education communities, and state agencies can use to work collaboratively to serve older adults.

ANE Intra-Agency Document
Members of the Cabinet worked collaboratively to create an educational document pertaining to ANE. The one-pager includes definitions of abuse, neglect and exploitation, instructions on how to report suspected abuse and information on the Uniform Power of Attorney Law. This informational resource is posted on all Cabinet members' websites to increase public awareness of ANE.

MEMBERS

EXECUTIVE COMMITTEE

Sandra Deal
First Lady of Georgia
Co-Chair

Robyn A. Crittenden
Commissioner, Department of Human Services
Co-Chair

Matt Arthur
Commissioner, Technical College System of Georgia

Frank Berry
Commissioner, Department of Community Health

Abby Cox
Director, Department of Human Services Division of Aging Services

Chris Carr
Attorney General, State of Georgia Office of Attorney General

Judy Fitzgerald
Commissioner, Department of Behavioral Health and Developmental Disabilities

Amy Jacobs
Commissioner, Department of Early Care and Learning

Vernon M. Keenan
Director, Georgia Bureau of Investigation

Russell R. McMurry
Commissioner, Department of Transportation

Christopher Nunn
Commissioner, Georgia Department of Community Affairs

J. Patrick O'Neal
Interim Commissioner, Department of Public Health

Virginia Pryor
Interim Director, Division of Family & Children Services

MEMBERS

LEGISLATORS

Senator Jack Hill
Chairman, Senate Appropriations Committee

Senator Renee S. Unterman
Chairman, Senate Health and Human Services
Vice Chairman, Human Development and Public Health, Senate Appropriations Committee

Representative Terry England
Chairman, House Appropriations Committee

Representative Katie Dempsey
Vice Chairman, Health and Human Services, House Appropriations Committee

Representative Sharon Cooper
Chairman, Health and Human Services

Representative Eddie Lumsden
Chairman, House Human Relations and Aging Committee

Representative Tommy Benton
State Representative, District 31
Member, House Study Committee on Grandparents Raising Grandchildren and Kinship Care

EDUCATIONAL INSTITUTIONS

Emory University
Dr. Allan Levey, Chairman, Department of Neurology, Director of Alzheimer's Disease Research Center

Georgia State University
Dr. Elisabeth Burgess, Director, Department of Gerontology

University of Georgia
Dr. Mary Ann Johnson, Interim Director, College of Public Health Institute of Gerontology

M E M B E R S

STAKEHOLDERS

AARP
Debra Tyler-Horton, State Director

Alliant Health Solutions, Inc.
Dr. Adrienne D. Mims, Vice President & Chief Medical Officer

Alzheimer's Association Georgia Chapter
Kathy Simpson, Director of Public Policy and Advocacy

Association County Commissioners of Georgia (ACCG)
Clint Mueller, Legislative Director

Athens Community Council on Aging
Eve Anthony, President and CEO

Atlanta Regional Commission
Doug Hooker, Executive Director

Community Representative
Ann Williams

Georgia Association of Area Agencies on Aging (G4A)
Julie Hall, Director

Georgia Association for Community Care Providers
Steve Neff, Executive Director

Georgia Association for Home Health Agencies
Judy Adams, Executive Director

Georgia Council on Aging
Kathy Floyd, Executive Director

Georgia Food Bank Association
Danah Craft, Executive Director

Georgia Gerontology Society
Amanda James, Executive Director

Georgia Health Care Association
Tony Marshall, President and CEO

Georgia Long-Term Care Ombudsman
Melanie McNeil, State Ombudsman

LeadingAge Georgia
Ginny Helms, President and CEO

Prosecuting Attorneys' Council of Georgia
Peter J. Skandalakis, Executive Director

Rosalynn Carter Institute for Caregiving
Dr. Leisa Easom, Executive Director

Thanks Mom & Dad Fund
Maureen Kelly, President

United Way of Greater Atlanta
Milton Little, President and CEO

Georgia Department of Human Services
Division of Child Support Services

Performance Update

DHS Board Meeting 11/14/2018

Tanguler Gray
Child Support Director

John Hurst
Child Support Deputy Director

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Child Support

DCSS is responsible for the statewide administration of the child support enforcement program under the provisions of Title IV-D of the Social Security Act (42 U.S.C. 651 - 669).

Performance indicators	FFY18 - 5 Federal Performance Measures: • Paternity establishment – Statewide PEP 93.63%, IV-D PEP 100.68% • Order establishment – 90.88% • Current support paid – 60.10% • Arrears support paid – 63.87% • Undistributed collections – 0.58%
Total offices	55 local offices excluding state, region and specialty/hub offices
Total number of positions	1,122 as of 9/30/18
Total caseload as of 9/30/18	390,639
Total budget SFY2019	$109,195,624
% State funds	27%=$29,672,610
% Federal funds	70%=$76,285,754
% Other Funds	3%=$2,841,500

Program Legislative Authority

State Authority / Reference	Official Code of Georgia, Annotated, Titles 9 and 19 and Departmental Rules, DHS Rules at 290-7-1.
Federal Authority / Reference	Code of Federal Regulations, Title 45, Parts 300-399

Child Support Services

Intake
Walk-ins
Mail
Portal
Referrals

Locate
Automated Interfaces and Manual Searches

Paternity Establishment
Paternity testing

Court Order Establishment
Financial Support, Medical Support
Process service (Sherriff or private process server)

Financial
Centralized Payment Processing by the Family Support Registry (FSR)

Enforcement
Administrative and Judicial Actions
Collect delinquent payments (drivers license suspension, passport denial, tax intercept, lottery winning intercept) etc.

Review & Modification
Administrative and/or Judicial Review of orders 36 months old or older
possible modification of support amount

Outreach Programs
DCSS has partnered with other government and community agencies to develop a comprehensive network of services – Fatherhood and Parental Accountability Court Programs.

State Level Indicators

3 Year Trend

Core Services	FFY 2016	FFY 2017	FFY 2018
Locate	3.02%	2.22%	1.94%
Caseload Count	411,151	411,491	390,096
Collections	$740 Million	$744 Million	$736 Million

Federal Level Indicators

3 Year Trend

	Paternity Establishment	Support Order Establishment	Current Support collections	Arrears Collections
FFY 2016	93.92%	89.36%	61.26%	65.56%
FFY 2017	97.18%	89.93%	60.32%	64.45%
FFY 2018	93.63%	90.88%	60.11%	63.87%

	FFY16	FFY17	FFY18
UDC Undistributed Collections	0.45%	0.51%	0.58%
Cost Effectiveness Ratio	$7.61	$8.04	TBD

Strategies

Improving Current Support Collections

Current Support Definition: The percentage of the monthly court ordered child support the Division collects and distributes.

Employer Database
Improves information accuracy

Challenges
Declining wages and court purge collections:
FFY 2018 achieved **60.11%**
Division goal was **62.3%**

New Employer Hub
Centralizes Federal Income Withholding processes

New Pre Contempt Screening
Increase cases eligible for Contempt while still conforming with new Federal Rules

Customer Engagement Centers
Efficiently balance high walk in traffic and case management activities

Strategies

Improving Arrears Collections

Arrears Collections Definition: The percent of cases with an arrears balance that receive an arrears payment

Challenge
Declining collections: FFY 2018 achieved **63.87%** Division goal was **66.7%**

Increased Outreach efforts with Fatherhood and Parental Accountability Courts

Agent Dashboard in Data Warehouse
System enhancements will impact arrears cases

Increase Customer Interaction
Self service technology and digital marketing

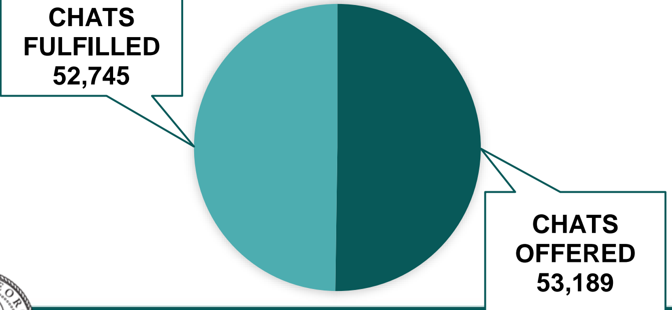
Strategies to improve Current Support Collections = Positive effect on Arrears Collections

Customer Self Service Options

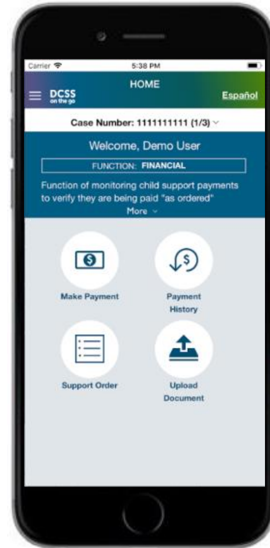
FFY October 1st 2017 to September 30th 2018

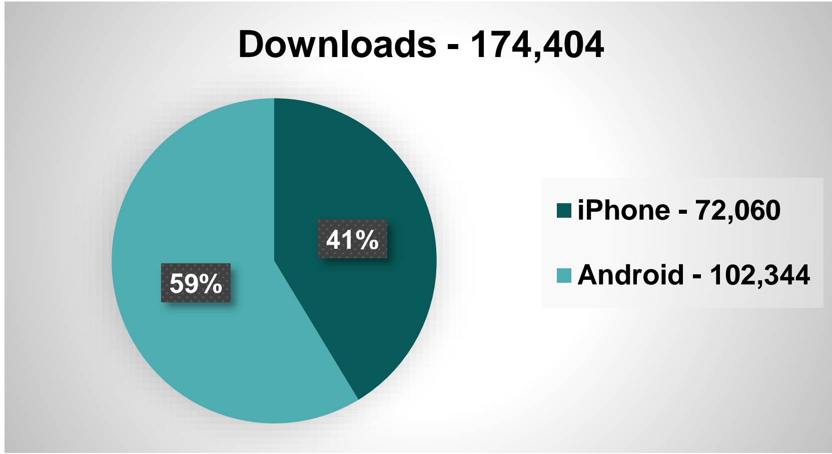
Customer Contact Center

Calls Logged



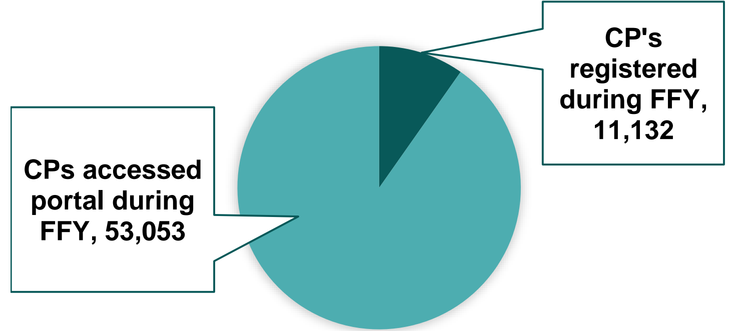
Mobile App



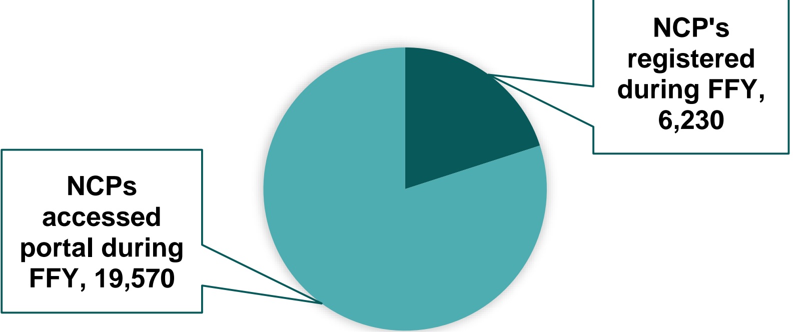


Customer Online Services Portal

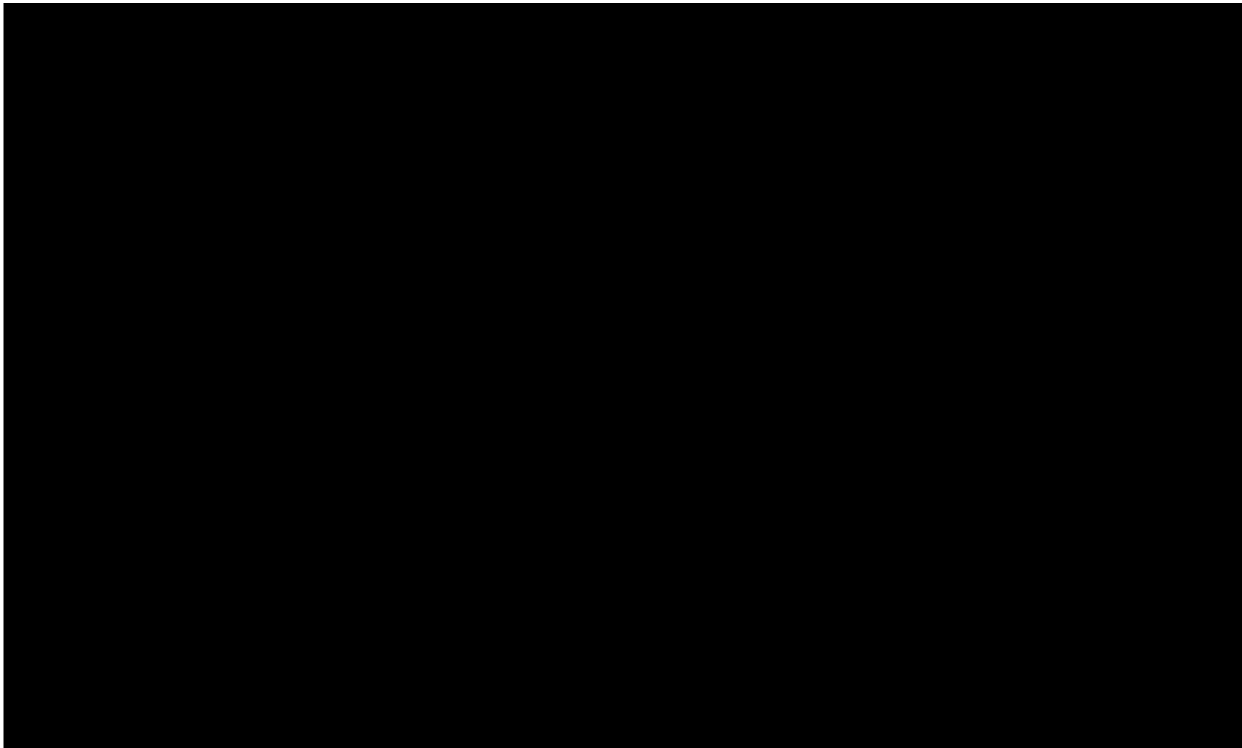
CUSTODIAL PARENTS



NON CUSTODIAL PARENTS



Digital Marketing



Digital content promotes self service options
Reaches parents who benefit from one-way communication
Also, improving two-way communication & engagement by promoting the Mobile App

GOAL:
Research how digital marketing may help the Division reach and serve families

Mobile App Commercial
Production Company and script writer provided Storyboard, production and voiceover services
DHS-DCSS has Copywriting and Full Ownership rights
Initial rollout on television monitors in local offices to display commercial

Discussion

Tanguler Gray, Director

Georgia Department of Human Services

Georgia Division of Child Support Services

Office phone: 404.463.0992

Email: tanguler.gray@dhs.ga.gov

John Hurst, Deputy Director

Georgia Department of Human Services

Georgia Division of Child Support Services

Office phone: 404.657.2347

Email: john.hurst@dhs.ga.gov

Questions

Georgia Department of Human Services
Division of Child Support Services

Parental Accountability Court Program

DHS Board Meeting Presentation

Tanguler Gray

Director, Division of Child Support Services

Wende R. Parker

Parental Accountability Court Program Manager

stronger families

FOR A STRONGER GEORGIA

Objectives

- PAC mission and structure
- Provide a breakdown of the DCSS PAC statewide services, phases, & research
- Review of the DCSS PAC coverage area & expansion plan
- Discuss statewide and national exposure through conferences
- Engage stakeholders in goals & resource collaboration

Parental Accountability Court Program

The Parental Accountability Court (PAC) program is a joint effort of the Division and Superior Court Judges to offer an alternative to incarceration and to help chronic nonpayers of child support make regular payments. The program uses community resources and judicial oversight to address barriers that keep parents from meeting their support obligations.

Each program, including services provided to participants, is tailored to the needs of the local community. Superior Court Judges provide judicial oversight and collaborate with PAC coordinators to implement the program. PAC coordinators connect participants to existing community resources.

- DCSS Deputy Director Administration
  John Hurst
  - PAC Program Manager
    Wende Parker
    - Parental Accountability Court Supervisor
      Frank Van Houten
      (Ellijay Office)
      - Appalachian
      - Blue Ridge
      - Cobb
      - Conasauga
      - Enotah
      - Lookout Mountain
      - Mountain
      - Northeastern
      - Northern
      - Piedmont
      - Western
    - Parental Accountability Court Supervisor
      Hamilton Bledsoe
      (State Office)
      - Alcovy
      - Chattahoochee
      - Coweta
      - Douglas
      - Fulton
      - Gwinnett
      - Macon
      - Paulding
      - Stone Mountain
      - Towaliga
    - Parental Accountability Court Program Consultant
      Susan Cosby
      (State Office)
    - Parental Accountability Court Supervisor
      Shannon Longino
      (Morrow Office))
      - Augusta
      - Clayton
      - Dublin
      - Flint
      - Middle
      - Ocmulgee
      - Ocmulgee
      - Rockdale
      - Oconee
    - Parental Accountability Court Supervisor
      Angela Williams-Jackson
      (Albany Office)
      - Alapaha
      - Atlantic
      - Dougherty
      - Patuala
      - Southern
      - Southwestern
      - South Georgia
      - Tifton
      - Waycross

Parental Accountability Court Program

- Collaboration between GA DHS and Council of Superior Court judges
- Alternative to incarceration
- Utilizes community resources tailored to meet the needs of the local community and individual participants
- Judicial oversight to address barriers
- Increase parental accountability, self-sufficiency, and child support collections

Judicial Support

"In other words, they haven't paid their child support, so they're headed to jail … The idea is that the participant addresses the issues that are keeping them back, and hopefully by the end of the program they will have received some kind of training or a GED in order to help them further their ability to earn for their families."

Judge Alison Burleson, Superior Court Judge Ocmulgee Judicial Circuit; PAC Subcommittee Chair, Judicial Council of Georgia

Statewide PAC Coverage

- **Judicial Circuits Pending:**
  - Bell-Forsyth
  - Brunswick
  - Griffin
  - Houston
  - Toombs

- **Judicial Circuits to Obtain:**
  - Cherokee
  - Eastern
  - Ogeechee
  - Rome
  - Tallapoosa

Judicial Circuits
No Parental Accountability Court
Parental Accountability Court

Evidence-Based Research

Applied Research Services - 2011

- Average monthly payments increased than year before participation
- Reduced incarceration time
- After program graduation, payments did not drop

Judicial Council of Georgia: Administrative Office of the Courts – 2018

- Child support payments increased 79% when noncustodial parent participated in PAC
- Participants who receive referred services increased payments by 84%
- Noncustodial parents exposed to PAC, but did not enroll, paid 29% more child support

Sources: 1) *Child Support Courts, Final Evaluation Report.* (2011). Applied Research Services; 2) Judicial Council of Georgia, Administrative Office of the Courts. (2018). *PAC Court Evaluation.*

Since 2012

6,212 have avoided incarceration

$6.6 million received in child support collections

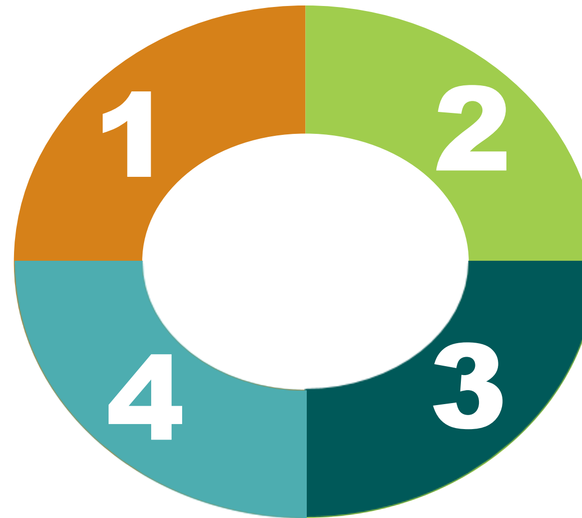
9,461 children have received support

PAC

PAC: Program Phases

Intake
- Complete forms, interviews, and assessments: Includes GCIC
- Sign Terms & Conditions
- Referrals to Service Providers
- Driver's License Reinstatement Review

Phase I
- Meet with coordinator as specified
- Compliance with service providers
- Complete weekly verifiable job search/training, obtain employment
- Communicate/cooperate with DCSS



Graduation
- Successful completion of program requirements (6 months with full payments)
- Increased self sufficiency
- More informed on child support process
- Increased work ethic
- Increased child support payments for children
- 12 month follow up

Phase II
- FT employment w/IWO & full payments (6 months)
- Compliance with Service Providers
- Review for Modification
- Referral for Access and Visitation if applicable
- Seek legitimation rights if applicable
- Request to negotiate payment on state arrears

Services Offered to Participants

Substance abuse treatment referrals

Mental health services

Short-term training when available

Volunteer work opportunities

Literacy Training

Employment referral assistance

Access and Visitation referrals

Additional services specific to the local area

PAC Program Highlights

Success Stories

- One district graduate became the first man in his family to earn a GED as
  a result of the program, and now earns $17 per hour working for the BAS chemical company

- Another district graduate earned her nurse assistant's certificate and celebrated five years of sobriety last May

State Fiscal Year Goals

- Leverage Department of Community Supervision Interface
- Increase employment resource collaboration
- Complete PAC expansion statewide

Chief Justice P. Harris Hines
Georgia Supreme Court

"This is Noble Work Indeed"

C:\Users\wrparker1\Videos\Chief Justice Hines Noble Work segment video.3gp

The Honorable P. Harris Hines, Chief Justice, Georgia Supreme Court, delivered his 2018 State of the Judiciary address to a joint session of the legislature on Feb. 22, 2018.

National Collaboration

Eastern Regional Interstate Child Support Association

National Child Support Enforcement Association

Federal Office of Child Support Enforcement

ERICSA

EASTERN REGIONAL INTERSTATE CHILD SUPPORT ASSOCIATION

National Award Recognition

Georgia's Department of Human Services, Division of Child Support Services PAC program was awarded NCSEA's Innovative Partnership/Collaboration Award on August 14, 2018 at the NCSEA Leadership Symposium in Pittsburg, PA.

- Recognizes innovative partnerships
- Collaborations between child support agency and courts or other organizations or programs serving families

Division of Child Support Services
Parental Accountability Court Program Team

Questions

Wende R. Parker, MPH

Parental Accountability Court Manager

Division of Child Support Services

Georgia Department of Human Services

2 Peachtree St., 20th Floor

Atlanta, GA 30303

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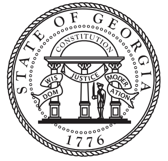
GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Child Support Services



Community Outreach

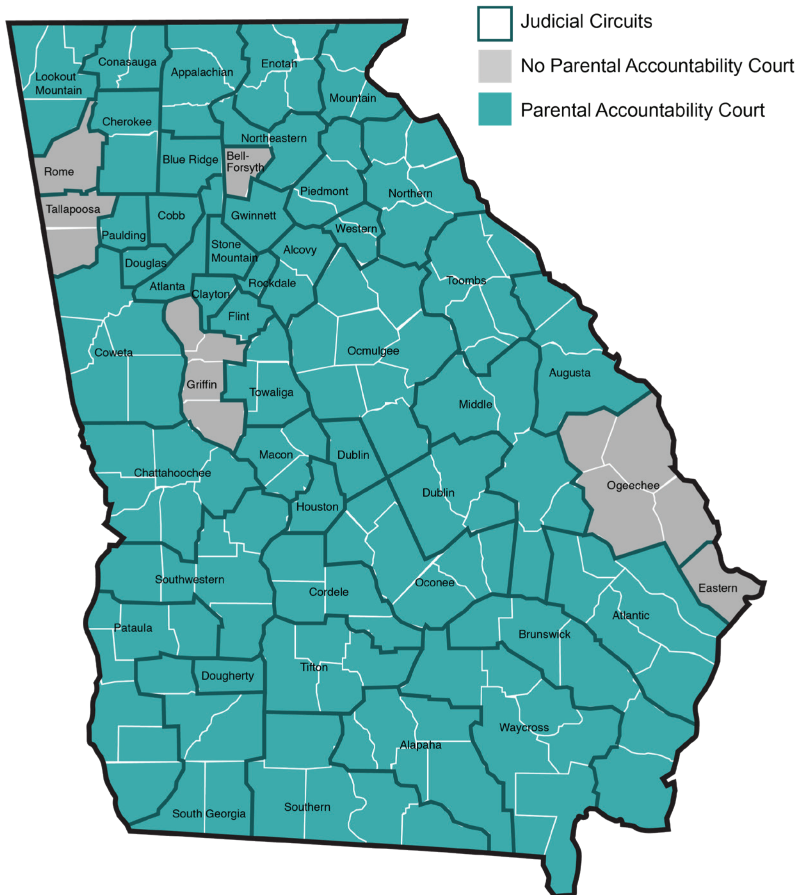
Helping parents support their children.

Parental Accountability Court Program

The Parental Accountability Court (PAC) program is a joint effort of the Division and Superior Court Judges to offer an alternative to incarceration and to help chronic nonpayers of child support make regular payments. The program uses community resources and judicial oversight to address barriers that keep parents from meeting their support obligations. Each program, including services provided to participants, is tailored to the needs of the local community. Superior Court Judges provide judicial oversight and collaborate with PAC coordinators to implement the program. PAC coordinators connect participants to existing community resources.

Judicial Circuits Served by Parental Accountability Courts

Parental Accountability Courts are in operations in 43 judicial circuits across the state. The Division's goal is to establish PACs in all 49 judicial circuits in SFY19.



SERVICES OFFERED TO PARTICIPANTS

- Volunteer work opportunities
- Literacy training
- Job assistance/placement
- Mental health services
- Clinical assessments
- Substance abuse treatment
- Coaching/mentoring
- Additional services specific to each local community

BY THE NUMBERS

Since SFY 2012, the Parental Accountability Court program has helped

6,212

noncustodial parents who were at risk of incarceration avoid jail time and provide much needed support to

9,461

of Georgia's children. Program participants paid an estimated

$6.6M

in support, which, in return, has saved the state millions in incarceration costs.

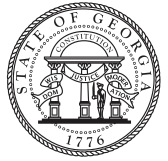
CONTACT INFORMATION
For information about the Parental Accountability Court Program and other outreach services, call **1-844-MYGADHS (1-844-694-2347)**.

Gerlda B. Hines, DHS Interim Commissioner | **Tanguler Gray**, Division Director | **John Hurst**, Division Deputy Director

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Child Support Services

Community Outreach

Helping parents support their children.



Fatherhood Program

Through the Fatherhood program, the Division works with parents who are unemployed or underemployed and are, as a result, unable to pay their full child support obligations. The program connects parents with resources that lead to jobs paying above minimum wage, greater self sufficiency and more emotional, parental and financial involvement in the lives of their children. Georgia has the only statewide program in the U.S. **Services include:**

- GED classes
- Short-term training
- Volunteer opportunities
- Resume writing
- Federal bonding
- Referrals for access and visitation
- Referrals for legitimization
- Job placement, coaching and mentoring

"FATHERHOOD: A CELEBRATION" EVENTS

In an effort to raise awareness for the Fatherhood program's ability to help parents meet their child support obligations, the Division hosts outreach events around the state. These events celebrate the roles fathers play in the lives of their children. It is a fun atmosphere for parents to spend time with their children and to learn about the resources available to parents struggling to pay their child support. The Division hosted events in Albany, Columbus and Morrow in SFY18 and has additional celebrations planned in Lowndes and Gwinnett counties for SFY19.

FATHERHOOD CONVERSATIONS

In an effort to provide child support information to parents who feel uncomfortable attending in-person events in fear of arrest, DCSS began hosting Fatherhood Conversations.

Fatherhood Conversations provide child support information to the general public in a nonthreatening environment. Fatherhood Conversations are interactive and are made available for participation via LiveStream. Some forums allow the public to attend for live engagement. Additional conversations are planned for SFY19.

91%

of noncustodial parents owing child support in Georgia are fathers.

83,040

cases are considered to be hard-to-serve and potentially eligible for an outreach program.

During FFY18,

6,511

parents were enrolled in the Fatherhood program, supporting **9,173** children.

24

Fatherhood agents across Georgia

1,340

noncustodial parents enrolled in General Education Development (GED) classes through the Fatherhood program.

1,174

participants enrolled in short-term training programs

Fatherhood participants who have had their driver's licenses suspended or who are subject to license suspension for nonpayment of child support have the opportunity to regain driving privileges.

CONTACT INFORMATION

For information about the Georgia Fatherhood program and other community outreach services, call **1-844-MYGADHS (1-844-694-2347)**. Custodial and noncustodial parents may apply for services, enter and receive information about their cases, make a payment online or check payment information by using the Customer Online Services portal at **www.dcss.dhs.georgia.gov**. Users receive a password to protect confidentiality.

Gerlda B. Hines, DHS Interim Commissioner | **Tanguler Gray**, Division Director | **John Hurst**, Division Deputy Director

Georgia Department of Community Health
IT - Decision Support Services

Total Medicaid and Peachcare Expenditures by County - FY 2018

	Medicaid		Peachcare	
County	Net Payment	CMO Paid Amount	Net Payment	CMO Paid Amount
Appling	$ 14,236,797.45	$ 7,696,574.86	$ 18,147.44	$ 308,658.50
Atkinson	$ 5,393,675.42	$ 4,220,509.13	$ 16,520.66	$ 222,485.18
Bacon	$ 12,026,047.37	$ 4,741,230.78	$ 26,220.89	$ 218,502.29
Baker	$ 2,358,267.40	$ 1,166,747.56	$ 288.10	$ 51,194.98
Baldwin	$ 36,598,587.02	$ 14,370,911.09	$ 38,262.97	$ 537,674.32
Banks	$ 9,174,794.98	$ 5,897,677.77	$ 26,073.03	$ 541,539.22
Barrow	$ 38,646,000.48	$ 25,362,555.53	$ 125,070.43	$ 2,833,588.91
Bartow	$ 50,862,034.96	$ 38,679,857.22	$ 63,969.49	$ 2,668,394.48
Ben Hill	$ 21,304,819.32	$ 8,983,706.62	$ 17,430.89	$ 281,165.79
Berrien	$ 14,913,174.75	$ 8,560,383.43	$ 22,908.25	$ 504,445.50
Bibb	$ 177,874,620.22	$ 67,906,725.81	$ 117,330.53	$ 1,889,102.61
Bleckley	$ 8,672,414.62	$ 4,821,352.10	$ 12,128.00	$ 218,857.84
Brantley	$ 9,112,913.68	$ 8,546,489.11	$ 27,713.57	$ 419,914.78
Brooks	$ 16,416,383.01	$ 5,668,355.64	$ 74,150.63	$ 348,751.32
Bryan	$ 12,229,318.46	$ 7,864,240.65	$ 39,727.76	$ 791,855.82
Bulloch	$ 38,515,264.66	$ 22,860,515.99	$ 45,467.93	$ 993,297.61
Burke	$ 17,991,560.22	$ 10,154,170.25	$ 5,723.09	$ 354,565.10
Butts	$ 19,290,906.10	$ 8,465,419.30	$ 61,405.40	$ 481,131.19
Calhoun	$ 9,549,423.94	$ 2,465,886.83	$ 16,533.51	$ 91,247.81
Camden	$ 12,846,210.56	$ 13,269,634.76	$ 15,956.99	$ 412,193.91
Candler	$ 18,732,898.93	$ 5,081,851.39	$ 17,920.61	$ 218,313.14
Carroll	$ 68,235,698.24	$ 41,222,554.35	$ 89,020.11	$ 2,104,557.29
Catoosa	$ 21,310,349.81	$ 17,778,278.06	$ 112,248.10	$ 911,143.68
Charlton	$ 6,533,421.95	$ 3,033,522.62	$ 15,203.62	$ 221,884.69
Chatham	$ 157,748,933.52	$ 80,737,807.22	$ 129,998.39	$ 3,263,687.10
Chattahoochee	$ 1,820,938.68	$ 2,083,121.04	$ 379.92	$ 45,772.87
Chattooga	$ 21,415,953.04	$ 11,633,229.80	$ 24,273.63	$ 567,710.41
Cherokee	$ 48,604,652.73	$ 43,358,227.63	$ 246,850.54	$ 5,131,517.74
Clarke	$ 69,291,015.15	$ 31,854,651.92	$ 120,253.29	$ 1,845,103.83
Clay	$ 4,076,564.79	$ 1,098,252.84	$ 1,799.29	$ 40,616.57
Clayton	$ 174,205,213.62	$ 131,518,513.98	$ 294,545.24	$ 5,698,005.75
Clinch	$ 8,398,591.51	$ 2,898,288.11	$ 8,207.03	$ 151,884.39
Cobb	$ 246,263,851.69	$ 145,160,938.14	$ 573,560.13	$ 13,097,012.64
Coffee	$ 30,541,015.43	$ 18,180,207.74	$ 99,087.89	$ 872,299.66
Colquitt	$ 39,775,498.42	$ 20,507,033.87	$ 60,877.82	$ 875,867.38
Columbia	$ 38,934,450.96	$ 22,403,137.89	$ 63,085.33	$ 1,750,009.83
Cook	$ 14,864,887.57	$ 8,632,067.04	$ 17,141.34	$ 544,213.63
Coweta	$ 45,327,962.74	$ 31,442,263.14	$ 190,955.59	$ 2,105,104.48
Crawford	$ 6,610,076.67	$ 4,508,026.49	$ 5,957.08	$ 290,043.17
Crisp	$ 20,539,894.56	$ 11,007,343.52	$ 11,856.93	$ 470,562.17
Dade	$ 7,178,536.78	$ 3,637,390.78	$ 15,541.33	$ 208,448.48
Dawson	$ 10,085,658.97	$ 6,491,518.69	$ 12,193.23	$ 865,252.49
DeKalb	$ 461,414,323.38	$ 247,432,203.94	$ 518,188.85	$ 10,614,066.05
Decatur	$ 22,695,863.38	$ 13,206,612.54	$ 26,489.24	$ 646,126.03
Dodge	$ 19,860,626.77	$ 8,523,817.58	$ 38,044.03	$ 429,521.83
Dooly	$ 13,722,180.69	$ 3,532,144.72	$ 7,374.80	$ 188,263.39
Dougherty	$ 92,108,956.49	$ 43,457,774.48	$ 65,133.49	$ 1,010,939.02
Douglas	$ 67,472,986.36	$ 47,748,194.14	$ 92,339.89	$ 3,410,755.27
Early	$ 10,434,311.11	$ 4,997,655.15	$ 6,198.34	$ 431,620.51
Echols	$ 475,406.77	$ 1,399,949.35	$ 10,925.68	$ 81,925.59
Effingham	$ 16,722,131.43	$ 14,544,680.46	$ 18,237.34	$ 1,097,267.91

Georgia Department of Community Health
IT - Decision Support Services

Total Medicaid and Peachcare Expenditures by County - FY 2018

	Medicaid		Peachcare	
County	Net Payment	CMO Paid Amount	Net Payment	CMO Paid Amount
Elbert	$ 17,261,245.84	$ 7,427,323.42	$ 12,030.11	$ 383,109.95
Emanuel	$ 25,679,180.03	$ 11,918,017.45	$ 10,206.83	$ 447,056.70
Evans	$ 9,010,883.49	$ 4,550,951.13	$ 16,565.81	$ 207,837.07
Fannin	$ 12,534,575.75	$ 8,456,478.22	$ 4,047.52	$ 596,300.63
Fayette	$ 28,683,388.73	$ 16,126,531.78	$ 29,516.65	$ 1,419,535.63
Floyd	$ 83,953,799.34	$ 40,889,192.45	$ 151,456.74	$ 1,967,730.01
Forsyth	$ 30,297,336.71	$ 23,880,027.10	$ 113,340.28	$ 3,357,679.57
Franklin	$ 19,378,124.17	$ 10,328,012.22	$ 27,903.30	$ 451,148.06
Fulton	$ 578,082,050.17	$ 281,896,461.70	$ 437,842.98	$ 10,573,248.24
Gilmer	$ 13,767,612.74	$ 11,307,993.99	$ 23,378.90	$ 675,047.42
Glascock	$ 5,247,361.82	$ 908,792.37	$ 513.08	$ 84,351.41
Glynn	$ 43,924,064.01	$ 27,504,229.95	$ 42,648.92	$ 972,971.85
Gordon	$ 28,156,932.53	$ 21,736,697.00	$ 55,613.72	$ 1,540,314.18
Grady	$ 15,440,315.67	$ 8,695,695.53	$ 23,512.74	$ 605,086.98
Greene	$ 12,489,226.99	$ 4,778,646.07	$ 17,485.44	$ 186,354.57
Gwinnett	$ 277,699,152.03	$ 232,616,343.13	$ 498,461.38	$ 24,906,258.00
Habersham	$ 22,127,027.69	$ 15,209,208.87	$ 17,913.74	$ 1,158,981.24
Hall	$ 85,122,919.77	$ 65,369,818.01	$ 307,780.00	$ 5,715,616.75
Hancock	$ 12,552,328.78	$ 4,179,480.01	$ 1,950.64	$ 89,679.04
Haralson	$ 20,961,779.48	$ 11,914,753.78	$ 26,677.17	$ 593,846.45
Harris	$ 11,348,828.18	$ 6,808,267.51	$ 1,900.08	$ 416,083.29
Hart	$ 15,358,703.39	$ 7,822,363.40	$ 11,188.66	$ 415,869.52
Heard	$ 9,101,282.30	$ 5,287,044.44	$ 5,685.74	$ 240,410.53
Henry	$ 80,318,277.77	$ 62,478,853.03	$ 838,824.81	$ 5,303,590.30
Houston	$ 78,220,665.84	$ 45,116,484.88	$ 127,345.75	$ 2,131,055.85
Irwin	$ 10,904,223.92	$ 4,367,015.63	$ 14,302.91	$ 257,599.36
Jackson	$ 32,160,739.68	$ 18,995,626.04	$ 49,743.12	$ 1,480,686.16
Jasper	$ 7,625,501.70	$ 4,833,077.75	$ 6,216.32	$ 405,011.87
Jeff Davis	$ 10,825,608.41	$ 7,119,166.59	$ 15,489.66	$ 307,754.63
Jefferson	$ 19,568,870.66	$ 7,378,039.28	$ 11,551.82	$ 369,928.75
Jenkins	$ 10,501,626.48	$ 3,912,473.55	$ 3,265.51	$ 73,145.55
Johnson	$ 13,294,403.12	$ 3,549,213.55	$ 7,933.13	$ 136,559.47
Jones	$ 13,637,890.14	$ 9,095,490.64	$ 11,005.73	$ 488,795.24
Lamar	$ 13,081,885.24	$ 7,889,652.04	$ 24,689.49	$ 415,791.78
Lanier	$ 7,684,041.75	$ 3,783,341.36	$ 8,046.07	$ 174,517.20
Laurens	$ 41,153,569.42	$ 22,607,188.38	$ 65,528.04	$ 1,252,315.23
Lee	$ 9,262,005.40	$ 9,599,860.17	$ 153,535.76	$ 678,677.07
Liberty	$ 23,142,186.37	$ 16,045,629.09	$ 14,659.62	$ 754,805.64
Lincoln	$ 2,863,821.07	$ 2,271,133.33	$ 3,494.26	$ 148,264.95
Long	$ 8,058,492.80	$ 5,706,876.98	$ 61,487.18	$ 175,888.13
Lowndes	$ 87,890,429.22	$ 41,601,573.73	$ 298,453.17	$ 2,136,346.99
Lumpkin	$ 15,666,271.72	$ 8,456,089.11	$ 66,531.99	$ 874,841.02
Macon	$ 17,201,411.20	$ 5,207,351.83	$ 6,949.67	$ 216,910.97
Madison	$ 19,345,622.14	$ 9,610,041.78	$ 34,929.00	$ 626,870.12
Marion	$ 5,414,779.11	$ 3,157,562.70	$ 1,354.18	$ 111,836.56
McDuffie	$ 18,074,238.93	$ 9,928,929.58	$ 24,505.59	$ 462,077.07
McIntosh	$ 4,842,733.88	$ 3,297,102.48	$ 4,335.48	$ 301,401.68
Meriwether	$ 22,744,423.70	$ 7,418,124.95	$ 16,354.59	$ 352,456.61
Miller	$ 22,378,282.47	$ 2,690,730.71	$ 3,358.40	$ 150,528.47
Mitchell	$ 21,684,607.90	$ 10,428,308.67	$ 63,256.57	$ 560,227.98
Monroe	$ 18,626,605.39	$ 7,612,798.56	$ 17,863.77	$ 426,131.14

Georgia Department of Community Health
IT - Decision Support Services

Total Medicaid and Peachcare Expenditures by County - FY 2018

	Medicaid		Peachcare	
County	Net Payment	CMO Paid Amount	Net Payment	CMO Paid Amount
Montgomery	$ 5,660,326.62	$ 3,091,139.33	$ 8,713.33	$ 205,585.28
Morgan	$ 8,416,688.94	$ 5,672,287.94	$ 62,769.07	$ 262,484.26
Murray	$ 21,811,613.34	$ 16,888,284.45	$ 37,965.17	$ 1,194,304.84
Muscogee	$ 157,185,159.62	$ 72,601,311.46	$ 61,739.69	$ 2,660,607.64
Newton	$ 59,410,247.37	$ 42,879,483.22	$ 80,938.45	$ 2,261,736.27
Oconee	$ 9,613,253.84	$ 3,782,832.77	$ 40,737.82	$ 473,625.98
Oglethorpe	$ 5,857,520.23	$ 4,113,221.42	$ 73,429.49	$ 254,852.44
Out of State	$ 2,061,676.48	$ 4,375,736.12	$ 54,690.22	$ 78,008.11
Paulding	$ 37,018,631.49	$ 40,410,750.35	$ 90,909.60	$ 5,001,410.67
Peach	$ 20,603,819.00	$ 9,247,800.70	$ 5,121.95	$ 371,813.22
Pickens	$ 15,722,508.32	$ 10,390,396.35	$ 23,068.43	$ 959,365.51
Pierce	$ 14,672,184.94	$ 7,247,508.44	$ 93,494.47	$ 453,423.55
Pike	$ 8,455,696.57	$ 5,510,986.42	$ 10,050.84	$ 587,894.24
Polk	$ 35,996,944.47	$ 23,153,456.52	$ 63,999.78	$ 1,105,665.27
Pulaski	$ 8,740,793.55	$ 4,276,104.30	$ 10,089.92	$ 181,820.56
Putnam	$ 11,388,346.45	$ 7,882,796.90	$ 63,567.15	$ 251,988.20
Quitman	$ 851,861.88	$ 1,212,172.95	$ 4,745.16	$ 38,950.60
Rabun	$ 11,017,994.03	$ 5,238,615.57	$ 15,615.10	$ 423,067.49
Randolph	$ 9,070,983.54	$ 2,914,556.18	$ 1,089.80	$ 94,142.45
Richmond	$ 197,415,513.79	$ 82,721,185.09	$ 154,436.18	$ 2,043,395.05
Rockdale	$ 46,596,417.90	$ 35,457,456.89	$ 27,741.55	$ 1,941,389.61
Schley	$ 2,100,579.74	$ 2,817,625.56	$ 7,139.42	$ 148,465.75
Screven	$ 12,114,643.42	$ 7,026,187.29	$ 5,754.92	$ 223,612.26
Seminole	$ 6,483,753.10	$ 3,437,832.60	$ 6,509.27	$ 290,828.18
Spalding	$ 52,219,126.03	$ 28,900,252.11	$ 56,942.05	$ 1,369,134.76
Stephens	$ 25,057,389.11	$ 13,890,323.55	$ 22,094.59	$ 678,637.75
Stewart	$ 6,416,994.98	$ 1,825,202.29	$ 274.76	$ 59,241.74
Sumter	$ 34,683,287.11	$ 15,441,358.92	$ 169,988.76	$ 471,222.04
Talbot	$ 4,190,494.73	$ 1,558,332.71	$ 5,302.27	$ 74,576.25
Taliaferro	$ 1,619,168.54	$ 502,227.65	$ -	$ 33,307.70
Tattnall	$ 23,902,324.40	$ 8,116,481.27	$ 176,509.65	$ 623,370.07
Taylor	$ 9,941,563.82	$ 3,780,476.29	$ 4,672.18	$ 113,941.42
Telfair	$ 13,383,015.68	$ 4,978,908.85	$ 7,847.87	$ 223,235.71
Terrell	$ 9,426,894.03	$ 4,391,105.25	$ 222.24	$ 95,357.62
Thomas	$ 42,225,288.15	$ 19,577,156.31	$ 57,396.72	$ 1,378,788.85
Tift	$ 35,038,046.32	$ 19,722,221.77	$ 29,424.69	$ 976,903.89
Toombs	$ 33,433,135.82	$ 13,681,330.44	$ 48,649.18	$ 682,103.38
Towns	$ 7,838,569.14	$ 2,322,655.67	$ 37,726.37	$ 207,536.08
Treutlen	$ 7,524,619.60	$ 3,082,043.07	$ 5,246.95	$ 173,113.15
Troup	$ 46,500,212.47	$ 30,738,920.33	$ 36,815.45	$ 1,462,424.98
Turner	$ 9,879,276.51	$ 5,044,687.11	$ 15,673.95	$ 184,804.32
Twiggs	$ 9,515,055.74	$ 2,827,346.87	$ 4,947.49	$ 123,208.59
Union	$ 14,458,252.41	$ 5,968,628.10	$ 10,896.77	$ 447,023.67
Upson	$ 27,483,876.33	$ 12,202,139.34	$ 45,947.99	$ 515,842.90
Walker	$ 46,523,028.68	$ 21,668,590.84	$ 91,968.62	$ 1,143,656.62
Walton	$ 57,025,308.59	$ 29,300,188.94	$ 37,682.73	$ 2,292,693.46
Ware	$ 41,424,315.01	$ 16,885,358.50	$ 40,989.50	$ 675,149.22
Warren	$ 7,347,775.48	$ 1,762,318.11	$ 862.16	$ 36,988.75
Washington	$ 20,372,646.11	$ 8,679,136.22	$ 14,268.24	$ 452,314.20
Wayne	$ 23,198,720.06	$ 12,008,706.67	$ 15,342.84	$ 500,700.75
Webster	$ 1,026,069.26	$ 974,967.35	$ 509.51	$ 67,113.16

Georgia Department of Community Health
IT - Decision Support Services

Total Medicaid and Peachcare Expenditures by County - FY 2018

	Medicaid		Peachcare	
County	Net Payment	CMO Paid Amount	Net Payment	CMO Paid Amount
Wheeler	$ 4,998,068.84	$ 2,607,728.07	$ 5,810.96	$ 127,038.77
White	$ 15,868,224.42	$ 8,735,560.29	$ 31,047.49	$ 1,298,632.91
Whitfield	$ 53,743,726.82	$ 36,796,838.85	$ 199,638.50	$ 4,327,942.27
Wilcox	$ 7,111,927.90	$ 3,552,298.38	$ 7,954.61	$ 173,435.74
Wilkes	$ 9,051,661.05	$ 3,188,992.79	$ 303,094.79	$ 212,391.30
Wilkinson	$ 8,125,219.09	$ 3,546,471.58	$ 3,069.55	$ 184,795.10
Worth	$ 13,693,615.00	$ 8,723,139.70	$ 23,734.03	$ 316,720.70
Grand Total	**$ 5,740,281,457.66**	**$ 3,233,916,091.98**	**$ 9,974,419.92**	**$ 194,348,382.28**

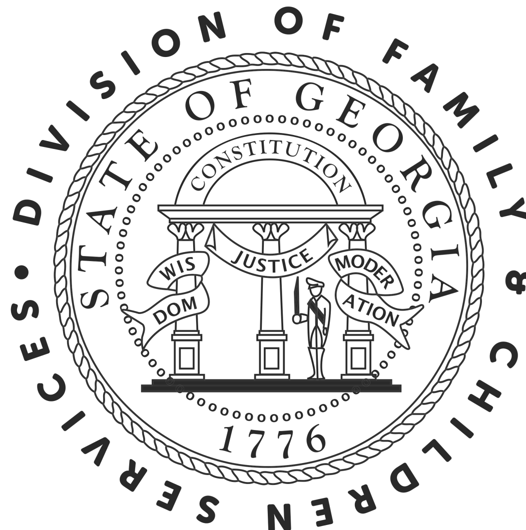
Notes:
1. Data is based on incurred claims from 07/01/2017 to 06/30/2018 with date of payments through 11/30/2018
2. Analysis includes CMO and FFS totals by County
3. Includes Medicaid and Peachcare
4. Net payment represents the amount paid for claims billed
5. CMO Paid Amount represents the amount each CMO vendor paid the provider
6. Report run in Truven, Advantage Suite 12/31/2018

The data presented in this report should be used for the purpose of the initial request only. Data accuracy of the report is assured based on the current information in the database and is subject to change based on database and data quality updates.

Georgia Division of Family & Children Services

State Fiscal Year 2018

DESCRIPTIVE DATA BY COUNTY



Report Compiled by:

Planning, Performance & Reporting Section
Division of Family & Children Services

Department of Human Services
Divison of Family & Children Services
Planning, Performance & reporting Section
Two Peachtree Street, N.W.. 21st floor
Atlanta, Georgia 30303

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

STATE FISCAL YEAR 2018

COUNTY	MONTHLY AVERAGES				TOTAL ANNUAL BENEFITS
	FAMILIES	ADULTS	CHILDREN	RECIPIENTS	
APPLING	46	1	75	76	$153,248
ATKINSON	13	0	18	18	$31,931
BACON	20	1	36	37	$64,596
BAKER	1	0	1	1	$7,200
BALDWIN	64	5	96	101	$209,032
BANKS	13	1	20	21	$36,734
BARROW	39	2	63	65	$134,002
BARTOW	72	5	127	132	$246,850
BEN HILL	24	0	40	40	$81,468
BERRIEN	23	0	41	41	$90,785
BIBB	381	55	698	753	$1,310,896
BLECKLEY	15	2	25	27	$47,127
BRANTLEY	42	0	74	74	$156,085
BROOKS	26	0	47	47	$132,027
BRYAN	20	2	30	32	$52,572
BULLOCH	83	7	140	147	$284,041
BURKE	50	8	85	93	$165,794
BUTTS	26	3	47	50	$96,570
CALHOUN	8	0	12	12	$26,361
CAMDEN	35	5	56	61	$112,716
CANDLER	35	1	60	61	$119,661
CARROLL	156	21	294	315	$503,578
CATOOSA	59	1	99	100	$211,002
CHARLTON	13	0	24	24	$52,729
CHATHAM	155	16	249	265	$486,613
CHATTAHOOCHEE	5	1	9	10	$13,861
CHATTOOGA	36	3	60	63	$120,134
CHEROKEE	50	8	102	110	$170,968
CLARKE	85	6	150	156	$284,189
CLAY	8	1	12	13	$26,491
CLAYTON	520	98	934	1,032	$1,676,621
CLINCH	12	0	20	20	$37,487
COBB	357	64	640	704	$1,089,396
COFFEE	65	1	110	111	$219,385
COLQUITT	82	2	143	145	$291,774
COLUMBIA	67	7	106	113	$236,684
COOK	19	1	40	41	$71,409
COWETA	101	15	164	179	$288,097
CRAWFORD	6	1	10	11	$39,035
CRISP	37	4	62	66	$114,614
DADE	9	0	14	14	$26,099
DAWSON	14	0	32	32	$59,521
DECATUR	44	5	71	76	$158,838
DEKALB	1,026	415	1,844	2,259	$3,978,030
DODGE	37	2	59	61	$106,746
DOOLY	17	2	26	28	$46,769

Note: TANF Issuance includes GRG

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

STATE FISCAL YEAR 2018

COUNTY	MONTHLY AVERAGES				TOTAL ANNUAL BENEFITS
	FAMILIES	ADULTS	CHILDREN	RECIPIENTS	
DOUGHERTY	257	23	415	438	$802,446
DOUGLAS	162	18	263	281	$498,907
EARLY	19	1	28	29	$64,445
ECHOLS	7	0	15	15	$29,342
EFFINGHAM	22	1	40	41	$76,011
ELBERT	32	5	49	54	$125,514
EMANUEL	34	2	53	55	$105,714
EVANS	18	1	38	39	$71,681
FANNIN	13	1	22	23	$40,391
FAYETTE	41	6	60	66	$125,481
FLOYD	106	6	182	188	$302,757
FORSYTH	24	4	46	50	$81,274
FRANKLIN	18	1	25	26	$61,883
FULTON	1,622	645	2,976	3,621	$6,303,841
GILMER	17	0	34	34	$73,631
GLASCOCK	2	0	3	3	$4,575
GLYNN	88	5	146	151	$316,008
GORDON	48	5	80	85	$156,538
GRADY	26	1	42	43	$78,896
GREENE	9	1	13	14	$25,329
GWINNETT	328	60	584	644	$1,247,394
HABERSHAM	20	1	41	42	$86,393
HALL	119	12	208	220	$490,552
HANCOCK	10	2	18	20	$32,630
HARALSON	27	1	48	49	$88,534
HARRIS	17	4	31	35	$60,310
HART	20	0	31	31	$65,717
HEARD	24	3	40	43	$87,291
HENRY	182	46	329	375	$564,336
HOUSTON	199	22	319	341	$636,849
IRWIN	13	0	26	26	$51,270
JACKSON	34	1	47	48	$110,833
JASPER	18	1	31	32	$58,226
JEFF DAVIS	32	1	50	51	$96,526
JEFFERSON	25	8	37	45	$74,030
JENKINS	25	2	39	41	$88,036
JOHNSON	20	1	31	32	$58,734
JONES	37	1	65	66	$129,482
LAMAR	28	4	44	48	$84,812
LANIER	11	0	18	18	$37,578
LAURENS	84	11	130	141	$260,134
LEE	22	2	40	42	$88,137
LIBERTY	42	5	72	77	$133,308
LINCOLN	12	1	25	26	$46,015
LONG	15	1	20	21	$41,597
LOWNDES	138	1	247	248	$494,981

Note: TANF Issuance includes GRG

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

STATE FISCAL YEAR 2018

COUNTY	MONTHLY AVERAGES				TOTAL ANNUAL BENEFITS
	FAMILIES	ADULTS	CHILDREN	RECIPIENTS	
LUMPKIN	26	1	41	42	$84,421
MACON	20	2	30	32	$66,564
MADISON	39	2	68	70	$148,562
MARION	22	3	40	43	$99,544
MCDUFFIE	52	11	86	97	$172,822
MCINTOSH	8	0	10	10	$23,728
MERIWETHER	46	6	98	104	$166,799
MILLER	9	0	15	15	$32,032
MITCHELL	40	0	58	58	$120,604
MONROE	28	0	43	43	$95,241
MONTGOMERY	8	0	12	12	$27,237
MORGAN	11	1	20	21	$44,920
MURRAY	43	4	81	85	$134,935
MUSCOGEE	418	111	779	890	$1,306,904
NEWTON	156	19	260	279	$610,519
OCONEE	6	0	8	8	$15,775
OGLETHORPE	16	0	24	24	$53,074
PAULDING	89	9	138	147	$269,531
PEACH	36	6	67	73	$123,644
PICKENS	24	2	38	40	$85,377
PIERCE	31	0	53	53	$108,041
PIKE	19	3	29	32	$48,893
POLK	61	4	109	113	$183,335
PULASKI	17	1	22	23	$48,970
PUTNAM	30	2	46	48	$98,651
QUITMAN	6	1	10	11	$15,199
RABUN	11	1	20	21	$44,952
RANDOLPH	23	12	43	55	$71,529
RICHMOND	392	78	709	787	$1,386,899
ROCKDALE	100	15	182	197	$353,999
SCHLEY	14	0	18	18	$37,683
SCREVEN	30	3	48	51	$102,896
SEMINOLE	9	1	15	16	$31,701
SPALDING	151	20	269	289	$484,191
STEPHENS	59	5	103	108	$321,796
STEWART	4	0	6	6	$11,811
SUMTER	73	11	118	129	$226,482
TALBOT	6	0	15	15	$25,063
TALIAFERRO	3	1	5	6	$7,880
TATTNALL	37	4	72	76	$136,457
TAYLOR	11	0	19	19	$38,864
TELFAIR	20	1	36	37	$71,585
TERRELL	20	0	33	33	$58,281
THOMAS	78	2	134	136	$485,628
TIFT	58	1	102	103	$242,153
TOOMBS	50	2	83	85	$169,405

Note: TANF Issuance includes GRG

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

STATE FISCAL YEAR 2018

COUNTY	MONTHLY AVERAGES				TOTAL ANNUAL BENEFITS
	FAMILIES	ADULTS	CHILDREN	RECIPIENTS	
TOWNS	7	1	11	12	$20,509
TREUTLEN	14	1	25	26	$92,855
TROUP	94	19	193	212	$340,883
TURNER	15	1	31	32	$61,651
TWIGGS	24	2	37	39	$81,430
UNION	7	1	12	13	$30,230
UPSON	41	5	70	75	$139,063
WALKER	72	4	122	126	$258,092
WALTON	150	5	232	237	$852,680
WARE	75	0	121	121	$237,739
WARREN	10	2	17	19	$38,210
WASHINGTON	36	3	54	57	$110,992
WAYNE	42	2	78	80	$148,861
WEBSTER	2	1	2	3	$5,034
WHEELER	6	1	12	13	$20,382
WHITE	17	1	29	30	$71,102
WHITFIELD	66	7	111	118	$218,788
WILCOX	16	0	26	26	$52,085
WILKES	13	1	24	25	$46,549
WILKINSON	18	1	33	34	$66,605
WORTH	27	0	42	42	$91,112
STATE TOTAL	**11,245**	**2,092**	**19,663**	**21,755**	**$39,907,564**

Note: TANF Issuance includes GRG

TANF CASELOAD FROM JUNE 2017 TO JUNE 2018

COUNTY	JUNE 2017	JUNE 2018	NUMERIC CHANGE	PERCENTAGE CHANGE
APPLING	39	46	7	0.18
ATKINSON	12	9	-3	-0.25
BACON	21	18	-3	-0.14
BAKER	3	1	-2	-0.67
BALDWIN	66	62	-4	-0.06
BANKS	8	13	5	0.63
BARROW	26	43	17	0.65
BARTOW	84	65	-19	-0.23
BEN HILL	24	25	1	0.04
BERRIEN	16	24	8	0.50
BIBB	433	368	-65	-0.15
BLECKLEY	15	13	-2	-0.13
BRANTLEY	37	45	8	0.22
BROOKS	35	28	-7	-0.20
BRYAN	15	19	4	0.27
BULLOCH	82	81	-1	-0.01
BURKE	59	48	-11	-0.19
BUTTS	31	24	-7	-0.23
CALHOUN	8	7	-1	-0.13
CAMDEN	32	29	-3	-0.09
CANDLER	34	36	2	0.06
CARROLL	156	140	-16	-0.10
CATOOSA	59	61	2	0.03
CHARLTON	13	11	-2	-0.15
CHATHAM	139	162	23	0.17
CHATTAHOOCHEE	3	5	2	0.67
CHATTOOGA	40	32	-8	-0.20
CHEROKEE	52	44	-8	-0.15
CLARKE	73	81	8	0.11
CLAY	8	7	-1	-0.13
CLAYTON	529	484	-45	-0.09
CLINCH	10	12	2	0.20
COBB	365	323	-42	-0.12
COFFEE	56	68	12	0.21
COLQUITT	81	79	-2	-0.02
COLUMBIA	66	77	11	0.17
COOK	19	17	-2	-0.11
COWETA	112	85	-27	-0.24
CRAWFORD	10	7	-3	-0.30
CRISP	28	39	11	0.39
DADE	8	7	-1	-0.13
DAWSON	13	14	1	0.08
DECATUR	35	43	8	0.23
DEKALB	900	1,063	163	0.18
DODGE	37	40	3	0.08
DOOLY	15	15	0	0.00
DOUGHERTY	234	236	2	0.01

TANF CASELOAD FROM JUNE 2017 TO JUNE 2018

COUNTY	JUNE 2017	JUNE 2018	NUMERIC CHANGE	PERCENTAGE CHANGE
DOUGLAS	182	146	-36	-0.20
EARLY	9	19	10	1.11
ECHOLS	7	7	0	0.00
EFFINGHAM	25	21	-4	-0.16
ELBERT	31	26	-5	-0.16
EMANUEL	39	27	-12	-0.31
EVANS	20	18	-2	-0.10
FANNIN	8	17	9	1.13
FAYETTE	41	37	-4	-0.10
FLOYD	107	108	1	0.01
FORSYTH	18	22	4	0.22
FRANKLIN	15	19	4	0.27
FULTON	1,583	1,636	53	0.03
GILMER	15	22	7	0.47
GLASCOCK	3	3	0	0.00
GLYNN	110	79	-31	-0.28
GORDON	54	47	-7	-0.13
GRADY	17	31	14	0.82
GREENE	6	6	0	0.00
GWINNETT	343	300	-43	-0.13
HABERSHAM	11	22	11	1.00
HALL	137	108	-29	-0.21
HANCOCK	8	12	4	0.50
HARALSON	24	27	3	0.13
HARRIS	17	15	-2	-0.12
HART	17	20	3	0.18
HEARD	25	22	-3	-0.12
HENRY	186	174	-12	-0.06
HOUSTON	228	185	-43	-0.19
IRWIN	15	15	0	0.00
JACKSON	20	36	16	0.80
JASPER	14	17	3	0.21
JEFF DAVIS	37	29	-8	-0.22
JEFFERSON	21	29	8	0.38
JENKINS	27	29	2	0.07
JOHNSON	18	19	1	0.06
JONES	37	34	-3	-0.08
LAMAR	32	21	-11	-0.34
LANIER	6	12	6	1.00
LAURENS	85	81	-4	-0.05
LEE	26	23	-3	-0.12
LIBERTY	45	35	-10	-0.22
LINCOLN	10	9	-1	-0.10
LONG	13	16	3	0.23
LOWNDES	143	136	-7	-0.05
LUMPKIN	27	24	-3	-0.11
MACON	20	18	-2	-0.10

TANF CASELOAD FROM JUNE 2017 TO JUNE 2018

COUNTY	JUNE 2017	JUNE 2018	NUMERIC CHANGE	PERCENTAGE CHANGE
MADISON	27	43	16	0.59
MARION	37	21	-16	-0.43
MCDUFFIE	50	53	3	0.06
MCINTOSH	6	8	2	0.33
MERIWETHER	53	42	-11	-0.21
MILLER	5	11	6	1.20
MITCHELL	38	44	6	0.16
MONROE	30	29	-1	-0.03
MONTGOMERY	9	8	-1	-0.11
MORGAN	6	9	3	0.50
MURRAY	40	43	3	0.08
MUSCOGEE	405	427	22	0.05
NEWTON	146	145	-1	-0.01
OCONEE	5	6	1	0.20
OGLETHORPE	6	14	8	1.33
PAULDING	83	88	5	0.06
PEACH	37	33	-4	-0.11
PICKENS	30	19	-11	-0.37
PIERCE	32	29	-3	-0.09
PIKE	17	18	1	0.06
POLK	61	59	-2	-0.03
PULASKI	18	17	-1	-0.06
PUTNAM	32	26	-6	-0.19
QUITMAN	7	3	-4	-0.57
RABUN	13	8	-5	-0.38
RANDOLPH	19	24	5	0.26
RICHMOND	413	377	-36	-0.09
ROCKDALE	90	89	-1	-0.01
SCHLEY	16	14	-2	-0.13
SCREVEN	25	26	1	0.04
SEMINOLE	4	11	7	1.75
SPALDING	155	143	-12	-0.08
STEPHENS	98	47	-51	-0.52
STEWART	3	4	1	0.33
SUMTER	75	65	-10	-0.13
TALBOT	5	6	1	0.20
TALIAFERRO	3	1	-2	-0.67
TATTNALL	33	39	6	0.18
TAYLOR	14	11	-3	-0.21
TELFAIR	17	19	2	0.12
TERRELL	16	23	7	0.44
THOMAS	158	68	-90	-0.57
TIFT	76	55	-21	-0.28
TOOMBS	48	51	3	0.06
TOWNS	6	7	1	0.17
TREUTLEN	36	12	-24	-0.67
TROUP	92	77	-15	-0.16

TANF CASELOAD FROM JUNE 2017 TO JUNE 2018

COUNTY	JUNE 2017	JUNE 2018	NUMERIC CHANGE	PERCENTAGE CHANGE
TURNER	16	12	-4	-0.25
TWIGGS	23	24	1	0.04
UNION	8	11	3	0.38
UPSON	41	40	-1	-0.02
WALKER	74	79	5	0.07
WALTON	321	122	-199	-0.62
WARE	50	75	25	0.50
WARREN	9	8	-1	-0.11
WASHINGTON	41	37	-4	-0.10
WAYNE	42	38	-4	-0.10
WEBSTER	2	2	0	0.00
WHEELER	5	5	0	0.00
WHITE	4	16	12	3.00
WHITFIELD	64	63	-1	-0.02
WILCOX	19	18	-1	-0.05
WILKES	10	15	5	0.50
WILKINSON	17	18	1	0.06
WORTH	16	24	8	0.50
STATE TOTAL	**11,380**	**10,894**	**-486**	**-0.04**

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
BY RACE/ETHICITY FOR RECIPIENTS

JUNE 2018

COUNTY	LATINO							NON-LATINO								
	White	Black	Pacific Islander / Alaskan	Asian	Native American	Other	Unknown	White	Black	Pacific Islander / Alaskan	Asian	Native American	Other	Unknown	Other	Unknown
APPLING	0	0	0	0	0	0	0	107	68	0	0	0	0	1	4	0
ATKINSON	0	0	0	0	0	0	0	11	13	0	0	0	0	0	2	0
BACON	0	0	0	0	0	0	0	17	42	0	0	0	0	5	1	0
BAKER	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0
BALDWIN	0	0	0	0	0	0	0	47	169	0	0	1	0	7	0	0
BANKS	0	0	0	0	0	0	0	44	1	0	0	0	0	2	0	0
BARROW	0	0	0	0	0	0	0	86	45	0	0	0	4	3	14	7
BARTOW	0	0	0	0	0	0	0	191	38	0	0	0	0	4	3	4
BEN HILL	0	0	0	0	0	0	0	41	50	0	0	1	0	0	2	1
BERRIEN	0	0	0	0	0	0	1	75	12	0	0	0	0	4	2	0
BIBB	0	0	0	0	0	0	0	159	1,128	0	0	2	1	47	18	20
BLECKLEY	0	0	0	0	0	0	0	15	34	0	0	0	0	0	0	0
BRANTLEY	0	0	0	0	0	0	0	159	6	0	0	0	0	3	1	5
BROOKS	0	0	0	0	0	0	0	16	87	0	0	0	0	6	6	0
BRYAN	0	0	0	0	0	0	0	40	27	0	0	0	0	1	2	2
BULLOCH	0	0	0	0	0	0	0	85	217	0	0	0	0	8	1	2
BURKE	0	0	0	0	0	0	0	34	124	0	0	0	0	8	0	7
BUTTS	0	0	0	0	0	0	0	44	36	0	0	0	0	5	3	0
CALHOUN	0	0	0	0	0	0	0	5	18	0	0	0	0	0	0	0
CAMDEN	0	0	0	0	0	0	0	49	41	0	0	0	0	4	0	1
CANDLER	0	0	0	0	0	0	0	63	91	0	0	0	0	6	2	1
CARROLL	0	0	0	0	0	0	0	292	170	0	0	0	1	19	31	3
CATOOSA	1	0	0	0	0	0	0	199	7	0	0	0	0	4	3	2
CHARLTON	0	0	0	0	0	0	0	26	8	0	0	0	0	0	1	0
CHATHAM	0	0	0	0	0	0	0	75	401	0	0	0	3	40	31	10
CHATTAHOOCHEE	0	0	0	0	0	0	0	8	6	0	0	0	0	3	0	0
CHATTOOGA	0	0	0	0	0	0	3	102	12	0	0	0	0	2	3	0
CHEROKEE	0	0	0	0	0	0	2	73	49	0	0	0	1	10	25	5
CLARKE	0	0	0	0	0	0	0	26	215	0	0	0	0	11	13	1
CLAY	0	0	0	0	0	0	0	0	21	0	0	0	0	1	0	1
CLAYTON	0	0	0	0	0	0	3	127	1,414	0	0	0	2	97	81	51
CLINCH	0	0	0	0	0	0	0	14	23	0	0	0	0	5	1	0
COBB	0	0	0	0	0	0	2	230	701	0	0	1	2	80	118	27
COFFEE	0	0	0	0	0	0	0	108	127	0	0	0	0	5	8	0
COLQUITT	0	0	0	0	0	0	0	147	125	0	0	0	0	6	19	4
COLUMBIA	0	0	0	0	0	0	7	117	124	0	0	2	1	7	12	2
COOK	0	0	0	0	0	0	0	28	39	0	0	0	0	1	5	0
COWETA	0	0	0	0	0	0	5	161	105	1	0	0	2	13	6	5
CRAWFORD	0	0	0	0	0	0	0	14	8	0	0	0	0	1	0	0
CRISP	0	0	0	0	0	0	0	15	114	0	0	0	0	5	3	0
DADE	0	0	0	0	0	0	0	25	0	0	0	0	0	0	0	0

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
BY RACE/ETHICITY FOR RECIPIENTS

JUNE 2018

COUNTY	LATINO							NON-LATINO								
	White	Black	Pacific Islander / Alaskan	Asian	Native American	Other	Unknown	White	Black	Pacific Islander / Alaskan	Asian	Native American	Other	Unknown	Other	Unknown
DAWSON	0	0	0	0	0	0	0	43	1	0	0	1	0	3	9	1
DECATUR	0	0	0	0	0	0	0	35	102	0	0	1	0	8	1	2
DEKALB	0	0	0	0	0	0	3	109	3,162	0	0	6	43	199	166	117
DODGE	0	0	0	0	0	0	0	74	56	0	0	0	0	5	2	2
DOOLY	0	0	0	0	0	0	0	12	28	0	0	0	0	1	1	0
DOUGHERTY	0	0	0	0	0	0	0	55	727	0	0	0	0	22	5	2
DOUGLAS	0	0	0	0	0	0	1	156	273	0	0	0	1	38	24	15
EARLY	0	0	0	0	0	0	0	15	55	0	0	0	0	1	0	1
ECHOLS	0	0	0	0	0	0	0	15	0	0	0	0	0	0	10	0
EFFINGHAM	0	0	0	0	0	0	0	35	36	0	0	0	0	2	1	0
ELBERT	0	0	0	0	0	0	0	39	40	0	0	0	0	2	1	0
EMANUEL	0	0	0	0	0	0	0	19	70	0	0	0	0	0	4	1
EVANS	0	0	0	0	0	0	0	11	36	0	0	0	0	3	17	0
FANNIN	0	0	0	0	0	0	0	66	0	0	0	0	0	8	0	2
FAYETTE	0	0	0	0	0	0	0	38	61	0	0	0	1	5	1	6
FLOYD	0	0	0	0	0	0	0	202	160	0	0	0	0	15	21	2
FORSYTH	0	0	0	0	0	0	0	57	18	0	0	0	0	2	7	3
FRANKLIN	0	0	0	0	0	0	0	46	16	0	0	0	0	2	1	0
FULTON	0	1	0	0	0	0	4	116	5,325	0	0	6	7	227	119	191
GILMER	0	0	0	0	0	0	0	86	0	0	0	0	0	4	0	0
GLASCOCK	0	0	0	0	0	0	0	6	5	0	0	0	0	0	0	0
GLYNN	0	0	0	0	0	0	4	104	156	0	0	0	0	9	11	1
GORDON	0	0	0	0	0	0	0	145	8	0	0	0	0	3	6	3
GRADY	0	0	0	0	0	0	1	46	50	0	0	0	0	5	7	0
GREENE	0	0	0	0	0	0	0	16	7	0	0	0	0	0	0	0
GWINNETT	0	0	0	0	0	0	5	189	706	1	1	4	8	41	139	22
HABERSHAM	0	0	0	0	0	0	0	72	8	0	0	0	0	0	15	1
HALL	1	0	0	0	0	0	1	222	123	1	0	0	0	8	37	3
HANCOCK	0	0	0	0	0	0	0	2	34	0	0	0	0	1	0	0
HARALSON	0	0	0	0	0	0	1	70	9	0	0	0	0	5	4	1
HARRIS	0	0	0	0	0	0	0	42	8	0	0	0	0	3	0	0
HART	0	0	0	0	0	0	0	42	29	0	0	0	0	2	0	2
HEARD	0	0	0	0	0	0	0	66	10	0	0	0	0	2	0	1
HENRY	0	0	0	0	0	0	1	118	382	0	0	0	0	39	31	23
HOUSTON	0	0	0	0	0	0	0	146	440	0	0	1	2	38	9	7
IRWIN	0	0	0	0	0	0	0	13	39	0	0	0	0	2	7	1
JACKSON	0	0	0	0	0	0	0	86	24	0	0	0	2	3	2	0
JASPER	0	0	0	0	0	0	0	46	20	0	0	0	0	2	0	0
JEFF DAVIS	0	0	0	0	0	0	0	76	12	0	0	0	0	4	8	3
JEFFERSON	0	0	0	0	0	0	0	13	83	0	0	0	0	2	1	0
JENKINS	0	0	0	0	0	0	2	17	69	0	0	0	0	2	1	1
JOHNSON	0	0	0	0	0	0	0	25	44	0	0	0	0	1	1	1

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
BY RACE/ETHICITY FOR RECIPIENTS

JUNE 2018

COUNTY	LATINO							NON-LATINO							Other	Unknown
	White	Black	Pacific Islander / Alaskan	Asian	Native American	Other	Unknown	White	Black	Pacific Islander / Alaskan	Asian	Native American	Other	Unknown		
JONES	0	0	0	0	0	0	0	65	53	0	0	0	0	1	0	0
LAMAR	0	0	0	0	0	0	0	30	40	0	0	0	0	4	0	0
LANIER	0	0	0	0	0	0	0	27	19	0	0	0	0	4	0	0
LAURENS	0	0	0	0	0	0	0	69	170	0	0	0	0	10	15	0
LEE	0	0	0	0	0	0	1	38	32	1	0	0	0	0	4	0
LIBERTY	0	0	0	0	0	0	0	19	90	0	0	0	0	6	3	0
LINCOLN	0	0	0	0	0	0	0	17	8	0	0	2	0	1	0	0
LONG	0	0	0	0	0	0	1	20	25	0	0	0	0	2	7	3
LOWNDES	5	0	0	0	0	0	0	83	360	0	0	0	0	15	14	7
LUMPKIN	0	0	0	0	0	0	0	72	3	0	0	0	1	7	3	0
MACON	0	0	0	0	0	0	0	13	45	0	0	0	0	2	1	1
MADISON	0	0	0	0	0	0	0	104	43	0	0	0	0	4	8	10
MARION	0	0	0	0	0	0	0	45	34	0	0	0	0	0	4	2
MCDUFFIE	0	0	0	0	0	0	5	63	117	0	0	0	0	10	0	0
MCINTOSH	0	0	0	0	0	0	0	9	7	0	0	1	0	2	0	0
MERIWETHER	0	0	0	0	0	0	0	77	78	0	0	0	0	4	3	2
MILLER	0	0	0	0	0	0	0	20	17	0	0	0	0	3	0	0
MITCHELL	0	0	0	0	0	0	0	28	114	0	0	0	0	3	0	0
MONROE	0	0	0	0	0	0	0	53	43	0	0	0	0	4	2	1
MONTGOMERY	0	0	0	0	0	0	0	13	8	0	0	0	0	1	4	0
MORGAN	0	0	0	0	0	0	0	16	11	0	0	0	0	1	0	0
MURRAY	0	0	0	0	0	0	0	157	10	0	0	0	0	17	9	0
MUSCOGEE	2	0	0	0	0	0	2	209	1,136	0	0	5	4	98	49	32
NEWTON	0	0	0	0	0	0	0	140	326	0	0	1	0	17	9	5
OCONEE	0	0	0	0	0	0	0	15	2	0	0	0	0	0	3	0
OGLETHORPE	0	0	0	0	0	0	0	33	12	0	0	0	0	0	0	0
PAULDING	0	0	0	0	0	0	1	144	123	0	0	1	0	18	13	4
PEACH	0	0	0	0	0	0	0	36	86	0	0	0	0	3	1	0
PICKENS	0	0	0	0	0	0	0	54	3	0	0	0	0	2	6	0
PIERCE	0	0	0	0	0	0	0	65	24	0	0	0	0	12	0	1
PIKE	0	0	0	0	0	0	0	49	12	0	0	0	0	1	0	2
POLK	0	0	0	0	0	0	0	117	64	0	1	0	0	8	20	1
PULASKI	0	0	0	0	0	0	0	14	35	0	0	0	0	1	1	0
PUTNAM	0	0	0	0	0	0	0	53	24	0	0	0	0	4	1	0
QUITMAN	0	0	0	0	0	0	0	2	12	0	0	0	0	0	0	0
RABUN	0	0	0	0	0	0	0	23	0	0	0	0	0	1	1	3
RANDOLPH	0	0	0	0	0	0	0	14	67	0	0	0	0	7	4	0
RICHMOND	2	1	0	0	0	0	2	217	1,005	2	0	3	0	79	18	15
ROCKDALE	0	0	0	0	0	0	1	81	203	0	0	0	0	13	20	6
SCHLEY	0	0	0	0	0	0	0	27	13	0	0	0	0	2	0	0
SCREVEN	0	0	0	0	0	0	0	29	58	0	0	0	0	4	0	0
SEMINOLE	0	0	0	0	0	0	0	22	16	0	0	0	0	4	1	0

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
BY RACE/ETHICITY FOR RECIPIENTS

JUNE 2018

COUNTY	LATINO							NON-LATINO								
	White	Black	Pacific Islander / Alaskan	Asian	Native American	Other	Unknown	White	Black	Pacific Islander / Alaskan	Asian	Native American	Other	Unknown	Other	Unknown
SPALDING	0	0	0	0	0	0	0	193	286	0	0	0	3	22	4	2
STEPHENS	0	0	0	0	0	0	0	134	31	0	0	0	0	6	13	1
STEWART	0	0	0	0	0	0	0	0	10	0	0	0	0	0	0	0
SUMTER	0	0	0	0	0	0	0	28	192	0	0	0	0	2	1	1
TALBOT	0	0	0	0	0	0	0	13	14	0	0	0	0	0	1	0
TALIAFERRO	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0
TATTNALL	1	0	0	0	0	0	0	81	57	0	0	0	0	7	3	0
TAYLOR	0	0	0	0	0	0	0	18	13	0	0	0	0	2	0	0
TELFAIR	0	0	0	0	0	0	0	33	31	0	0	0	0	1	0	0
TERRELL	0	0	0	0	0	0	0	11	67	0	0	0	0	1	0	0
THOMAS	0	0	0	0	0	0	0	63	162	0	0	0	0	12	13	0
TIFT	1	0	0	0	0	0	1	67	97	1	0	0	2	7	12	3
TOOMBS	0	0	0	0	0	0	0	59	109	0	0	0	0	6	0	3
TOWNS	0	0	0	0	0	0	0	17	0	0	0	0	0	2	6	0
TREUTLEN	0	0	0	0	0	0	0	24	13	0	0	0	0	3	0	0
TROUP	0	0	0	0	0	0	0	73	203	0	0	0	0	17	4	2
TURNER	0	0	0	0	0	0	0	6	41	0	0	0	0	3	0	0
TWIGGS	0	0	0	0	0	0	0	38	40	0	0	0	0	0	0	0
UNION	0	0	0	0	0	0	0	31	0	0	0	0	0	6	3	3
UPSON	0	0	0	0	0	0	0	62	64	0	0	0	0	3	2	2
WALKER	0	0	0	0	0	0	0	255	14	0	0	0	0	19	8	1
WALTON	0	0	0	0	0	0	0	219	146	0	0	0	1	9	16	1
WARE	0	0	0	0	0	0	0	124	123	0	0	0	0	12	9	7
WARREN	0	0	0	0	0	0	0	0	31	0	0	0	0	0	0	0
WASHINGTON	0	0	0	0	0	0	0	34	87	0	0	1	0	4	1	1
WAYNE	0	0	0	0	0	0	0	66	62	0	0	0	0	3	0	1
WEBSTER	0	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0
WHEELER	0	0	0	0	0	0	0	3	11	0	0	0	0	2	0	0
WHITE	0	0	0	0	0	0	0	54	0	0	0	0	0	1	1	0
WHITFIELD	0	0	0	0	0	0	0	164	46	0	0	1	0	3	22	3
WILCOX	0	0	0	0	0	0	0	34	22	0	0	0	0	2	0	0
WILKES	0	0	0	0	0	0	0	15	34	0	0	0	0	2	1	0
WILKINSON	0	0	0	0	0	0	0	37	28	0	0	0	0	3	1	3
WORTH	0	0	0	0	0	0	0	30	50	0	0	0	0	2	1	1
STATE TOTAL	**13**	**2**	**0**	**0**	**0**	**0**	**60**	**10,239**	**24,986**	**7**	**2**	**41**	**92**	**1680**	**1,436**	**706**

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
RECIPIENTS BY AGE

JUNE 2018

COUNTY	AGE 0-6	AGE 7-15	AGE 16-17	AGE 18-21	AGE 22-34	AGE 35-44	AGE 45-64	AGE 65+
APPLING	34	55	13	7	11	13	41	6
ATKINSON	0	12	0	2	1	3	6	2
BACON	11	24	4	2	4	1	18	1
BAKER	2	0	0	0	0	0	1	0
BALDWIN	35	80	8	20	21	11	40	9
BANKS	8	10	6	1	4	2	10	6
BARROW	27	54	13	9	12	13	25	6
BARTOW	33	76	24	21	7	15	53	11
BEN HILL	7	40	7	4	8	7	17	5
BERRIEN	17	31	4	4	2	6	24	6
BIBB	286	481	77	90	115	81	202	43
BLECKLEY	6	23	2	2	2	3	10	1
BRANTLEY	29	58	14	12	4	7	42	8
BROOKS	21	43	8	7	3	7	24	2
BRYAN	11	26	3	8	3	7	14	0
BULLOCH	47	102	28	29	17	19	56	15
BURKE	34	61	10	10	16	9	27	6
BUTTS	20	27	4	1	4	7	15	10
CALHOUN	3	7	2	3	1	2	4	1
CAMDEN	16	30	9	5	6	8	18	3
CANDLER	27	58	15	14	7	12	24	6
CARROLL	86	192	26	24	33	33	95	27
CATOOSA	26	72	13	14	10	8	59	14
CHARLTON	3	15	1	0	1	3	10	2
CHATHAM	85	195	41	38	25	34	121	21
CHATTAHOOCHEE	1	9	1	1	0	1	4	0
CHATTOOGA	18	33	11	14	9	2	32	3
CHEROKEE	30	61	7	13	12	10	22	10
CLARKE	46	110	11	15	27	11	41	5
CLAY	2	5	3	4	0	1	5	3
CLAYTON	340	601	112	127	146	92	281	76
CLINCH	6	14	4	2	1	3	10	3
COBB	207	389	68	85	92	76	185	59
COFFEE	34	81	19	22	14	16	50	12
COLQUITT	63	98	15	23	21	18	48	15
COLUMBIA	54	93	12	13	14	15	64	7
COOK	13	26	5	4	6	4	10	5
COWETA	38	109	24	10	27	10	64	16
CRAWFORD	5	6	1	2	1	0	7	1
CRISP	26	48	7	5	19	6	22	4
DADE	1	9	0	3	3	1	4	4
DAWSON	12	23	1	3	3	2	11	3
DECATUR	24	49	10	14	14	11	17	10
DEKALB	981	1,152	187	214	549	198	430	94
DODGE	25	48	6	11	8	9	26	6
DOOLY	10	10	3	3	4	2	8	2

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
RECIPIENTS BY AGE
JUNE 2018

COUNTY	AGE 0-6	AGE 7-15	AGE 16-17	AGE 18-21	AGE 22-34	AGE 35-44	AGE 45-64	AGE 65+
DOUGHERTY	137	295	46	45	70	61	120	37
DOUGLAS	82	172	26	35	32	32	95	34
EARLY	9	23	2	9	7	4	12	6
ECHOLS	6	8	1	0	5	1	4	0
EFFINGHAM	10	27	7	4	5	5	12	4
ELBERT	14	23	7	2	2	7	23	4
EMANUEL	12	34	8	6	4	9	18	3
EVANS	12	33	1	0	4	4	9	4
FANNIN	13	24	3	6	5	4	19	2
FAYETTE	28	28	7	5	4	4	25	11
FLOYD	66	136	32	18	26	23	86	13
FORSYTH	16	32	5	3	4	3	20	4
FRANKLIN	8	22	4	3	4	3	14	7
FULTON	1,656	1,700	323	418	830	334	572	163
GILMER	20	27	5	4	2	4	17	11
GLASCOCK	1	5	0	0	2	0	2	1
GLYNN	49	98	17	20	17	12	48	24
GORDON	36	49	8	4	10	12	35	11
GRADY	14	42	6	5	5	6	22	9
GREENE	3	8	0	1	1	0	8	2
GWINNETT	209	358	77	91	78	64	195	44
HABERSHAM	20	34	5	4	9	3	19	2
HALL	53	142	25	25	18	26	89	18
HANCOCK	8	15	2	0	2	3	5	2
HARALSON	8	35	11	3	3	2	19	9
HARRIS	8	15	5	4	0	3	13	5
HART	15	24	3	2	4	7	15	5
HEARD	8	26	7	9	4	2	20	3
HENRY	121	174	40	42	54	33	98	32
HOUSTON	108	232	39	43	42	47	102	30
IRWIN	9	24	4	4	3	4	12	2
JACKSON	18	37	3	9	5	4	35	6
JASPER	9	25	2	7	4	5	13	3
JEFF DAVIS	21	28	7	4	6	5	23	9
JEFFERSON	23	30	3	7	19	5	10	2
JENKINS	11	34	7	3	12	6	12	7
JOHNSON	11	22	5	9	5	6	11	3
JONES	18	38	7	9	4	3	33	7
LAMAR	11	25	9	2	3	3	16	5
LANIER	9	17	3	4	1	3	9	4
LAURENS	45	86	18	16	18	13	57	11
LEE	14	28	5	2	4	0	19	4
LIBERTY	16	36	5	13	13	5	29	1
LINCOLN	5	11	1	0	2	3	6	0
LONG	5	20	4	8	4	6	7	4
LOWNDES	63	183	37	31	29	24	95	22

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
RECIPIENTS BY AGE

JUNE 2018

COUNTY	AGE 0-6	AGE 7-15	AGE 16-17	AGE 18-21	AGE 22-34	AGE 35-44	AGE 45-64	AGE 65+
LUMPKIN	10	26	4	5	7	6	21	7
MACON	9	18	3	9	3	3	14	3
MADISON	32	58	6	9	12	9	30	13
MARION	10	32	2	6	8	3	17	7
MCDUFFIE	37	68	8	15	18	8	36	5
MCINTOSH	0	7	3	1	0	2	6	0
MERIWETHER	25	56	11	13	8	5	32	14
MILLER	3	16	5	4	2	2	7	1
MITCHELL	18	57	5	11	9	8	31	6
MONROE	8	33	12	9	3	7	24	7
MONTGOMERY	1	7	5	2	0	1	7	3
MORGAN	3	10	3	0	0	1	10	1
MURRAY	27	58	15	15	9	16	39	14
MUSCOGEE	408	480	82	89	175	79	195	29
NEWTON	80	158	47	30	35	43	78	27
OCONEE	6	3	1	2	2	0	5	1
OGLETHORPE	4	13	5	6	1	4	11	1
PAULDING	59	97	18	18	11	23	66	12
PEACH	27	42	7	6	10	5	19	10
PICKENS	8	20	4	9	1	3	15	5
PIERCE	17	30	10	8	3	5	26	3
PIKE	13	18	5	2	4	3	13	6
POLK	34	76	16	13	11	13	36	12
PULASKI	5	15	4	6	3	2	11	5
PUTNAM	10	29	1	8	3	8	19	4
QUITMAN	2	3	0	3	1	0	5	0
RABUN	1	11	4	2	0	3	6	1
RANDOLPH	32	24	7	2	13	7	5	2
RICHMOND	291	436	79	85	135	81	202	35
ROCKDALE	52	106	23	25	24	13	61	20
SCHLEY	3	16	1	4	2	2	11	3
SCREVEN	17	29	4	6	6	7	21	1
SEMINOLE	5	17	3	2	2	2	7	5
SPALDING	93	171	32	37	27	28	93	29
STEPHENS	20	66	19	17	9	13	32	9
STEWART	0	4	1	1	0	1	2	1
SUMTER	29	67	18	26	21	12	33	18
TALBOT	4	14	1	2	0	2	4	1
TALIAFERRO	1	1	0	1	0	0	1	0
TATTNALL	29	45	14	13	9	7	27	5
TAYLOR	6	10	3	2	1	0	6	5
TELFAIR	9	23	5	3	2	5	11	7
TERRELL	9	27	4	12	3	4	15	5
THOMAS	40	80	23	18	16	18	45	10
TIFT	36	60	14	12	9	12	35	13
TOOMBS	28	54	12	15	9	11	38	10

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
RECIPIENTS BY AGE
JUNE 2018

COUNTY	AGE 0-6	AGE 7-15	AGE 16-17	AGE 18-21	AGE 22-34	AGE 35-44	AGE 45-64	AGE 65+
TOWNS	4	9	0	1	1	1	7	2
TREUTLEN	3	14	5	2	1	2	10	3
TROUP	59	116	13	18	16	14	51	12
TURNER	11	17	3	6	4	1	4	4
TWIGGS	6	27	8	5	7	1	17	7
UNION	10	13	2	2	5	2	7	2
UPSON	25	36	16	8	8	7	23	10
WALKER	54	99	19	10	13	11	76	15
WALTON	48	129	35	22	20	18	86	34
WARE	45	96	23	9	9	22	64	7
WARREN	11	10	2	1	1	0	3	3
WASHINGTON	22	35	10	12	7	9	28	5
WAYNE	15	57	8	6	5	7	26	8
WEBSTER	0	1	1	0	0	1	1	0
WHEELER	3	8	0	0	1	1	3	0
WHITE	15	14	2	1	0	2	16	6
WHITFIELD	28	83	23	12	16	18	39	20
WILCOX	5	22	2	3	4	3	16	3
WILKES	9	21	4	4	3	3	7	1
WILKINSON	10	25	9	3	4	3	15	3
WORTH	9	32	3	7	6	5	15	7
STATE TOTAL	**7,801**	**12,786**	**2,418**	**2,570**	**3,430**	**2,230**	**6,362**	**1,667**

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

UNDUPLICATED CASES SFY 2018

COUNTY	Number of Unduplicated Cases	Number who have been on TANF for:			
		1-3 Months	4-7 Months	8-11 Months	12 Months
APPLING	191	48	52	48	43
ATKINSON	54	12	14	15	13
BACON	91	22	24	23	22
BAKER	6	2	1	1	2
BALDWIN	280	70	72	75	63
BANKS	52	14	17	14	7
BARROW	169	48	51	46	24
BARTOW	314	69	82	88	75
BEN HILL	97	26	25	24	22
BERRIEN	96	26	27	26	17
BIBB	1,704	432	422	439	411
BLECKLEY	62	13	17	17	15
BRANTLEY	171	46	47	42	36
BROOKS	119	28	30	27	34
BRYAN	81	21	24	21	15
BULLOCH	361	88	91	100	82
BURKE	225	53	54	62	56
BUTTS	114	26	29	31	28
CALHOUN	36	8	10	10	8
CAMDEN	149	33	38	45	33
CANDLER	147	37	36	41	33
CARROLL	678	167	186	179	146
CATOOSA	257	65	67	65	60
CHARLTON	55	11	14	16	14
CHATHAM	671	182	178	167	144
CHATTAHOOCHEE	21	7	8	3	3
CHATTOOGA	160	42	39	40	39
CHEROKEE	224	51	60	61	52
CLARKE	362	93	93	106	70
CLAY	33	8	8	9	8
CLAYTON	2,304	579	614	601	510
CLINCH	48	12	13	13	10
COBB	1,613	381	446	436	350
COFFEE	274	73	74	72	55
COLQUITT	352	88	86	96	82
COLUMBIA	295	82	75	73	65
COOK	78	18	22	21	17
COWETA	450	107	116	121	106
CRAWFORD	32	8	5	10	9
CRISP	160	45	42	41	32
DADE	36	9	9	10	8
DAWSON	60	15	15	18	12
DECATUR	192	54	53	51	34

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

UNDUPLICATED CASES SFY 2018

COUNTY	Number of Unduplicated Cases	Number who have been on TANF for:			
		1-3 Months	4-7 Months	8-11 Months	12 Months
DEKALB	4,721	1,290	1,305	1,240	886
DODGE	157	41	42	39	35
DOOLY	77	16	24	22	15
DOUGHERTY	1,089	275	297	290	227
DOUGLAS	730	167	198	195	170
EARLY	73	21	22	22	8
ECHOLS	30	9	8	7	6
EFFINGHAM	96	24	26	23	23
ELBERT	135	31	36	39	29
EMANUEL	145	30	38	38	39
EVANS	83	20	23	21	19
FANNIN	55	18	15	12	10
FAYETTE	181	43	48	50	40
FLOYD	454	117	122	113	102
FORSYTH	105	29	30	29	17
FRANKLIN	79	22	24	20	13
FULTON	7,377	1,907	1,950	1,964	1,556
GILMER	71	22	21	15	13
GLASCOCK	11	3	3	3	2
GLYNN	393	87	98	101	107
GORDON	212	55	55	57	45
GRADY	107	32	29	31	15
GREENE	35	8	9	12	6
GWINNETT	1,488	345	398	419	326
HABERSHAM	81	24	24	23	10
HALL	525	120	131	149	125
HANCOCK	42	13	11	12	6
HARALSON	118	29	35	27	27
HARRIS	80	19	18	25	18
HART	83	21	20	23	19
HEARD	103	25	28	25	25
HENRY	825	215	216	218	176
HOUSTON	891	212	219	236	224
IRWIN	60	17	15	15	13
JACKSON	138	40	40	41	17
JASPER	73	18	20	21	14
JEFF DAVIS	139	34	37	36	32
JEFFERSON	109	32	30	27	20
JENKINS	109	32	27	25	25
JOHNSON	88	24	24	21	19
JONES	161	37	43	43	38
LAMAR	120	24	30	33	33
LANIER	46	14	13	12	7

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

UNDUPLICATED CASES SFY 2018

COUNTY	Number of Unduplicated Cases	Number who have been on TANF for:			
		1-3 Months	4-7 Months	8-11 Months	12 Months
LAURENS	366	87	100	98	81
LEE	94	23	23	24	24
LIBERTY	189	42	51	52	44
LINCOLN	53	14	14	13	12
LONG	68	17	18	19	14
LOWNDES	587	144	154	151	138
LUMPKIN	111	27	30	31	23
MACON	87	22	24	22	19
MADISON	160	46	43	44	27
MARION	105	22	21	29	33
MCDUFFIE	227	59	60	60	48
MCINTOSH	34	8	10	10	6
MERIWETHER	196	47	50	53	46
MILLER	35	11	9	9	6
MITCHELL	166	46	44	40	36
MONROE	122	31	30	31	30
MONTGOMERY	39	8	11	11	9
MORGAN	46	13	15	12	6
MURRAY	190	49	49	50	42
MUSCOGEE	1,857	498	500	474	385
NEWTON	668	159	175	189	145
OCONEE	24	6	6	7	5
OGLETHORPE	61	16	18	20	7
PAULDING	392	100	113	100	79
PEACH	166	46	43	42	35
PICKENS	106	24	27	29	26
PIERCE	133	33	35	35	30
PIKE	82	22	24	18	18
POLK	264	67	71	67	59
PULASKI	79	20	21	20	18
PUTNAM	133	28	36	37	32
QUITMAN	27	3	7	10	7
RABUN	50	9	14	15	12
RANDOLPH	103	29	31	27	16
RICHMOND	1,761	446	461	449	405
ROCKDALE	440	107	121	124	88
SCHLEY	58	16	13	15	14
SCREVEN	128	30	34	39	25
SEMINOLE	36	11	11	10	4
SPALDING	662	166	176	169	151
STEPHENS	286	56	62	72	96
STEWART	17	5	5	4	3
SUMTER	318	78	82	82	76

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

UNDUPLICATED CASES SFY 2018

COUNTY	Number of Unduplicated Cases	Number who have been on TANF for:			
		1-3 Months	4-7 Months	8-11 Months	12 Months
TALBOT	26	6	7	7	6
TALIAFERRO	11	2	3	3	3
TATTNALL	161	44	46	38	33
TAYLOR	49	11	13	13	12
TELFAIR	83	21	22	23	17
TERRELL	83	23	23	21	16
THOMAS	392	76	78	82	156
TIFT	255	57	65	61	72
TOOMBS	213	54	58	54	47
TOWNS	28	7	8	7	6
TREUTLEN	74	13	13	15	33
TROUP	408	101	110	108	89
TURNER	64	14	16	19	15
TWIGGS	99	28	27	25	19
UNION	37	12	8	9	8
UPSON	177	48	47	44	38
WALKER	312	85	81	75	71
WALTON	750	145	148	160	297
WARE	305	82	89	82	52
WARREN	41	10	10	11	10
WASHINGTON	159	40	40	41	38
WAYNE	187	42	48	54	43
WEBSTER	9	2	3	2	2
WHEELER	27	7	7	6	7
WHITE	62	18	20	21	3
WHITFIELD	291	72	78	75	66
WILCOX	66	18	17	17	14
WILKES	55	17	13	14	11
WILKINSON	77	20	18	21	18
WORTH	102	27	30	30	15
STATE TOTAL	**49,898**	**12,574**	**13,176**	**13,129**	**11,019**

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

FORMERLY FOOD STAMP

FOOD STAMPS

STATE FISCAL YEAR 2018

COUNTY	MONTHLY AVERAGE HOUSEHOLDS	MONTHLY AVERAGE RECIPIENTS	TOTAL BENEFIT DOLLARS
APPLING	1,699	3,800	$5,687,440
ATKINSON	803	1,807	$2,587,452
BACON	1,009	2,224	$3,352,285
BAKER	432	776	$1,174,241
BALDWIN	3,863	7,904	$11,940,173
BANKS	942	2,094	$2,852,715
BARROW	4,331	9,401	$13,921,763
BARTOW	6,142	13,574	$20,382,148
BEN HILL	1,961	4,029	$5,641,668
BERRIEN	1,652	3,557	$5,120,572
BIBB	18,226	37,997	$59,384,214
BLECKLEY	1,081	2,256	$3,199,512
BRANTLEY	1,667	3,736	$5,828,590
BROOKS	1,525	3,170	$4,585,679
BRYAN	1,468	3,267	$4,953,811
BULLOCH	5,322	11,603	$17,490,060
BURKE	2,752	5,796	$8,659,990
BUTTS	2,047	4,171	$6,438,565
CALHOUN	882	1,670	$2,563,210
CAMDEN	2,769	6,236	$9,688,597
CANDLER	1,175	2,603	$4,019,254
CARROLL	8,284	17,864	$27,067,849
CATOOSA	3,418	7,678	$10,945,978
CHARLTON	818	1,764	$2,398,776
CHATHAM	18,554	39,795	$61,144,869
CHATTAHOOCHEE	400	839	$1,299,402
CHATTOOGA	2,538	5,082	$7,514,215
CHEROKEE	5,311	12,181	$18,716,593
CLARKE	8,313	16,716	$25,389,841
CLAY	532	1,004	$1,436,568
CLAYTON	28,353	66,424	$105,320,387
CLINCH	788	1,696	$2,383,570
COBB	24,670	55,479	$86,226,635
COFFEE	3,627	8,263	$12,472,720
COLQUITT	4,977	10,667	$16,091,284
COLUMBIA	3,626	8,620	$12,900,657
COOK	1,814	3,916	$5,786,065
COWETA	5,588	12,654	$19,049,875
CRAWFORD	1,009	1,992	$2,979,705
CRISP	3,142	6,194	$9,305,884
DADE	775	1,586	$2,160,515
DAWSON	961	2,062	$3,203,715
DECATUR	3,928	8,074	$12,045,432
DEKALB	70,577	138,015	$206,715,522
DODGE	2,129	4,306	$6,321,585

FOOD STAMPS

STATE FISCAL YEAR 2018

COUNTY	MONTHLY AVERAGE HOUSEHOLDS	MONTHLY AVERAGE RECIPIENTS	TOTAL BENEFIT DOLLARS
DOOLY	1,206	2,316	$3,457,243
DOUGHERTY	13,868	28,130	$44,239,197
DOUGLAS	8,833	20,635	$32,190,219
EARLY	1,608	3,340	$4,743,921
ECHOLS	297	756	$1,178,229
EFFINGHAM	2,438	5,665	$8,545,189
ELBERT	2,221	4,406	$6,308,522
EMANUEL	2,792	6,040	$9,496,929
EVANS	1,199	2,634	$4,200,416
FANNIN	1,452	3,076	$4,234,277
FAYETTE	2,354	5,284	$8,097,754
FLOYD	7,667	15,839	$23,613,751
FORSYTH	2,816	6,375	$9,880,774
FRANKLIN	1,815	3,832	$5,494,971
FULTON	73,927	149,521	$240,115,092
GILMER	1,723	3,930	$5,570,409
GLASCOCK	226	466	$681,558
GLYNN	6,215	13,271	$20,765,521
GORDON	3,506	7,699	$11,072,569
GRADY	2,389	4,932	$7,042,459
GREENE	1,326	2,707	$3,953,707
GWINNETT	31,790	79,600	$123,876,623
HABERSHAM	2,379	5,312	$7,960,503
HALL	8,391	19,727	$30,440,141
HANCOCK	1,007	1,898	$2,900,777
HARALSON	2,618	5,471	$8,147,507
HARRIS	1,175	2,347	$3,504,814
HART	1,995	4,060	$5,825,042
HEARD	1,038	2,258	$3,262,344
HENRY	11,748	27,389	$42,838,481
HOUSTON	9,576	21,384	$32,124,741
IRWIN	862	1,829	$2,724,481
JACKSON	2,948	6,781	$10,162,067
JASPER	1,142	2,487	$3,789,670
JEFF DAVIS	1,498	3,288	$5,066,983
JEFFERSON	2,015	4,129	$6,062,292
JENKINS	1,095	2,213	$3,380,837
JOHNSON	945	1,818	$2,739,015
JONES	1,749	3,688	$5,647,763
LAMAR	1,756	3,421	$5,039,046
LANIER	882	1,938	$2,909,012
LAURENS	5,912	11,919	$18,029,755
LEE	1,812	4,127	$6,522,125
LIBERTY	4,105	9,532	$14,532,116
LINCOLN	656	1,292	$1,822,072
LONG	1,233	3,117	$4,791,839

FOOD STAMPS

STATE FISCAL YEAR 2018

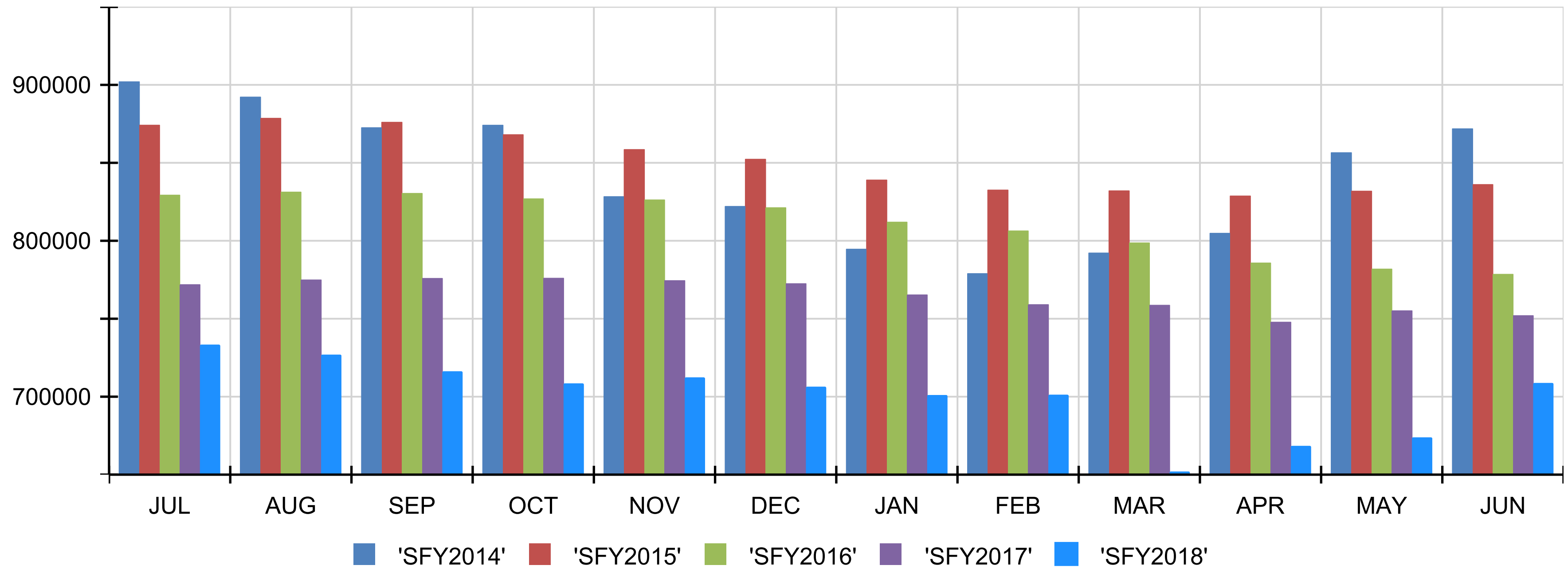
COUNTY	MONTHLY AVERAGE HOUSEHOLDS	MONTHLY AVERAGE RECIPIENTS	TOTAL BENEFIT DOLLARS
LOWNDES	9,086	20,774	$31,753,090
LUMPKIN	1,574	3,251	$4,784,972
MACON	1,474	2,672	$4,043,188
MADISON	1,833	4,132	$5,786,925
MARION	884	1,794	$2,685,615
MCDUFFIE	2,582	5,604	$8,152,913
MCINTOSH	1,079	2,069	$3,160,470
MERIWETHER	2,205	4,341	$6,441,203
MILLER	739	1,430	$2,040,415
MITCHELL	2,916	5,902	$8,894,121
MONROE	1,626	3,247	$4,732,574
MONTGOMERY	747	1,487	$2,157,732
MORGAN	1,315	2,711	$4,124,215
MURRAY	3,133	6,849	$9,742,766
MUSCOGEE	19,832	40,563	$62,833,983
NEWTON	8,922	20,549	$32,434,114
OCONEE	674	1,478	$2,178,930
OGLETHORPE	842	1,850	$2,718,996
PAULDING	5,915	14,419	$21,548,669
PEACH	2,781	5,397	$8,580,988
PICKENS	1,596	3,442	$5,128,155
PIERCE	1,667	3,516	$5,222,367
PIKE	956	2,000	$2,987,725
POLK	4,264	8,981	$13,372,658
PULASKI	877	1,763	$2,636,031
PUTNAM	1,810	3,743	$5,639,539
QUITMAN	348	643	$922,910
RABUN	930	1,959	$2,711,096
RANDOLPH	1,075	2,091	$3,092,000
RICHMOND	20,232	44,080	$68,204,991
ROCKDALE	7,005	16,401	$26,840,566
SCHLEY	392	817	$1,180,092
SCREVEN	1,573	3,302	$5,106,417
SEMINOLE	1,175	2,320	$3,361,860
SPALDING	7,297	14,970	$23,160,500
STEPHENS	2,820	5,714	$8,305,842
STEWART	700	1,223	$1,896,387
SUMTER	4,340	8,606	$13,053,627
TALBOT	760	1,308	$1,891,117
TALIAFERRO	234	426	$618,332
TATTNALL	1,825	4,049	$5,953,208
TAYLOR	999	1,864	$2,709,833
TELFAIR	1,399	2,848	$4,354,758
TERRELL	1,646	3,222	$4,847,911
THOMAS	5,063	10,144	$14,773,374
TIFT	4,196	8,977	$13,578,279

FOOD STAMPS

STATE FISCAL YEAR 2018

COUNTY	MONTHLY AVERAGE HOUSEHOLDS	MONTHLY AVERAGE RECIPIENTS	TOTAL BENEFIT DOLLARS
TOOMBS	3,035	6,602	$9,631,090
TOWNS	559	1,063	$1,514,857
TREUTLEN	803	1,593	$2,257,798
TROUP	5,690	12,518	$18,607,294
TURNER	1,115	2,232	$3,323,180
TWIGGS	982	1,798	$2,696,604
UNION	1,083	2,266	$3,112,645
UPSON	3,506	6,653	$9,977,114
WALKER	4,266	9,322	$13,270,674
WALTON	5,156	11,365	$16,756,122
WARE	4,291	8,973	$13,297,626
WARREN	724	1,434	$2,133,781
WASHINGTON	2,185	4,474	$6,750,730
WAYNE	2,678	5,971	$9,078,782
WEBSTER	292	555	$881,656
WHEELER	579	1,247	$1,873,004
WHITE	1,432	3,202	$4,771,146
WHITFIELD	5,712	12,779	$17,556,069
WILCOX	855	1,709	$2,603,593
WILKES	1,145	2,232	$3,296,010
WILKINSON	1,041	2,072	$3,129,267
WORTH	2,165	4,358	$6,725,600
STATE TOTAL	**700,713**	**1,499,768**	**$2,290,922,430**

Georgia's Food Stamp Households



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2014	901,963	892,156	872,518	874,110	828,293	822,027	794,600	778,913	792,133	804,798	856,465	871,803
SFY2015	874,132	878,554	875,992	868,027	858,497	852,279	838,949	832,518	832,014	828,707	831,818	836,051
SFY2016	829,262	831,209	830,375	826,889	826,196	821,182	811,941	806,306	798,628	785,736	781,834	778,478
SFY2017	771,834	774,861	775,850	775,959	774,419	772,462	765,272	759,013	758,631	747,775	755,080	751,950
SFY2018	733,363	726,973	716,258	708,530	712,341	706,380	701,060	701,243	651,251	668,465	673,891	708,804

FOOD STAMP RECIPIENTS BY RACE AND ETHNICITY

JUNE 2018

COUNTY	LATINO							NON-LATINO							Other	Unknown
	Asian	Black	Native American	Pacific Islander / Alaskan	White	Other	Unknown	Asian	Black	Native American	Pacific Islander / Alaskan	White	Other	Unknown		
APPLING	0	0	0	0	4	0	8	1	1,298	0	0	2,126	3	138	330	35
ATKINSON	0	0	0	0	4	0	10	0	467	1	0	947	0	67	315	22
BACON	0	0	0	0	0	0	23	0	855	0	0	1,209	3	129	171	16
BAKER	0	0	0	0	0	0	1	0	475	0	0	266	1	20	23	10
BALDWIN	0	0	0	0	3	0	6	0	5,380	3	1	2,118	56	251	122	69
BANKS	1	0	0	0	1	0	6	0	106	0	2	1,763	5	54	93	24
BARROW	0	0	0	0	7	0	51	9	2,341	4	4	5,577	164	392	926	124
BARTOW	0	1	2	0	33	0	43	3	2,461	11	2	9,043	63	758	1,043	134
BEN HILL	0	0	0	0	3	0	5	0	2,238	4	0	1,506	6	149	113	36
BERRIEN	0	0	0	0	4	0	10	0	685	0	0	2,547	1	158	130	28
BIBB	0	0	0	0	9	0	40	0	30,719	20	4	5,275	120	1,505	660	296
BLECKLEY	0	0	0	0	2	0	11	0	1,115	0	0	1,016	15	101	33	26
BRANTLEY	0	0	0	0	0	0	7	0	225	4	1	3,319	4	153	50	39
BROOKS	0	0	0	0	1	0	6	0	1,984	1	2	1,002	1	156	132	19
BRYAN	0	0	0	0	3	0	8	4	1,123	10	1	1,736	33	215	78	56
BULLOCH	0	1	0	0	6	0	15	3	6,745	3	3	4,032	38	712	416	153
BURKE	0	0	0	0	1	0	14	0	4,013	3	1	1,437	11	178	75	97
BUTTS	0	0	0	0	0	0	6	1	1,770	3	2	2,061	1	214	90	53
CALHOUN	0	0	0	0	0	0	3	0	1,220	0	0	321	1	66	54	9
CAMDEN	0	0	0	0	0	0	34	1	2,541	8	4	3,007	26	516	313	87
CANDLER	0	0	0	0	3	0	22	0	1,120	0	0	1,149	10	92	329	32
CARROLL	0	1	0	0	7	0	43	1	5,787	28	2	9,958	80	770	1,141	301
CATOOSA	0	0	0	0	3	0	7	0	278	8	1	6,365	48	427	168	229
CHARLTON	0	0	0	0	0	0	3	0	698	0	0	970	6	98	31	22
CHATHAM	0	1	0	0	21	0	186	1	30,434	38	23	6,735	295	1,745	1,529	698
CHATTAHOOCHEE	0	0	0	0	0	0	3	0	342	0	1	402	3	57	21	7
CHATTOOGA	0	1	0	0	7	0	5	0	562	3	0	4,084	10	244	215	39
CHEROKEE	0	1	0	0	15	0	72	5	1,951	16	7	6,648	199	612	2,775	240
CLARKE	1	0	0	0	14	0	57	4	11,184	15	2	3,455	95	658	1,686	227
CLAY	0	0	0	0	0	0	0	0	883	0	1	98	0	37	2	10
CLAYTON	0	6	0	0	59	2	281	4	49,613	54	18	5,541	1,187	3,687	6,264	1,434
CLINCH	0	0	0	0	0	0	1	0	876	2	0	728	2	78	28	13
COBB	1	9	0	0	134	0	436	9	29,283	77	22	10,821	809	3,663	9,968	1,505
COFFEE	0	0	1	0	6	0	10	7	3,491	7	1	3,854	15	329	615	139
COLQUITT	2	0	0	0	41	0	77	1	4,395	9	1	4,157	7	414	1,663	124
COLUMBIA	0	0	1	0	6	0	56	2	2,985	5	11	4,282	109	477	504	161
COOK	0	0	0	0	4	0	8	1	1,807	1	0	1,752	6	139	154	112
COWETA	0	1	0	0	16	0	69	2	5,746	11	6	5,193	58	669	740	215
CRAWFORD	0	0	0	0	4	0	0	0	660	0	2	1,205	1	78	22	22
CRISP	0	0	0	0	6	0	5	0	4,460	7	1	1,457	22	241	110	43
DADE	0	0	0	0	0	0	0	0	22	2	0	1,449	2	105	12	29

FOOD STAMP RECIPIENTS BY RACE AND ETHNICITY

JUNE 2018

COUNTY	LATINO							NON-LATINO							Other	Unknown
	Asian	Black	Native American	Pacific Islander / Alaskan	White	Other	Unknown	Asian	Black	Native American	Pacific Islander / Alaskan	White	Other	Unknown		
DAWSON	0	0	0	0	0	0	4	0	78	6	0	1,784	10	86	89	26
DECATUR	0	0	0	0	28	0	43	2	5,606	6	2	2,085	33	393	327	166
DEKALB	1	11	4	1	61	3	300	36	97,349	186	84	9,072	7,685	4,694	10,740	2,161
DODGE	0	1	0	0	2	0	4	0	2,033	2	2	2,162	9	177	85	42
DOOLY	0	0	0	0	4	0	2	0	1,652	1	0	517	8	99	170	14
DOUGHERTY	0	0	0	0	5	0	23	3	23,802	14	4	2,872	41	1,001	506	254
DOUGLAS	0	0	0	0	21	0	82	6	11,596	18	16	5,379	85	1,270	1,928	406
EARLY	0	0	0	0	0	0	2	0	2,644	2	1	562	5	103	54	37
ECHOLS	0	0	0	0	3	0	11	0	50	1	0	340	0	23	296	4
EFFINGHAM	0	0	0	0	0	0	37	0	1,895	3	0	3,346	15	337	216	119
ELBERT	0	0	0	0	3	0	1	0	2,043	4	4	1,946	8	121	149	45
EMANUEL	0	0	0	0	5	0	5	1	3,229	2	0	2,381	4	173	266	49
EVANS	0	0	0	0	52	0	20	0	1,312	0	0	958	2	111	340	24
FANNIN	0	0	0	0	1	0	3	0	63	2	0	2,714	1	172	94	41
FAYETTE	0	1	0	1	16	0	33	0	2,303	8	6	1,815	129	258	487	145
FLOYD	0	0	0	0	24	0	26	4	4,687	6	2	8,545	109	656	1,372	143
FORSYTH	0	0	0	0	4	0	33	5	611	4	8	3,849	340	303	1,213	128
FRANKLIN	0	0	0	0	3	0	5	0	754	2	1	2,898	16	124	154	57
FULTON	0	11	0	0	68	1	324	3	127,789	147	60	7,409	1,173	5,530	7,917	2,310
GILMER	0	0	0	0	5	0	20	0	65	2	0	2,884	11	147	728	39
GLASCOCK	0	0	0	0	0	0	0	0	82	0	0	351	0	10	5	9
GLYNN	0	0	0	0	12	0	32	1	7,066	9	5	4,804	47	533	885	124
GORDON	0	0	0	0	15	0	39	2	502	8	0	5,700	22	306	905	86
GRADY	0	0	0	0	17	0	28	4	2,430	5	0	1,838	3	171	508	41
GREENE	0	0	0	0	0	0	1	0	1,837	2	0	648	5	69	133	29
GWINNETT	0	10	0	0	110	2	582	55	33,454	110	76	14,194	6,279	3,530	20,428	1,431
HABERSHAM	0	0	0	0	10	0	33	2	279	7	0	3,859	58	164	898	116
HALL	2	4	0	2	194	0	174	4	3,173	21	4	9,190	206	650	6,033	251
HANCOCK	0	0	0	0	0	0	0	0	1,733	0	0	178	0	55	4	9
HARALSON	0	0	0	0	0	0	2	0	409	3	1	4,508	7	265	70	48
HARRIS	0	0	0	0	0	0	10	0	868	5	0	1,293	9	135	31	35
HART	0	0	0	0	0	0	1	1	1,386	1	1	2,260	25	170	109	64
HEARD	0	0	0	0	0	0	3	0	301	0	0	1,780	4	120	32	18
HENRY	0	4	0	0	17	0	161	6	16,213	33	13	6,678	451	1,986	1,674	732
HOUSTON	0	0	0	0	13	0	84	4	12,339	11	9	6,783	221	1,174	1,058	306
IRWIN	0	0	0	0	0	0	2	0	878	0	0	832	3	69	45	10
JACKSON	1	0	0	0	5	0	20	0	1,085	3	6	4,833	63	305	447	78
JASPER	0	0	0	0	1	0	6	0	847	1	0	1,451	2	109	76	13
JEFF DAVIS	0	1	0	0	3	0	4	0	828	1	0	2,111	6	129	303	27
JEFFERSON	0	0	1	0	1	0	4	0	3,165	0	0	796	3	134	66	37

FOOD STAMP RECIPIENTS BY RACE AND ETHNICITY

JUNE 2018

COUNTY	LATINO							NON-LATINO							Other	Unknown
	Asian	Black	Native American	Pacific Islander / Alaskan	White	Other	Unknown	Asian	Black	Native American	Pacific Islander / Alaskan	White	Other	Unknown		
JENKINS	0	0	0	0	0	0	12	1	1,348	2	0	720	3	87	56	17
JOHNSON	0	0	0	0	0	0	0	0	1,020	1	1	779	1	53	51	18
JONES	0	0	0	0	0	0	2	4	1,214	8	0	2,207	6	158	46	22
LAMAR	0	0	0	0	0	0	3	2	1,417	4	1	1,629	6	174	74	40
LANIER	0	0	0	0	0	0	1	0	674	2	5	1,035	13	117	91	23
LAURENS	0	0	0	0	6	0	14	0	7,326	4	0	4,182	17	544	244	79
LEE	0	0	0	0	0	0	4	3	1,529	6	0	2,417	40	172	77	71
LIBERTY	0	0	0	0	5	0	104	1	6,132	6	40	2,187	51	898	613	165
LINCOLN	0	0	0	0	0	0	0	0	695	3	0	535	6	43	16	13
LONG	0	2	0	0	9	0	29	0	1,065	3	5	1,439	15	252	388	36
LOWNDES	0	3	0	0	37	0	82	4	13,706	20	15	5,249	96	1,231	1,054	351
LUMPKIN	0	0	0	0	1	0	4	0	88	7	1	2,837	7	124	147	35
MACON	0	1	0	0	4	0	4	0	2,130	1	0	456	2	98	75	27
MADISON	0	0	0	0	2	0	6	0	648	1	0	3,006	119	151	248	34
MARION	0	0	0	0	2	0	6	0	793	1	0	767	7	71	120	14
MCDUFFIE	0	0	0	0	1	0	7	0	3,682	4	1	1,593	3	254	81	40
MCINTOSH	0	0	0	0	0	0	0	0	924	2	1	1,126	2	72	17	57
MERIWETHER	0	0	0	0	0	0	1	0	2,532	1	1	1,514	5	185	52	51
MILLER	0	0	0	0	1	0	2	0	817	3	0	499	0	51	17	18
MITCHELL	0	0	0	0	1	0	5	2	4,194	0	1	1,381	6	190	164	45
MONROE	0	0	0	0	0	0	9	0	1,438	1	0	1,678	3	104	52	44
MONTGOMERY	0	0	0	0	0	0	2	0	503	1	0	813	1	52	87	16
MORGAN	0	0	0	0	0	0	4	0	1,376	0	0	1,125	4	117	66	24
MURRAY	0	1	0	0	6	0	19	2	82	0	4	5,508	1	256	822	94
MUSCOGEE	0	6	0	0	11	0	163	1	29,139	48	30	7,437	186	2,112	1,910	592
NEWTON	0	3	0	0	26	0	64	1	12,880	9	2	5,729	82	979	1,064	322
OCONEE	0	0	0	0	0	0	8	3	304	4	1	911	28	60	134	33
OGLETHORPE	0	0	0	0	0	0	1	0	605	3	0	1,146	20	55	68	12
PAULDING	0	0	0	0	2	0	63	7	4,608	23	9	7,514	91	1,040	890	303
PEACH	0	0	0	0	11	0	4	0	3,779	1	0	1,264	12	165	320	67
PICKENS	0	1	0	0	0	0	8	0	75	0	0	3,059	7	121	77	54
PIERCE	0	0	0	0	0	0	6	0	612	2	1	2,643	2	196	141	40
PIKE	0	0	0	0	0	0	0	0	472	1	0	1,350	2	70	21	24
POLK	0	0	0	0	7	0	9	1	1,798	4	0	5,567	11	305	882	152
PULASKI	0	0	0	0	3	0	2	0	993	0	2	687	5	39	37	37
PUTNAM	0	0	0	0	2	0	11	0	1,788	4	0	1,603	16	145	217	54
QUITMAN	0	0	0	0	0	0	0	0	394	3	0	201	0	37	7	14
RABUN	0	0	0	0	5	0	7	0	36	5	0	1,629	2	95	128	60
RANDOLPH	0	0	0	0	0	0	0	0	1,703	3	0	315	2	66	24	19
RICHMOND	0	3	0	0	8	0	86	0	32,254	40	24	6,883	157	2,015	984	551

FOOD STAMP RECIPIENTS BY RACE AND ETHNICITY

JUNE 2018

COUNTY	LATINO							NON-LATINO							Other	Unknown
	Asian	Black	Native American	Pacific Islander / Alaskan	White	Other	Unknown	Asian	Black	Native American	Pacific Islander / Alaskan	White	Other	Unknown		
ROCKDALE	0	0	0	0	6	0	72	1	10,780	20	9	3,177	113	939	1,416	327
SCHLEY	0	0	0	0	1	0	0	0	338	0	0	396	0	24	29	11
SCREVEN	0	0	0	0	0	0	3	0	2,049	2	0	1,103	10	145	46	32
SEMINOLE	0	0	0	0	0	0	3	0	1,340	2	0	886	2	98	56	37
SPALDING	0	1	0	0	3	0	44	0	8,319	8	5	5,335	38	730	395	164
STEPHENS	0	0	0	0	0	0	4	0	1,157	3	1	4,036	10	278	192	55
STEWART	0	0	0	0	0	0	0	0	984	1	0	163	1	49	4	8
SUMTER	0	0	0	0	7	0	9	5	6,675	0	1	1,346	22	301	311	52
TALBOT	0	0	0	0	0	0	0	0	997	1	0	235	0	47	18	11
TALIAFERRO	0	0	0	0	0	0	0	0	296	0	1	88	1	11	14	6
TATTNALL	0	0	0	0	8	0	24	0	1,483	2	2	2,005	9	151	419	49
TAYLOR	0	0	0	0	0	0	4	0	1,150	0	0	668	2	74	31	13
TELFAIR	0	0	0	0	0	0	5	1	1,664	2	0	1,125	5	97	66	34
TERRELL	0	0	0	0	0	0	1	0	2,759	3	0	331	4	87	29	25
THOMAS	0	0	0	0	0	0	11	0	6,307	7	0	3,044	10	341	260	137
TIFT	0	0	0	1	19	0	51	0	5,050	3	1	2,908	20	299	1,021	115
TOOMBS	0	0	0	0	3	0	31	0	2,934	8	0	2,786	12	247	745	92
TOWNS	0	0	0	0	0	0	5	0	15	0	0	953	5	45	28	35
TREUTLEN	0	0	0	0	0	0	0	0	803	0	0	729	2	68	16	13
TROUP	0	1	0	0	4	0	19	2	7,384	16	3	4,306	35	616	286	219
TURNER	0	0	0	0	0	0	2	2	1,583	2	0	619	2	114	48	17
TWIGGS	0	0	0	0	0	0	1	0	966	1	0	715	3	63	24	15
UNION	0	0	0	0	0	0	3	0	118	1	0	1,991	6	117	57	23
UPSON	0	0	0	0	0	0	5	0	2,972	7	3	3,211	12	259	108	52
WALKER	0	0	0	0	11	0	23	0	559	8	2	7,866	9	648	149	185
WALTON	0	0	0	0	1	0	14	2	4,595	11	9	5,652	90	527	439	183
WARE	1	0	0	0	0	0	19	0	4,175	9	4	4,204	15	539	246	80
WARREN	0	0	0	0	0	0	0	0	1,149	0	0	200	2	51	11	20
WASHINGTON	0	0	0	0	0	0	0	0	3,414	2	0	912	6	166	50	24
WAYNE	0	0	0	0	2	0	10	0	2,123	2	2	3,491	9	294	255	33
WEBSTER	0	0	0	0	0	0	0	0	396	0	0	120	0	18	21	5
WHEELER	0	0	0	0	0	0	0	0	527	0	0	655	0	40	56	6
WHITE	0	0	0	0	0	0	2	0	103	6	0	2,770	2	114	79	34
WHITFIELD	1	0	0	0	29	0	135	0	807	5	1	7,415	51	477	3,487	188
WILCOX	0	0	0	0	0	0	0	0	859	0	0	791	2	62	49	13
WILKES	0	0	0	0	0	0	1	0	1,491	0	0	557	4	86	65	19
WILKINSON	0	0	0	0	0	0	1	0	1,151	1	0	830	2	102	38	17
WORTH	0	0	0	0	1	0	1	0	2,284	1	2	1,900	2	165	43	32
STATE TOTAL	**11**	**87**	**9**	**5**	**1,375**	**8**	**5,067**	**243**	**841,303**	**1,359**	**622**	**440,355**	**22,169**	**67,857**	**116,154**	**22,658**

FOOD STAMP RECIPIENTS BY AGE

JUNE 2018

COUNTY	AGE 0-6	AGE 7-15	AGE 16-17	AGE 18-21	AGE 22-34	AGE 35-44	AGE 45-64	AGE 65+
APPLING	696	954	135	202	597	387	675	297
ATKINSON	336	450	85	98	265	150	310	139
BACON	483	572	85	103	386	222	391	164
BAKER	110	148	28	38	152	75	162	83
BALDWIN	1,282	1,871	286	414	1,413	876	1,430	437
BANKS	305	416	75	86	320	206	396	251
BARROW	1,520	2,316	359	414	1,405	984	1,759	842
BARTOW	2,286	3,242	572	579	2,022	1,368	2,554	974
BEN HILL	611	885	176	208	664	416	782	318
BERRIEN	550	740	116	159	583	370	750	295
BIBB	6,902	8,918	1,500	2,010	6,434	4,012	6,556	2,316
BLECKLEY	393	466	90	118	425	254	413	160
BRANTLEY	608	784	139	196	663	406	777	229
BROOKS	539	736	116	158	497	321	628	309
BRYAN	575	696	134	159	561	369	531	242
BULLOCH	2,292	2,684	438	734	2,420	1,163	1,774	622
BURKE	1,054	1,288	256	290	883	618	979	462
BUTTS	690	877	150	203	686	432	851	312
CALHOUN	232	332	70	104	272	182	318	164
CAMDEN	1,088	1,543	274	312	1,188	729	1,045	358
CANDLER	468	699	120	155	377	268	453	217
CARROLL	3,211	4,181	708	912	2,994	1,806	3,050	1,257
CATOOSA	1,143	1,690	288	358	1,139	828	1,383	705
CHARLTON	273	388	64	97	295	180	357	174
CHATHAM	7,870	10,265	1,577	1,835	6,763	4,219	6,411	2,766
CHATTAHOOCHEE	118	178	35	66	134	109	161	35
CHATTOOGA	793	1,035	204	256	786	530	1,119	447
CHEROKEE	2,314	3,419	530	517	1,619	1,264	1,953	925
CLARKE	3,174	4,200	628	809	2,885	1,743	2,877	1,082
CLAY	129	220	42	65	160	124	175	116
CLAYTON	13,411	18,343	3,027	3,717	11,472	6,727	8,416	3,037
CLINCH	288	365	65	91	274	176	349	120
COBB	10,801	15,364	2,503	2,916	8,331	5,572	7,476	3,774
COFFEE	1,623	1,983	359	402	1,390	797	1,348	573
COLQUITT	1,913	2,832	399	516	1,562	982	1,897	790
COLUMBIA	1,443	2,176	409	444	1,290	1,006	1,314	517
COOK	664	939	150	218	630	440	649	294
COWETA	2,305	3,172	539	587	1,960	1,236	2,038	889
CRAWFORD	265	398	75	86	344	215	426	185
CRISP	1,022	1,363	224	318	1,150	682	1,122	471
DADE	220	315	48	68	253	180	347	190
DAWSON	350	455	67	90	305	222	394	200
DECATUR	1,456	1,852	314	530	1,674	895	1,446	524
DEKALB	23,205	30,649	5,119	6,592	19,944	12,574	18,604	15,701
DODGE	712	920	165	220	733	481	930	358
DOOLY	377	539	91	134	363	245	466	252

FOOD STAMP RECIPIENTS BY AGE

JUNE 2018

COUNTY	AGE 0-6	AGE 7-15	AGE 16-17	AGE 18-21	AGE 22-34	AGE 35-44	AGE 45-64	AGE 65+
DOUGHERTY	4,745	6,354	1,117	1,646	5,175	3,089	4,657	1,742
DOUGLAS	3,762	5,373	951	1,135	3,298	2,355	2,874	1,059
EARLY	492	743	162	191	566	356	582	318
ECHOLS	166	228	31	30	92	51	93	37
EFFINGHAM	1,130	1,374	251	304	1,005	638	926	340
ELBERT	673	870	132	169	701	454	884	441
EMANUEL	1,047	1,462	224	344	982	645	1,009	402
EVANS	540	725	128	154	412	253	420	187
FANNIN	439	604	107	144	441	335	671	350
FAYETTE	844	1,306	222	264	726	583	805	452
FLOYD	2,599	3,598	578	668	2,294	1,624	3,116	1,097
FORSYTH	1,133	1,669	260	260	749	629	1,032	766
FRANKLIN	658	808	144	154	631	426	824	369
FULTON	25,841	34,896	5,923	8,016	25,671	15,651	25,703	11,041
GILMER	642	973	182	150	489	386	711	368
GLASCOCK	47	106	17	30	46	54	113	44
GLYNN	2,534	3,249	496	646	2,274	1,365	2,164	790
GORDON	1,216	1,845	281	355	1,124	745	1,353	666
GRADY	919	1,213	198	253	719	441	865	437
GREENE	463	622	105	120	359	304	488	263
GWINNETT	15,484	23,545	3,898	4,049	9,835	7,605	8,834	7,011
HABERSHAM	968	1,285	206	216	774	502	917	558
HALL	3,859	5,723	952	916	2,364	1,589	2,943	1,562
HANCOCK	261	410	80	89	297	220	433	189
HARALSON	803	1,042	182	258	850	584	1,142	452
HARRIS	366	513	81	111	399	278	434	204
HART	631	850	143	180	587	423	840	364
HEARD	334	492	88	114	322	223	470	215
HENRY	4,770	7,149	1,361	1,673	4,405	3,175	3,796	1,639
HOUSTON	3,819	5,471	936	1,173	3,785	2,479	3,223	1,116
IRWIN	273	425	79	106	280	195	322	159
JACKSON	1,131	1,582	280	326	1,037	701	1,249	540
JASPER	387	597	94	124	396	261	461	186
JEFF DAVIS	632	813	147	181	553	340	538	209
JEFFERSON	688	897	161	247	705	394	733	382
JENKINS	364	466	98	105	350	233	441	189
JOHNSON	278	370	75	118	325	222	357	179
JONES	559	794	160	187	632	430	669	236
LAMAR	517	659	109	153	553	363	684	312
LANIER	294	452	80	93	307	230	349	156
LAURENS	2,050	2,634	483	717	2,208	1,351	2,206	767
LEE	666	1,042	200	271	750	521	614	255
LIBERTY	1,937	2,464	401	543	1,951	1,101	1,349	456
LINCOLN	171	263	47	63	190	147	279	151
LONG	588	847	161	158	540	350	454	145
LOWNDES	4,066	5,532	886	1,150	3,660	2,170	3,208	1,176

FOOD STAMP RECIPIENTS BY AGE

JUNE 2018

COUNTY	AGE 0-6	AGE 7-15	AGE 16-17	AGE 18-21	AGE 22-34	AGE 35-44	AGE 45-64	AGE 65+
LUMPKIN	422	675	122	133	508	348	686	357
MACON	415	518	100	185	509	289	511	271
MADISON	683	974	178	185	637	425	803	330
MARION	260	411	78	101	285	160	337	149
MCDUFFIE	934	1,354	215	339	913	571	970	370
MCINTOSH	315	393	81	108	354	244	526	180
MERIWETHER	660	874	167	181	649	460	922	429
MILLER	190	259	51	73	245	149	299	142
MITCHELL	962	1,383	225	311	938	580	1,094	496
MONROE	488	712	116	149	521	354	675	314
MONTGOMERY	191	316	56	94	194	153	323	148
MORGAN	443	580	111	123	445	281	489	244
MURRAY	1,083	1,565	252	318	991	660	1,319	607
MUSCOGEE	7,216	9,639	1,483	2,071	7,357	4,342	7,082	2,445
NEWTON	3,595	5,209	993	1,303	3,316	2,298	3,344	1,103
OCONEE	223	363	67	79	192	167	263	132
OGLETHORPE	291	403	74	105	268	222	391	156
PAULDING	2,521	3,682	625	721	2,144	1,679	2,223	955
PEACH	842	1,171	202	335	1,058	621	982	412
PICKENS	507	684	140	145	477	376	738	335
PIERCE	572	792	139	185	561	423	707	264
PIKE	282	400	80	112	285	222	395	164
POLK	1,417	2,050	364	403	1,249	920	1,667	666
PULASKI	268	403	77	80	283	171	342	181
PUTNAM	607	896	133	174	603	398	738	291
QUITMAN	89	116	21	30	114	67	142	77
RABUN	332	414	67	66	291	190	401	206
RANDOLPH	336	425	67	123	339	236	392	214
RICHMOND	7,925	10,514	1,750	2,070	7,168	4,447	6,694	2,437
ROCKDALE	3,020	4,370	802	933	2,738	1,757	2,337	903
SCHLEY	117	173	26	49	133	81	137	83
SCREVEN	544	761	115	157	560	311	627	315
SEMINOLE	334	457	83	156	441	264	482	207
SPALDING	2,465	3,343	517	802	2,636	1,559	2,778	942
STEPHENS	926	1,122	199	257	901	613	1,222	496
STEWART	147	215	34	59	190	122	300	143
SUMTER	1,330	1,905	360	537	1,501	901	1,502	693
TALBOT	155	250	37	55	191	131	317	173
TALIAFERRO	57	75	16	18	59	36	101	55
TATTNALL	724	1,027	171	192	589	383	721	345
TAYLOR	280	368	67	110	309	206	420	182
TELFAIR	493	633	104	166	468	333	569	233
TERRELL	466	672	121	172	576	342	568	322
THOMAS	1,579	2,162	377	486	1,649	1,041	1,955	868
TIFT	1,726	2,263	379	463	1,582	958	1,549	568
TOOMBS	1,239	1,717	283	360	1,013	634	1,077	535

FOOD STAMP RECIPIENTS BY AGE

JUNE 2018

COUNTY	AGE 0-6	AGE 7-15	AGE 16-17	AGE 18-21	AGE 22-34	AGE 35-44	AGE 45-64	AGE 65+
TOWNS	149	161	34	46	156	100	271	169
TREUTLEN	237	355	62	69	253	180	327	148
TROUP	2,356	3,132	521	620	2,097	1,297	1,973	895
TURNER	414	490	79	128	393	272	413	200
TWIGGS	233	320	60	77	287	175	448	188
UNION	317	445	84	99	340	256	500	275
UPSON	982	1,190	231	347	1,190	737	1,425	527
WALKER	1,530	1,945	355	431	1,521	1,031	1,824	823
WALTON	1,944	2,587	455	601	1,819	1,139	2,064	914
WARE	1,634	1,986	331	425	1,615	972	1,698	631
WARREN	216	316	54	72	228	121	280	146
WASHINGTON	721	971	172	221	749	467	889	384
WAYNE	1,050	1,401	255	312	1,030	708	1,077	388
WEBSTER	78	113	24	35	89	50	114	57
WHEELER	210	294	44	79	188	134	216	119
WHITE	473	678	119	114	484	325	613	304
WHITFIELD	2,190	3,106	535	545	1,783	1,110	2,223	1,104
WILCOX	241	359	74	97	260	202	372	171
WILKES	319	465	87	119	323	226	465	219
WILKINSON	316	474	80	128	356	233	441	114
WORTH	714	920	125	229	782	441	816	404
STATE TOTAL	**263,881**	**362,589**	**61,237**	**77,006**	**240,845**	**154,813**	**245,043**	**113,868**

MEDICAID

FAMILY MEDICAID

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CASES

COUNTY	RSM	LIM	OTHER FAMILY MEDICAID	TOTAL FAMILY MEDICAID
APPLING	1,023	344	219	1,586
ATKINSON	578	160	122	860
BACON	595	242	146	983
BAKER	146	71	41	258
BALDWIN	1,782	841	425	3,048
BANKS	637	228	162	1,027
BARROW	3,113	1,120	688	4,921
BARTOW	3,602	1,709	942	6,253
BEN HILL	1,001	443	236	1,680
BERRIEN	924	360	222	1,506
BIBB	7,477	3,950	2,380	13,807
BLECKLEY	576	203	129	908
BRANTLEY	900	461	249	1,610
BROOKS	752	318	181	1,251
BRYAN	966	356	218	1,540
BULLOCH	2,890	1,217	770	4,877
BURKE	1,217	596	346	2,159
BUTTS	966	382	220	1,568
CALHOUN	276	164	68	508
CAMDEN	1,645	724	440	2,809
CANDLER	599	235	130	964
CARROLL	3,680	1,902	1,023	6,605
CATOOSA	3,595	1,036	583	5,214
CHARLTON	439	182	87	708
CHATHAM	10,804	3,738	2,761	17,303
CHATTAHOOCHEE	104	65	21	190
CHATTOOGA	955	552	272	1,779
CHEROKEE	4,903	1,207	1,110	7,220
CLARKE	5,788	1,743	1,287	8,818
CLAY	156	72	43	271
CLAYTON	16,902	7,098	4,153	28,153
CLINCH	442	151	75	668
COBB	18,837	5,486	4,545	28,868
COFFEE	2,461	903	592	3,956
COLQUITT	2,828	1,101	658	4,587
COLUMBIA	2,938	1,085	669	4,692
COOK	941	394	235	1,570
COWETA	3,495	1,386	828	5,709
CRAWFORD	521	230	101	852
CRISP	1,072	475	297	1,844
DADE	330	120	91	541
DAWSON	612	227	162	1,001
DECATUR	1,642	693	411	2,746
DEKALB	32,705	12,059	8,665	53,429

FAMILY MEDICAID
STATE FISCAL YEAR 2018
MONTHLY AVERAGE CASES

COUNTY	RSM	LIM	OTHER FAMILY MEDICAID	TOTAL FAMILY MEDICAID
DODGE	808	409	197	1,414
DOOLY	418	157	90	665
DOUGHERTY	5,498	2,908	1,536	9,942
DOUGLAS	5,092	2,155	1,264	8,511
EARLY	522	149	85	756
ECHOLS	232	82	50	364
EFFINGHAM	1,799	718	446	2,963
ELBERT	1,221	528	304	2,053
EMANUEL	1,338	606	339	2,283
EVANS	619	268	158	1,045
FANNIN	748	223	148	1,119
FAYETTE	1,786	635	373	2,794
FLOYD	3,639	1,536	1,010	6,185
FORSYTH	2,920	723	643	4,286
FRANKLIN	936	415	230	1,581
FULTON	41,648	15,947	26,435	84,030
GILMER	1,076	266	252	1,594
GLASCOCK	112	61	28	201
GLYNN	3,537	1,398	866	5,801
GORDON	2,236	846	588	3,670
GRADY	1,439	434	311	2,184
GREENE	611	196	144	951
GWINNETT	33,824	8,450	7,089	49,363
HABERSHAM	1,496	475	422	2,393
HALL	13,053	2,301	2,247	17,601
HANCOCK	316	176	81	573
HARALSON	1,069	519	303	1,891
HARRIS	530	245	143	918
HART	1,160	465	260	1,885
HEARD	453	203	103	759
HENRY	5,032	2,169	1,331	8,532
HOUSTON	5,840	2,288	1,506	9,634
IRWIN	402	196	95	693
JACKSON	1,912	643	480	3,035
JASPER	629	242	142	1,013
JEFF DAVIS	976	340	223	1,539
JEFFERSON	896	369	220	1,485
JENKINS	434	187	108	729
JOHNSON	345	164	88	597
JONES	926	435	220	1,581
LAMAR	821	362	222	1,405
LANIER	461	180	110	751
LAURENS	2,860	1,228	698	4,786
LEE	1,178	409	221	1,808

FAMILY MEDICAID

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CASES

COUNTY	RSM	LIM	OTHER FAMILY MEDICAID	TOTAL FAMILY MEDICAID
LIBERTY	2,253	1,109	642	4,004
LINCOLN	342	136	71	549
LONG	672	357	190	1,219
LOWNDES	5,157	2,053	1,367	8,577
LUMPKIN	963	306	243	1,512
MACON	493	255	152	900
MADISON	1,099	427	284	1,810
MARION	341	176	81	598
MCDUFFIE	1,223	539	327	2,089
MCINTOSH	496	201	111	808
MERIWETHER	917	377	208	1,502
MILLER	310	157	83	550
MITCHELL	1,274	574	311	2,159
MONROE	813	343	186	1,342
MONTGOMERY	378	130	79	587
MORGAN	703	205	170	1,078
MURRAY	1,179	472	325	1,976
MUSCOGEE	7,572	3,822	2,192	13,586
NEWTON	4,363	2,268	1,253	7,884
OCONEE	483	137	94	714
OGLETHORPE	368	182	89	639
PAULDING	3,934	1,631	1,039	6,604
PEACH	1,073	526	269	1,868
PICKENS	1,001	323	217	1,541
PIERCE	925	358	216	1,499
PIKE	530	244	124	898
POLK	2,006	846	546	3,398
PULASKI	384	168	82	634
PUTNAM	947	292	183	1,422
QUITMAN	76	39	18	133
RABUN	718	141	132	991
RANDOLPH	319	216	94	629
RICHMOND	9,864	4,901	2,715	17,480
ROCKDALE	4,059	1,947	1,074	7,080
SCHLEY	196	85	47	328
SCREVEN	607	300	137	1,044
SEMINOLE	398	203	96	697
SPALDING	2,572	1,337	746	4,655
STEPHENS	1,478	602	339	2,419
STEWART	170	98	48	316
SUMTER	1,346	770	402	2,518
TALBOT	226	96	41	363
TALIAFERRO	81	34	18	133
TATTNALL	1,039	378	237	1,654

FAMILY MEDICAID

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CASES

COUNTY	RSM	LIM	OTHER FAMILY MEDICAID	TOTAL FAMILY MEDICAID
TAYLOR	297	170	108	575
TELFAIR	572	228	132	932
TERRELL	489	308	180	977
THOMAS	2,473	962	568	4,003
TIFT	2,366	707	497	3,570
TOOMBS	1,649	618	395	2,662
TOWNS	234	72	56	362
TREUTLEN	351	149	80	580
TROUP	2,752	1,155	744	4,651
TURNER	480	177	126	783
TWIGGS	334	175	81	590
UNION	734	225	169	1,128
UPSON	1,131	636	288	2,055
WALKER	2,014	1,001	539	3,554
WALTON	3,089	1,363	798	5,250
WARE	1,825	813	500	3,138
WARREN	248	108	67	423
WASHINGTON	1,048	403	205	1,656
WAYNE	1,696	718	340	2,754
WEBSTER	104	40	21	165
WHEELER	226	113	62	401
WHITE	785	239	163	1,187
WHITFIELD	4,322	1,077	1,028	6,427
WILCOX	315	193	86	594
WILKES	475	198	111	784
WILKINSON	449	198	117	764
WORTH	836	390	212	1,438
STATE TOTAL	**397,305**	**150,932**	**113,763**	**662,000**

AGED, BLIND AND DISABLED MEDICAID

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CASES

COUNTY	QMB	OTHER	TOTAL ABD
APPLING	310	210	520
ATKINSON	172	104	276
BACON	235	233	468
BAKER	97	83	180
BALDWIN	611	614	1,225
BANKS	320	289	609
BARROW	725	532	1,257
BARTOW	1,283	1,077	2,360
BEN HILL	520	549	1,069
BERRIEN	467	416	883
BIBB	2,783	2,412	5,195
BLECKLEY	178	147	325
BRANTLEY	341	289	630
BROOKS	418	380	798
BRYAN	244	209	453
BULLOCH	785	713	1,498
BURKE	521	410	931
BUTTS	270	274	544
CALHOUN	268	447	715
CAMDEN	409	347	756
CANDLER	310	411	721
CARROLL	1,544	1,483	3,027
CATOOSA	2,095	1,992	4,087
CHARLTON	212	212	424
CHATHAM	3,201	2,649	5,850
CHATTAHOOCHEE	30	30	60
CHATTOOGA	470	495	965
CHEROKEE	864	820	1,684
CLARKE	1,558	1,335	2,893
CLAY	103	80	183
CLAYTON	2,854	2,093	4,947
CLINCH	223	218	441
COBB	3,200	3,028	6,228
COFFEE	864	609	1,473
COLQUITT	994	848	1,842
COLUMBIA	709	657	1,366
COOK	387	383	770
COWETA	754	687	1,441
CRAWFORD	226	222	448
CRISP	471	332	803
DADE	370	385	755
DAWSON	370	294	664
DECATUR	623	550	1,173
DEKALB	13,544	9,240	22,784
DODGE	343	306	649
DOOLY	265	176	441

AGED, BLIND AND DISABLED MEDICAID

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CASES

COUNTY	QMB	OTHER	TOTAL ABD
DOUGHERTY	1,661	1,292	2,953
DOUGLAS	1,118	898	2,016
EARLY	309	270	579
ECHOLS	47	38	85
EFFINGHAM	442	364	806
ELBERT	543	501	1,044
EMANUEL	456	411	867
EVANS	169	135	304
FANNIN	385	340	725
FAYETTE	355	371	726
FLOYD	1,372	1,391	2,763
FORSYTH	610	634	1,244
FRANKLIN	467	403	870
FULTON	8,804	8,813	17,617
GILMER	295	272	567
GLASCOCK	85	129	214
GLYNN	1,073	1,017	2,090
GORDON	561	486	1,047
GRADY	591	444	1,035
GREENE	222	209	431
GWINNETT	4,664	3,716	8,380
HABERSHAM	562	487	1,049
HALL	1,909	1,690	3,599
HANCOCK	214	219	433
HARALSON	545	511	1,056
HARRIS	271	261	532
HART	624	570	1,194
HEARD	390	445	835
HENRY	1,850	1,568	3,418
HOUSTON	1,308	1,150	2,458
IRWIN	251	225	476
JACKSON	362	309	671
JASPER	112	81	193
JEFF DAVIS	354	364	718
JEFFERSON	450	419	869
JENKINS	215	180	395
JOHNSON	217	275	492
JONES	318	338	656
LAMAR	396	346	742
LANIER	170	170	340
LAURENS	1,088	1,004	2,092
LEE	169	127	296
LIBERTY	538	437	975
LINCOLN	154	127	281
LONG	154	164	318
LOWNDES	1,540	1,429	2,969

AGED, BLIND AND DISABLED MEDICAID

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CASES

COUNTY	QMB	OTHER	TOTAL ABD
LUMPKIN	546	564	1,110
MACON	225	260	485
MADISON	457	366	823
MARION	195	184	379
MCDUFFIE	487	387	874
MCINTOSH	219	139	358
MERIWETHER	569	532	1,101
MILLER	130	168	298
MITCHELL	672	507	1,179
MONROE	443	478	921
MONTGOMERY	132	79	211
MORGAN	141	126	267
MURRAY	703	657	1,360
MUSCOGEE	2,624	2,097	4,721
NEWTON	675	461	1,136
OCONEE	69	63	132
OGLETHORPE	176	153	329
PAULDING	854	747	1,601
PEACH	393	265	658
PICKENS	389	371	760
PIERCE	441	381	822
PIKE	152	208	360
POLK	707	681	1,388
PULASKI	154	174	328
PUTNAM	325	269	594
QUITMAN	59	45	104
RABUN	569	524	1,093
RANDOLPH	208	174	382
RICHMOND	3,191	2,623	5,814
ROCKDALE	578	459	1,037
SCHLEY	65	36	101
SCREVEN	313	288	601
SEMINOLE	217	204	421
SPALDING	827	698	1,525
STEPHENS	1,176	1,094	2,270
STEWART	158	154	312
SUMTER	776	725	1,501
TALBOT	163	131	294
TALIAFERRO	64	30	94
TATTNALL	331	303	634
TAYLOR	144	146	290
TELFAIR	302	365	667
TERRELL	143	96	239
THOMAS	969	783	1,752
TIFT	935	827	1,762
TOOMBS	1,382	1,301	2,683

AGED, BLIND AND DISABLED MEDICAID

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CASES

COUNTY	QMB	OTHER	TOTAL ABD
TOWNS	141	109	250
TREUTLEN	127	109	236
TROUP	744	738	1,482
TURNER	162	162	324
TWIGGS	212	202	414
UNION	428	374	802
UPSON	907	905	1,812
WALKER	635	631	1,266
WALTON	3,339	3,171	6,510
WARE	842	799	1,641
WARREN	208	202	410
WASHINGTON	483	432	915
WAYNE	863	863	1,726
WEBSTER	45	36	81
WHEELER	97	86	183
WHITE	511	455	966
WHITFIELD	908	862	1,770
WILCOX	171	131	302
WILKES	295	217	512
WILKINSON	176	193	369
WORTH	697	637	1,334
STATE TOTAL	**122,370**	**106,937**	**229,307**

COUNTY STATISTICAL REPORTING SYSTEM (COSTAR)

PAYMENTS BY CATEGORY FOR CHILDREN IN CHILDCARE

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CHILDREN RECEIVING PAYMENTS

COUNTY	APPLICANT SERVICES	TANF	TRANSITIONAL	LOW INCOME WORKING	Pre-K	FOSTER CARE SUPPLEMENTAL SUPERVISION	TOTAL
APPLING	0	0	1	35	1	13	50
ATKINSON	0	0	0	6	0	8	14
BACON	0	0	0	28	1	28	57
BAKER	0	0	0	7	0	0	7
BALDWIN	5	2	2	437	20	89	555
BANKS	0	0	0	10	0	39	49
BARROW	0	1	2	107	8	130	248
BARTOW	0	1	10	253	9	116	389
BEN HILL	0	0	0	26	1	48	75
BERRIEN	0	0	0	38	4	37	79
BIBB	63	13	25	2,202	75	293	2,671
BLECKLEY	0	1	0	27	1	27	56
BRANTLEY	0	0	0	24	2	45	71
BROOKS	0	0	0	52	0	32	84
BRYAN	0	0	3	33	1	31	68
BULLOCH	0	0	3	237	15	92	347
BURKE	0	0	3	197	9	60	269
BUTTS	0	1	3	81	8	40	133
CALHOUN	0	0	0	0	0	7	7
CAMDEN	0	0	2	201	8	112	323
CANDLER	0	0	0	14	1	5	20
CARROLL	1	4	7	128	8	142	290
CATOOSA	0	0	0	53	11	117	181
CHARLTON	0	0	0	10	0	25	35
CHATHAM	1	0	6	2,239	69	309	2,624
CHATTAHOOCHEE	0	0	0	2	2	9	13
CHATTOOGA	1	0	0	3	0	12	16
CHEROKEE	0	1	2	289	38	266	596
CLARKE	0	0	14	334	14	145	507
CLAY	0	0	0	2	2	0	4
CLAYTON	8	8	183	4,174	186	435	4,994
CLINCH	0	0	0	2	0	5	7
COBB	8	4	167	2,652	129	636	3,596
COFFEE	0	0	0	136	2	121	259
COLQUITT	0	0	2	108	2	50	162
COLUMBIA	0	0	10	176	9	72	267
COOK	0	0	0	82	3	13	98
COWETA	0	5	10	260	13	94	382
CRAWFORD	0	0	0	25	0	18	43
CRISP	0	0	0	38	7	38	83
DADE	0	0	0	0	0	17	17
DAWSON	0	0	6	42	4	53	105
DECATUR	0	0	10	103	2	85	200

PAYMENTS BY CATEGORY FOR CHILDREN IN CHILDCARE

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CHILDREN RECEIVING PAYMENTS

COUNTY	APPLICANT SERVICES	TANF	TRANSITIONAL	LOW INCOME WORKING	Pre-K	FOSTER CARE SUPPLEMENTAL SUPERVISION	TOTAL
DEKALB	28	141	778	6,078	276	841	8,142
DODGE	0	0	1	90	2	66	159
DOOLY	0	0	0	7	0	1	8
DOUGHERTY	1	2	29	1,316	41	240	1,629
DOUGLAS	6	2	28	932	89	207	1,264
EARLY	0	0	1	27	0	18	46
ECHOLS	0	0	0	3	0	0	3
EFFINGHAM	0	0	0	100	9	70	179
ELBERT	0	0	0	18	0	19	37
EMANUEL	0	0	0	144	6	28	178
EVANS	0	0	0	7	0	19	26
FANNIN	0	0	0	15	1	16	32
FAYETTE	2	2	10	112	11	56	193
FLOYD	1	2	9	247	12	116	387
FORSYTH	0	0	10	133	17	98	258
FRANKLIN	0	0	0	33	0	62	95
FULTON	82	220	1,021	7,378	208	568	9,477
GILMER	0	0	0	2	1	12	15
GLASCOCK	0	0	0	0	0	2	2
GLYNN	0	0	0	267	15	84	366
GORDON	0	1	2	65	6	82	156
GRADY	0	0	0	104	3	67	174
GREENE	0	0	0	3	0	6	9
GWINNETT	18	55	158	2,170	214	981	3,596
HABERSHAM	0	0	2	20	6	47	75
HALL	5	3	15	369	44	183	619
HANCOCK	0	0	0	14	1	1	16
HARALSON	0	0	4	30	4	71	109
HARRIS	0	0	0	32	2	19	53
HART	0	0	1	30	0	34	65
HEARD	0	0	0	13	1	5	19
HENRY	6	9	42	1,172	77	428	1,734
HOUSTON	26	4	15	599	35	121	800
IRWIN	0	0	0	20	0	36	56
JACKSON	0	0	0	48	5	99	152
JASPER	0	0	0	25	0	38	63
JEFF DAVIS	0	0	1	25	0	21	47
JEFFERSON	0	0	2	72	4	15	93
JENKINS	0	0	0	0	1	2	3
JOHNSON	0	0	0	34	1	3	38
JONES	0	0	0	44	1	41	86
LAMAR	0	1	8	136	6	27	178
LANIER	0	0	0	35	0	25	60
LAURENS	0	1	7	195	14	82	299

PAYMENTS BY CATEGORY FOR CHILDREN IN CHILDCARE

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CHILDREN RECEIVING PAYMENTS

COUNTY	APPLICANT SERVICES	TANF	TRANSITIONAL	LOW INCOME WORKING	Pre-K	FOSTER CARE SUPPLEMENTAL SUPERVISION	TOTAL
LEE	1	0	0	189	10	47	247
LIBERTY	0	1	2	230	19	107	359
LINCOLN	0	0	0	6	0	15	21
LONG	0	0	0	17	4	22	43
LOWNDES	0	0	0	1,239	47	185	1,471
LUMPKIN	0	0	1	56	7	50	114
MACON	2	0	0	30	2	56	90
MADISON	0	0	2	47	4	39	92
MARION	0	0	0	6	0	4	10
MCDUFFIE	0	0	2	191	13	22	228
MCINTOSH	0	0	0	6	0	9	15
MERIWETHER	0	3	1	52	3	13	72
MILLER	0	0	0	5	0	18	23
MITCHELL	0	0	0	68	0	40	108
MONROE	0	0	2	44	2	35	83
MONTGOMERY	0	0	0	3	1	12	16
MORGAN	0	0	1	11	2	12	26
MURRAY	0	0	4	48	4	45	101
MUSCOGEE	3	42	37	1,355	53	425	1,915
NEWTON	7	4	33	561	26	237	868
OCONEE	0	0	0	39	3	23	65
OGLETHORPE	0	0	0	18	4	16	38
PAULDING	4	0	17	427	54	163	665
PEACH	0	1	2	72	13	30	118
PICKENS	0	0	0	18	4	25	47
PIERCE	0	0	0	16	0	39	55
PIKE	1	1	4	43	5	35	89
POLK	0	0	0	38	5	79	122
PULASKI	0	0	0	62	6	14	82
PUTNAM	0	11	0	175	5	29	220
QUITMAN	0	0	0	0	0	2	2
RABUN	0	0	0	8	0	20	28
RANDOLPH	0	0	0	0	0	3	3
RICHMOND	1	12	176	2,465	128	287	3,069
ROCKDALE	6	3	97	829	58	169	1,162
SCHLEY	0	0	3	8	3	10	24
SCREVEN	0	1	3	60	10	45	119
SEMINOLE	1	0	0	69	6	29	105
SPALDING	11	5	41	489	28	121	695
STEPHENS	0	0	0	49	2	37	88
STEWART	0	0	0	1	0	4	5
SUMTER	0	0	0	57	3	86	146
TALBOT	0	0	0	3	0	12	15
TALIAFERRO	0	0	0	2	0	0	2

PAYMENTS BY CATEGORY FOR CHILDREN IN CHILDCARE

STATE FISCAL YEAR 2018
MONTHLY AVERAGE CHILDREN RECEIVING PAYMENTS

COUNTY	APPLICANT SERVICES	TANF	TRANSITIONAL	LOW INCOME WORKING	Pre-K	FOSTER CARE SUPPLEMENTAL SUPERVISION	TOTAL
TATTNALL	0	0	0	56	3	16	75
TAYLOR	0	0	0	0	0	8	8
TELFAIR	0	0	0	37	3	10	50
TERRELL	0	0	2	63	2	41	108
THOMAS	0	0	0	123	0	55	178
TIFT	0	0	0	329	8	70	407
TOOMBS	0	0	0	187	5	65	257
TOWNS	0	0	0	11	1	6	18
TREUTLEN	0	0	0	16	2	5	23
TROUP	1	4	17	263	20	130	435
TURNER	0	0	0	59	4	35	98
TWIGGS	0	0	0	6	0	2	8
UNION	0	0	0	21	0	37	58
UPSON	0	1	4	57	6	86	154
WALKER	0	0	0	18	2	119	139
WALTON	2	0	2	215	10	157	386
WARE	0	0	0	57	2	73	132
WARREN	0	0	0	25	0	0	25
WASHINGTON	0	0	20	158	5	18	201
WAYNE	0	0	0	75	2	16	93
WEBSTER	0	0	0	0	0	1	1
WHEELER	0	0	0	17	0	1	18
WHITE	0	0	0	24	5	37	66
WHITFIELD	0	0	1	105	9	145	260
WILCOX	0	0	2	0	0	2	4
WILKES	0	0	0	19	2	8	29
WILKINSON	0	0	0	23	1	17	41
WORTH	0	0	0	63	5	40	108
STATE TOTAL	**302**	**573**	**3,091**	**48,176**	**2,409**	**12,742**	**67,293**

PAYMENTS BY CATEGORY FOR CHILDREN IN CHILDCARE

STATE FISCAL YEAR 2018
Annual Expenditures

COUNTY	APPLICANT SERVICES	TANF	TRANSITIONAL	LOW INCOME WORKING	Pre-K	FOSTER CARE SUPPLEMENTAL SUPERVISION	TOTAL
APPLING	$0	$0	$1,118	$39,607	$428	$32,080	$73,233
ATKINSON	$0	$0	$0	$5,654	$0	$21,454	$27,108
BACON	$0	$0	$0	$24,893	$642	$48,150	$73,685
BAKER	$0	$0	$0	$10,868	$0	$0	$10,868
BALDWIN	$11,625	$1,975	$3,981	$643,697	$20,833	$225,287	$907,398
BANKS	$0	$0	$0	$11,817	$228	$103,130	$115,175
BARROW	$140	$700	$3,837	$172,863	$8,009	$427,955	$613,504
BARTOW	$0	$32,700	$18,559	$372,940	$9,602	$354,671	$788,472
BEN HILL	$0	$0	$0	$20,797	$1,520	$98,198	$120,515
BERRIEN	$0	$0	$0	$40,075	$2,681	$77,153	$119,909
BIBB	$124,173	$303,865	$46,894	$3,259,627	$93,176	$749,450	$4,577,185
BLECKLEY	$0	$330	$0	$30,913	$76	$56,880	$88,199
BRANTLEY	$0	$0	$0	$27,245	$438	$104,472	$132,155
BROOKS	$0	$0	$0	$76,276	$0	$90,524	$166,800
BRYAN	$0	$0	$4,997	$48,888	$1,236	$120,000	$175,121
BULLOCH	$0	$210	$6,474	$331,979	$16,488	$320,810	$675,961
BURKE	$0	$535	$3,805	$203,947	$6,756	$90,919	$305,962
BUTTS	$0	$1,500	$5,822	$128,329	$13,455	$102,158	$251,264
CALHOUN	$0	$0	$0	$0	$0	$18,935	$18,935
CAMDEN	$0	$142	$5,041	$381,934	$11,947	$377,386	$776,450
CANDLER	$0	$200	$0	$20,673	$3,515	$9,965	$34,353
CARROLL	$1,844	$10,650	$8,413	$167,576	$7,503	$469,501	$665,487
CATOOSA	$0	$0	$0	$76,111	$12,576	$361,211	$449,898
CHARLTON	$0	$0	$0	$11,372	$0	$52,136	$63,508
CHATHAM	$2,976	$170	$10,576	$2,997,741	$80,096	$916,259	$4,007,818
CHATTAHOOCHEE	$0	$0	$0	$2,120	$2,260	$15,757	$20,137
CHATTOOGA	$700	$75	$0	$2,851	$0	$30,596	$34,222
CHEROKEE	$0	$31,333	$5,541	$563,335	$44,394	$1,216,208	$1,860,811
CLARKE	$231	$99	$32,415	$522,133	$20,629	$457,593	$1,033,100
CLAY	$0	$0	$0	$1,474	$280	$0	$1,754
CLAYTON	$20,226	$3,373	$455,676	$8,567,583	$262,535	$1,328,394	$10,637,787
CLINCH	$0	$0	$0	$2,384	$0	$11,721	$14,105
COBB	$15,892	$21,519	$415,254	$5,302,161	$172,204	$2,662,493	$8,589,523
COFFEE	$0	$0	$0	$158,507	$1,128	$263,704	$423,339
COLQUITT	$0	$0	$3,332	$139,956	$2,643	$133,944	$279,875
COLUMBIA	$0	$600	$18,563	$247,285	$7,073	$237,232	$510,753
COOK	$0	$0	$0	$102,598	$2,437	$30,783	$135,818
COWETA	$729	$12,395	$15,755	$375,209	$12,772	$298,635	$715,495
CRAWFORD	$0	$125	$0	$34,097	$105	$35,457	$69,784
CRISP	$0	$146	$0	$45,266	$9,892	$70,775	$126,079
DADE	$0	$0	$0	$330	$0	$41,921	$42,251
DAWSON	$0	$0	$8,406	$64,180	$5,771	$177,564	$255,921
DECATUR	$0	$50	$24,789	$128,885	$1,202	$195,059	$349,985
DEKALB	$68,781	$454,193	$2,043,738	$12,700,434	$389,339	$2,641,413	$18,297,898

PAYMENTS BY CATEGORY FOR CHILDREN IN CHILDCARE

STATE FISCAL YEAR 2018
Annual Expenditures

COUNTY	APPLICANT SERVICES	TANF	TRANSITIONAL	LOW INCOME WORKING	Pre-K	FOSTER CARE SUPPLEMENTAL SUPERVISION	TOTAL
DODGE	$0	$0	$910	$94,633	$1,440	$132,853	$229,836
DOOLY	$0	$0	$0	$8,352	$0	$1,651	$10,003
DOUGHERTY	$616	$1,225	$55,915	$1,876,932	$40,496	$556,329	$2,531,513
DOUGLAS	$14,671	$1,315	$75,962	$1,947,486	$124,961	$612,507	$2,776,902
EARLY	$0	$0	$2,322	$22,968	$341	$32,827	$58,458
ECHOLS	$0	$0	$0	$3,456	$0	$0	$3,456
EFFINGHAM	$364	$0	$0	$147,016	$11,132	$226,522	$385,034
ELBERT	$0	$295	$0	$18,674	$0	$42,779	$61,748
EMANUEL	$0	$0	$0	$129,692	$4,549	$38,569	$172,810
EVANS	$0	$105	$0	$5,775	$0	$46,337	$52,217
FANNIN	$0	$0	$0	$14,066	$576	$43,082	$57,724
FAYETTE	$3,297	$5,065	$24,233	$211,821	$17,900	$227,220	$489,536
FLOYD	$1,178	$35,690	$14,654	$344,652	$11,714	$276,609	$684,497
FORSYTH	$0	$0	$27,665	$270,881	$21,042	$504,010	$823,598
FRANKLIN	$0	$0	$0	$43,584	$444	$139,983	$184,011
FULTON	$191,483	$682,812	$2,604,131	$15,087,623	$314,410	$2,013,645	$20,894,104
GILMER	$0	$0	$0	$3,211	$391	$36,038	$39,640
GLASCOCK	$0	$0	$0	$0	$0	$3,211	$3,211
GLYNN	$0	$95	$0	$379,458	$15,720	$254,327	$649,600
GORDON	$0	$640	$5,063	$102,513	$7,547	$210,071	$325,834
GRADY	$0	$0	$0	$99,166	$2,781	$152,290	$254,237
GREENE	$0	$0	$0	$2,905	$0	$23,009	$25,914
GWINNETT	$45,810	$322,261	$391,653	$4,239,018	$277,070	$3,548,683	$8,824,495
HABERSHAM	$0	$0	$3,430	$20,068	$4,199	$156,607	$184,304
HALL	$9,869	$4,287	$35,940	$744,179	$55,869	$740,182	$1,590,326
HANCOCK	$0	$220	$0	$10,653	$673	$2,060	$13,606
HARALSON	$0	$0	$3,762	$30,377	$3,755	$197,309	$235,203
HARRIS	$0	$190	$0	$44,559	$700	$42,383	$87,832
HART	$0	$0	$1,400	$36,464	$0	$82,620	$120,484
HEARD	$0	$750	$0	$18,133	$1,595	$15,310	$35,788
HENRY	$17,584	$27,504	$101,662	$2,278,674	$95,765	$1,276,410	$3,797,599
HOUSTON	$42,927	$4,070	$28,522	$838,766	$38,291	$366,427	$1,319,003
IRWIN	$0	$0	$0	$17,721	$0	$55,359	$73,080
JACKSON	$0	$0	$460	$79,407	$7,221	$357,025	$444,113
JASPER	$0	$0	$0	$26,026	$415	$83,257	$109,698
JEFF DAVIS	$0	$0	$2,074	$25,282	$0	$46,896	$74,252
JEFFERSON	$0	$0	$1,746	$76,430	$3,504	$29,552	$111,232
JENKINS	$0	$0	$0	$188	$404	$5,370	$5,962
JOHNSON	$0	$0	$0	$32,813	$213	$9,326	$42,352
JONES	$0	$0	$0	$61,128	$1,750	$112,598	$175,476
LAMAR	$715	$2,405	$13,349	$192,112	$6,169	$66,146	$280,896
LANIER	$0	$0	$0	$42,778	$0	$62,536	$105,314
LAURENS	$0	$690	$11,468	$222,583	$12,275	$167,460	$414,476
LEE	$1,179	$0	$0	$288,960	$10,854	$121,269	$422,262
LIBERTY	$0	$400	$4,751	$324,613	$25,513	$281,694	$636,971

PAYMENTS BY CATEGORY FOR CHILDREN IN CHILDCARE

STATE FISCAL YEAR 2018
Annual Expenditures

COUNTY	APPLICANT SERVICES	TANF	TRANSITIONAL	LOW INCOME WORKING	Pre-K	FOSTER CARE SUPPLEMENTAL SUPERVISION	TOTAL
LINCOLN	$0	$0	$0	$6,423	$0	$27,205	$33,628
LONG	$0	$0	$0	$23,504	$4,822	$56,390	$84,716
LOWNDES	$0	$0	$0	$1,987,217	$56,882	$457,110	$2,501,209
LUMPKIN	$0	$0	$2,816	$70,256	$6,659	$130,749	$210,480
MACON	$2,230	$0	$0	$28,034	$1,764	$109,765	$141,793
MADISON	$0	$0	$5,064	$61,150	$5,226	$122,663	$194,103
MARION	$0	$0	$0	$9,269	$0	$15,370	$24,639
MCDUFFIE	$0	$70	$3,006	$261,561	$13,189	$59,439	$337,265
MCINTOSH	$0	$0	$0	$9,112	$0	$26,849	$35,961
MERIWETHER	$0	$7,365	$1,260	$63,717	$2,787	$39,604	$114,733
MILLER	$0	$0	$0	$6,417	$350	$26,734	$33,501
MITCHELL	$0	$0	$0	$76,796	$132	$91,291	$168,219
MONROE	$0	$0	$502	$56,628	$339	$94,599	$152,068
MONTGOMERY	$0	$0	$0	$3,411	$182	$39,402	$42,995
MORGAN	$0	$0	$1,485	$14,465	$2,406	$41,988	$60,344
MURRAY	$0	$0	$6,675	$78,842	$5,472	$121,861	$212,850
MUSCOGEE	$6,367	$150,215	$59,982	$2,019,631	$64,694	$1,159,795	$3,460,684
NEWTON	$11,958	$5,323	$59,004	$877,828	$27,924	$646,139	$1,628,176
OCONEE	$0	$0	$0	$56,880	$4,560	$103,774	$165,214
OGLETHORPE	$0	$0	$0	$24,872	$3,439	$41,721	$70,032
PAULDING	$8,071	$245	$39,347	$889,147	$69,675	$679,416	$1,685,901
PEACH	$528	$1,170	$3,351	$100,544	$20,849	$76,731	$203,173
PICKENS	$0	$0	$0	$20,159	$4,220	$59,768	$84,147
PIERCE	$0	$0	$0	$16,037	$250	$80,938	$97,225
PIKE	$1,184	$2,400	$8,341	$58,443	$6,587	$85,839	$162,794
POLK	$0	$0	$194	$48,094	$6,433	$197,848	$252,569
PULASKI	$0	$0	$678	$75,938	$8,522	$40,614	$125,752
PUTNAM	$0	$154,809	$412	$217,881	$6,608	$87,560	$467,270
QUITMAN	$0	$0	$0	$0	$0	$5,410	$5,410
RABUN	$0	$0	$0	$8,802	$0	$46,742	$55,544
RANDOLPH	$0	$0	$0	$330	$0	$9,628	$9,958
RICHMOND	$2,249	$20,117	$300,370	$3,555,212	$145,488	$687,029	$4,710,465
ROCKDALE	$11,102	$4,590	$218,352	$1,573,501	$87,122	$494,118	$2,388,785
SCHLEY	$0	$0	$5,920	$9,010	$2,178	$16,956	$34,064
SCREVEN	$0	$675	$4,452	$59,337	$4,460	$87,841	$156,765
SEMINOLE	$2,053	$0	$0	$86,179	$5,080	$56,360	$149,672
SPALDING	$19,685	$15,862	$66,577	$709,285	$32,171	$289,575	$1,133,155
STEPHENS	$0	$0	$0	$51,994	$2,264	$87,711	$141,969
STEWART	$0	$0	$0	$1,066	$0	$7,862	$8,928
SUMTER	$0	$300	$0	$57,810	$4,005	$147,631	$209,746
TALBOT	$0	$0	$0	$3,645	$0	$34,910	$38,555
TALIAFERRO	$0	$0	$0	$2,943	$0	$0	$2,943
TATTNALL	$0	$0	$0	$66,783	$2,679	$30,360	$99,822
TAYLOR	$0	$0	$0	$58	$0	$22,633	$22,691
TELFAIR	$0	$0	$0	$36,628	$2,427	$21,265	$60,320

PAYMENTS BY CATEGORY FOR CHILDREN IN CHILDCARE

STATE FISCAL YEAR 2018
Annual Expenditures

COUNTY	APPLICANT SERVICES	TANF	TRANSITIONAL	LOW INCOME WORKING	Pre-K	FOSTER CARE SUPPLEMENTAL SUPERVISION	TOTAL
TERRELL	$0	$0	$2,296	$67,576	$1,435	$97,227	$168,534
THOMAS	$0	$0	$468	$128,566	$0	$133,782	$262,816
TIFT	$0	$0	$0	$457,141	$10,726	$177,610	$645,477
TOOMBS	$0	$0	$0	$200,766	$5,113	$122,481	$328,360
TOWNS	$0	$0	$0	$14,174	$324	$14,410	$28,908
TREUTLEN	$0	$0	$52	$18,547	$619	$7,930	$27,148
TROUP	$767	$14,025	$29,154	$373,809	$22,564	$303,204	$743,523
TURNER	$0	$0	$0	$61,812	$4,405	$73,936	$140,153
TWIGGS	$0	$135	$0	$7,200	$0	$6,850	$14,185
UNION	$0	$0	$0	$25,583	$0	$113,305	$138,888
UPSON	$0	$2,250	$6,418	$64,905	$4,064	$187,035	$264,672
WALKER	$0	$0	$0	$19,473	$1,513	$298,688	$319,674
WALTON	$4,467	$75	$3,456	$330,913	$13,642	$463,116	$815,669
WARE	$0	$0	$0	$55,339	$1,898	$168,595	$225,832
WARREN	$0	$150	$0	$27,875	$0	$429	$28,454
WASHINGTON	$0	$150	$27,573	$168,151	$4,860	$33,451	$234,185
WAYNE	$0	$0	$0	$85,693	$1,879	$44,496	$132,068
WEBSTER	$0	$0	$0	$0	$0	$1,280	$1,280
WHEELER	$0	$0	$0	$16,581	$0	$1,999	$18,580
WHITE	$0	$0	$0	$30,711	$2,441	$109,703	$142,855
WHITFIELD	$0	$0	$2,600	$164,172	$10,263	$398,273	$575,308
WILCOX	$0	$0	$4,010	$0	$0	$4,416	$8,426
WILKES	$0	$0	$0	$20,486	$561	$16,359	$37,406
WILKINSON	$0	$250	$0	$23,402	$209	$39,229	$63,090
WORTH	$0	$0	$0	$63,906	$4,477	$96,374	$164,757
STATE TOTAL	**$647,671**	**$2,347,079**	**$7,417,873**	**$84,344,026**	**$3,050,386**	**$38,159,652**	**$135,966,687**

FOSTER CARE PER DIEM CLIENTS

STATE FISCAL YEAR 2018
Monthly Average Clients

COUNTY	FAMILY	SPECIALIZED
APPLING	7	0
ATKINSON	11	0
BACON	17	1
BAKER	5	1
BALDWIN	47	0
BANKS	18	1
BARROW	27	3
BARTOW	42	4
BEN HILL	18	1
BERRIEN	7	0
BIBB	70	5
BLECKLEY	9	0
BRANTLEY	13	0
BROOKS	9	1
BRYAN	14	2
BULLOCH	33	0
BURKE	19	2
BUTTS	14	0
CALHOUN	3	0
CAMDEN	45	1
CANDLER	11	0
CARROLL	69	2
CATOOSA	70	3
CHARLTON	17	0
CHATHAM	87	5
CHATTAHOOCHEE	5	0
CHATTOOGA	21	1
CHEROKEE	73	1
CLARKE	30	1
CLAY	0	0
CLAYTON	116	23
CLINCH	12	0
COBB	211	27
COFFEE	63	3
COLQUITT	49	3
COLUMBIA	16	1
COOK	6	0
COWETA	27	1
CRAWFORD	9	1
CRISP	31	0
DADE	15	1
DAWSON	5	3
DECATUR	38	1
DEKALB	105	12
DODGE	19	0

FOSTER CARE PER DIEM CLIENTS

STATE FISCAL YEAR 2018
Monthly Average Clients

COUNTY	FAMILY	SPECIALIZED
DOOLY	2	0
DOUGHERTY	90	6
DOUGLAS	56	10
EARLY	8	0
ECHOLS	2	0
EFFINGHAM	23	0
ELBERT	9	1
EMANUEL	14	3
EVANS	1	0
FANNIN	28	0
FAYETTE	8	0
FLOYD	58	4
FORSYTH	50	1
FRANKLIN	29	1
FULTON	96	16
GILMER	17	1
GLASCOCK	0	0
GLYNN	17	0
GORDON	47	0
GRADY	15	2
GREENE	3	0
GWINNETT	164	9
HABERSHAM	54	0
HALL	66	4
HANCOCK	8	0
HARALSON	17	4
HARRIS	14	0
HART	8	0
HEARD	1	0
HENRY	37	1
HOUSTON	40	3
IRWIN	6	0
JACKSON	43	1
JASPER	9	0
JEFF DAVIS	31	0
JEFFERSON	6	0
JENKINS	3	0
JOHNSON	1	0
JONES	26	3
LAMAR	14	0
LANIER	8	0
LAURENS	34	0
LEE	11	0
LIBERTY	20	0
LINCOLN	1	1
LONG	8	0

FOSTER CARE PER DIEM CLIENTS

STATE FISCAL YEAR 2018
Monthly Average Clients

COUNTY	FAMILY	SPECIALIZED
LOWNDES	31	1
LUMPKIN	22	0
MACON	4	0
MADISON	10	0
MARION	3	0
MCDUFFIE	16	1
MCINTOSH	5	0
MERIWETHER	11	0
MILLER	5	1
MITCHELL	13	0
MONROE	5	0
MONTGOMERY	1	0
MORGAN	17	0
MURRAY	34	0
MUSCOGEE	161	5
NEWTON	16	1
OCONEE	7	0
OGLETHORPE	2	0
PAULDING	42	5
PEACH	7	1
PICKENS	22	2
PIERCE	20	1
PIKE	11	0
POLK	44	5
PULASKI	5	0
PUTNAM	26	0
QUITMAN	1	2
RABUN	17	2
RANDOLPH	6	0
RICHMOND	52	5
ROCKDALE	22	2
SCHLEY	1	0
SCREVEN	8	0
SEMINOLE	5	0
SPALDING	64	2
STEPHENS	24	0
STEWART	3	0
SUMTER	28	2
TALBOT	2	0
TALIAFERRO	0	0
TATTNALL	5	0
TAYLOR	4	0
TELFAIR	13	0
TERRELL	5	0
THOMAS	23	3
TIFT	17	0

FOSTER CARE PER DIEM CLIENTS

STATE FISCAL YEAR 2018
Monthly Average Clients

COUNTY	FAMILY	SPECIALIZED
TOOMBS	28	0
TOWNS	6	1
TREUTLEN	2	0
TROUP	27	1
TURNER	1	0
TWIGGS	8	0
UNION	23	3
UPSON	35	0
WALKER	45	4
WALTON	44	4
WARE	41	0
WARREN	0	0
WASHINGTON	6	0
WAYNE	24	1
WEBSTER	0	0
WHEELER	1	0
WHITE	23	0
WHITFIELD	103	9
WILCOX	5	0
WILKES	2	0
WILKINSON	13	0
WORTH	22	0
STATE TOTAL	**4,035**	**246**

FOSTER CARE ANNUAL EXPENDITURES

STATE FISCAL YEAR 2018

COUNTY	FAMILY	SPECIALIZED
APPLING	$60,557	$0
ATKINSON	$117,665	$3,290
BACON	$171,321	$20,887
BAKER	$49,813	$15,315
BALDWIN	$433,040	$2,245
BANKS	$163,621	$15,404
BARROW	$242,016	$52,024
BARTOW	$353,316	$72,677
BEN HILL	$156,731	$36,976
BERRIEN	$58,871	$5,890
BIBB	$637,219	$87,259
BLECKLEY	$75,009	$1,340
BRANTLEY	$126,467	$0
BROOKS	$84,190	$22,759
BRYAN	$124,703	$23,473
BULLOCH	$305,144	$0
BURKE	$174,833	$41,182
BUTTS	$121,241	$0
CALHOUN	$27,638	$0
CAMDEN	$399,244	$16,029
CANDLER	$106,736	$450
CARROLL	$615,589	$22,258
CATOOSA	$590,148	$39,792
CHARLTON	$169,022	$0
CHATHAM	$745,264	$113,656
CHATTAHOOCHEE	$46,469	$0
CHATTOOGA	$186,693	$17,332
CHEROKEE	$628,269	$11,297
CLARKE	$265,534	$19,369
CLAY	$0	$0
CLAYTON	$980,314	$364,363
CLINCH	$118,526	$0
COBB	$1,730,745	$358,834
COFFEE	$625,971	$55,712
COLQUITT	$425,973	$34,358
COLUMBIA	$138,706	$27,892
COOK	$53,315	$3,975
COWETA	$255,259	$12,811
CRAWFORD	$89,387	$23,343
CRISP	$305,428	$0
DADE	$107,292	$19,500
DAWSON	$44,979	$36,085
DECATUR	$327,408	$15,314
DEKALB	$976,830	$194,558
DODGE	$183,666	$0
DOOLY	$7,361	$0
DOUGHERTY	$824,663	$99,212

FOSTER CARE ANNUAL EXPENDITURES

STATE FISCAL YEAR 2018

COUNTY	FAMILY	SPECIALIZED
DOUGLAS	$497,067	$229,846
EARLY	$73,974	$0
ECHOLS	$22,993	$0
EFFINGHAM	$201,415	$0
ELBERT	$77,784	$18,179
EMANUEL	$125,973	$36,232
EVANS	$5,556	$1,201
FANNIN	$227,311	$2,570
FAYETTE	$57,296	$0
FLOYD	$518,231	$56,391
FORSYTH	$411,636	$12,063
FRANKLIN	$275,046	$10,545
FULTON	$972,557	$272,376
GILMER	$144,774	$13,150
GLASCOCK	$3,532	$0
GLYNN	$148,832	$5,093
GORDON	$417,301	$5,330
GRADY	$128,659	$29,846
GREENE	$24,815	$0
GWINNETT	$1,304,868	$150,356
HABERSHAM	$459,921	$0
HALL	$554,092	$53,130
HANCOCK	$81,472	$0
HARALSON	$152,589	$77,093
HARRIS	$134,528	$0
HART	$84,298	$0
HEARD	$10,417	$0
HENRY	$348,646	$21,049
HOUSTON	$344,542	$36,094
IRWIN	$46,297	$0
JACKSON	$364,770	$25,871
JASPER	$86,348	$638
JEFF DAVIS	$285,044	$0
JEFFERSON	$51,097	$0
JENKINS	$28,254	$3,996
JOHNSON	$10,080	$0
JONES	$227,461	$51,784
LAMAR	$124,288	$0
LANIER	$73,253	$0
LAURENS	$292,666	$0
LEE	$99,890	$308
LIBERTY	$164,207	$2,996
LINCOLN	$12,461	$14,123
LONG	$71,719	$0
LOWNDES	$262,921	$20,574
LUMPKIN	$217,502	$8,625
MACON	$38,495	$0

FOSTER CARE ANNUAL EXPENDITURES

STATE FISCAL YEAR 2018

COUNTY	FAMILY	SPECIALIZED
MADISON	$88,234	$0
MARION	$29,369	$0
MCDUFFIE	$147,758	$11,433
MCINTOSH	$37,483	$0
MERIWETHER	$92,866	$0
MILLER	$50,033	$7,768
MITCHELL	$114,026	$1,759
MONROE	$32,890	$5,568
MONTGOMERY	$5,790	$0
MORGAN	$164,804	$1,380
MURRAY	$274,303	$0
MUSCOGEE	$1,528,429	$70,206
NEWTON	$141,478	$16,876
OCONEE	$47,693	$973
OGLETHORPE	$5,085	$0
PAULDING	$351,379	$72,183
PEACH	$64,433	$20,136
PICKENS	$194,011	$27,043
PIERCE	$196,619	$7,561
PIKE	$104,076	$0
POLK	$387,455	$82,945
PULASKI	$50,897	$3,395
PUTNAM	$256,887	$0
QUITMAN	$16,214	$30,034
RABUN	$147,488	$28,250
RANDOLPH	$59,127	$0
RICHMOND	$461,365	$93,229
ROCKDALE	$172,091	$33,937
SCHLEY	$4,621	$0
SCREVEN	$68,840	$3,925
SEMINOLE	$44,416	$0
SPALDING	$569,451	$56,056
STEPHENS	$218,675	$5,500
STEWART	$22,988	$0
SUMTER	$259,585	$45,646
TALBOT	$8,097	$0
TALIAFERRO	$0	$0
TATTNALL	$46,915	$2,083
TAYLOR	$33,849	$0
TELFAIR	$125,089	$175
TERRELL	$45,427	$0
THOMAS	$186,407	$40,589
TIFT	$143,762	$4,150
TOOMBS	$247,847	$0
TOWNS	$57,319	$13,108
TREUTLEN	$16,593	$0
TROUP	$235,959	$15,217

FOSTER CARE ANNUAL EXPENDITURES

STATE FISCAL YEAR 2018

COUNTY	FAMILY	SPECIALIZED
TURNER	$12,928	$2,993
TWIGGS	$69,880	$566
UNION	$180,709	$40,210
UPSON	$308,870	$0
WALKER	$380,711	$43,166
WALTON	$385,975	$49,837
WARE	$384,372	$0
WARREN	$1,592	$0
WASHINGTON	$49,931	$0
WAYNE	$231,128	$8,231
WEBSTER	$0	$0
WHEELER	$9,504	$0
WHITE	$213,812	$0
WHITFIELD	$843,736	$125,036
WILCOX	$40,481	$0
WILKES	$27,062	$0
WILKINSON	$119,868	$423
WORTH	$172,630	$0
STATE TOTAL	**$35,690,377**	**$4,017,908**

FAMILY PRESERVATION SERVICES

STATE FISCAL YEAR 2018

COUNTY	CHILD AND FAMILY ASSESSMENT	EARLY INTERVENTION	HOMESTEAD	PARENT AIDE	PREVENTION OF OUT-OF-HOME PLACEMENT
APPLING	19	0	12	17	274
ATKINSON	9	7	2	3	49
BACON	11	31	43	7	175
BAKER	4	0	0	6	36
BALDWIN	42	29	115	379	1,026
BANKS	25	0	0	6	347
BARROW	51	0	235	0	880
BARTOW	89	0	7	0	1,289
BEN HILL	74	23	620	315	1,014
BERRIEN	39	0	39	29	500
BIBB	97	0	96	46	1,687
BLECKLEY	8	6	11	4	114
BRANTLEY	34	0	132	0	254
BROOKS	16	77	44	32	307
BRYAN	33	92	149	0	283
BULLOCH	50	7	31	69	668
BURKE	27	0	28	10	294
BUTTS	18	0	87	0	395
CALHOUN	2	0	1	0	33
CAMDEN	71	68	115	63	742
CANDLER	20	0	12	6	101
CARROLL	100	68	303	50	1,943
CATOOSA	133	56	262	180	1,581
CHARLTON	10	0	94	0	92
CHATHAM	156	0	377	1,105	1,566
CHATTAHOOCHEE	0	0	3	0	171
CHATTOOGA	29	37	104	446	556
CHEROKEE	239	62	24	294	4,419
CLARKE	165	6	189	48	1,410
CLAY	0	0	6	0	37
CLAYTON	118	12	327	14	1,071
CLINCH	11	16	35	0	328
COBB	357	128	268	431	3,396
COFFEE	75	72	243	240	764
COLQUITT	49	0	130	122	1,213
COLUMBIA	33	7	25	33	829
COOK	11	0	62	30	484
COWETA	59	42	82	11	1,202
CRAWFORD	1	0	116	5	339
CRISP	30	9	86	20	469
DADE	31	1	12	23	246
DAWSON	12	0	7	10	220
DECATUR	40	0	98	56	392
DEKALB	366	35	1,003	750	3,699
DODGE	21	7	33	19	128

FAMILY PRESERVATION SERVICES

STATE FISCAL YEAR 2018

COUNTY	CHILD AND FAMILY ASSESSMENT	EARLY INTERVENTION	HOMESTEAD	PARENT AIDE	PREVENTION OF OUT-OF-HOME PLACEMENT
DOOLY	15	0	17	10	96
DOUGHERTY	13	281	766	221	2,212
DOUGLAS	91	57	259	56	166
EARLY	3	0	14	0	66
ECHOLS	2	0	16	34	48
EFFINGHAM	36	161	407	11	525
ELBERT	20	4	82	0	310
EMANUEL	26	13	3	0	94
EVANS	10	0	9	0	143
FANNIN	27	0	0	0	184
FAYETTE	25	69	107	80	377
FLOYD	108	0	247	178	1,887
FORSYTH	96	0	121	190	1,990
FRANKLIN	35	0	0	0	101
FULTON	245	0	265	175	5,507
GILMER	18	0	5	0	415
GLASCOCK	1	0	0	0	48
GLYNN	42	16	33	117	412
GORDON	147	12	0	95	767
GRADY	37	0	27	18	449
GREENE	15	0	12	9	240
GWINNETT	157	18	196	483	3,298
HABERSHAM	57	0	23	6	628
HALL	187	48	112	121	2,688
HANCOCK	14	0	11	0	63
HARALSON	27	38	120	28	659
HARRIS	13	1	21	3	416
HART	12	0	0	0	54
HEARD	4	0	21	0	205
HENRY	92	75	500	160	3,491
HOUSTON	56	0	144	60	900
IRWIN	18	26	255	113	323
JACKSON	64	2	40	14	968
JASPER	18	55	109	71	334
JEFF DAVIS	21	8	28	31	334
JEFFERSON	22	0	0	0	184
JENKINS	19	0	1	0	81
JOHNSON	9	2	4	0	90
JONES	28	43	799	326	826
LAMAR	55	5	9	14	319
LANIER	34	70	76	15	589
LAURENS	57	14	17	63	526
LEE	33	0	172	67	500
LIBERTY	60	19	242	97	552
LINCOLN	5	9	35	14	62
LONG	25	9	60	65	258

FAMILY PRESERVATION SERVICES

STATE FISCAL YEAR 2018

COUNTY	CHILD AND FAMILY ASSESSMENT	EARLY INTERVENTION	HOMESTEAD	PARENT AIDE	PREVENTION OF OUT-OF-HOME PLACEMENT
LOWNDES	81	311	383	280	1,643
LUMPKIN	28	0	40	3	467
MACON	9	6	0	9	115
MADISON	20	5	13	21	281
MARION	0	0	9	0	126
MCDUFFIE	15	2	1	2	195
MCINTOSH	18	0	8	17	211
MERIWETHER	25	0	5	4	611
MILLER	0	0	61	0	91
MITCHELL	21	7	71	42	399
MONROE	26	57	176	1	449
MONTGOMERY	5	23	0	0	44
MORGAN	45	14	17	2	483
MURRAY	53	0	15	22	1,399
MUSCOGEE	247	0	78	35	3,558
NEWTON	57	11	262	20	759
OCONEE	22	0	44	1	100
OGLETHORPE	10	9	9	0	95
PAULDING	76	0	0	0	1,060
PEACH	21	36	229	3	460
PICKENS	56	0	14	6	512
PIERCE	24	19	52	7	358
PIKE	10	0	6	16	106
POLK	67	49	22	53	1,009
PULASKI	9	9	4	10	37
PUTNAM	17	41	184	121	359
QUITMAN	10	0	13	0	102
RABUN	17	0	0	0	376
RANDOLPH	7	0	0	0	106
RICHMOND	227	12	60	10	2,289
ROCKDALE	55	56	210	58	1,806
SCHLEY	3	0	0	0	149
SCREVEN	23	0	3	0	124
SEMINOLE	0	0	50	0	58
SPALDING	65	83	171	51	1,417
STEPHENS	41	0	2	0	410
STEWART	5	0	47	0	111
SUMTER	36	0	14	6	524
TALBOT	0	0	0	0	55
TALIAFERRO	0	0	6	0	7
TATTNALL	15	0	37	0	295
TAYLOR	4	4	9	10	104
TELFAIR	18	13	28	0	103
TERRELL	14	0	82	49	149
THOMAS	22	63	79	62	270
TIFT	59	38	204	151	499

FAMILY PRESERVATION SERVICES

STATE FISCAL YEAR 2018

COUNTY	CHILD AND FAMILY ASSESSMENT	EARLY INTERVENTION	HOMESTEAD	PARENT AIDE	PREVENTION OF OUT-OF-HOME PLACEMENT
TOOMBS	45	25	3	2	282
TOWNS	3	0	63	11	209
TREUTLEN	4	2	12	0	48
TROUP	114	61	247	238	1,208
TURNER	6	3	27	9	100
TWIGGS	18	0	34	16	218
UNION	26	0	191	51	539
UPSON	46	0	162	62	1,224
WALKER	103	225	454	171	2,706
WALTON	98	6	34	52	1,359
WARE	62	0	53	18	508
WARREN	5	0	0	0	7
WASHINGTON	35	4	17	11	166
WAYNE	45	0	5	0	241
WEBSTER	0	0	4	0	28
WHEELER	3	3	13	0	16
WHITE	17	0	15	25	327
WHITFIELD	129	206	66	182	1,583
WILCOX	7	3	2	4	40
WILKES	11	6	43	23	92
WILKINSON	30	0	57	91	489
WORTH	59	0	108	88	623
STATE TOTAL	**7,333**	**3,365**	**15,381**	**9,950**	**107,302**

FAMILY PRESERVATION SERVICES EXPENDITURES

STATE FISCAL YEAR 2018

COUNTY	CHILD AND FAMILY ASSESSMENT	EARLY INTERVENTION	HOMESTEAD	PARENT AIDE	PREVENTION OF OUT-OF-HOME PLACEMENT
APPLING	$7,600	$0	$3,300	$1,627	$36,872
ATKINSON	$2,850	$440	$86	$82	$11,872
BACON	$5,250	$2,281	$5,640	$391	$21,264
BAKER	$1,700	$0	$0	$400	$8,874
BALDWIN	$15,450	$2,827	$46,742	$53,352	$126,912
BANKS	$9,300	$0	$0	$178	$30,064
BARROW	$25,600	$0	$40,726	$0	$138,822
BARTOW	$37,900	$0	$505	$0	$178,323
BEN HILL	$31,850	$1,461	$120,199	$34,999	$180,744
BERRIEN	$17,075	$0	$4,604	$2,664	$45,964
BIBB	$43,550	$0	$34,079	$6,382	$261,803
BLECKLEY	$3,100	$265	$1,777	$201	$17,627
BRANTLEY	$14,550	$0	$10,142	$0	$25,735
BROOKS	$7,350	$5,344	$4,722	$1,745	$64,691
BRYAN	$12,285	$4,237	$16,755	$0	$36,840
BULLOCH	$18,900	$744	$2,229	$5,399	$54,698
BURKE	$10,400	$0	$3,708	$1,071	$54,057
BUTTS	$7,150	$0	$9,502	$0	$48,329
CALHOUN	$1,200	$0	$350	$0	$7,789
CAMDEN	$25,455	$3,065	$12,520	$3,518	$112,812
CANDLER	$7,050	$0	$3,441	$857	$15,015
CARROLL	$42,750	$4,471	$25,835	$4,123	$165,045
CATOOSA	$52,450	$2,793	$24,415	$12,710	$175,715
CHARLTON	$4,600	$0	$5,579	$0	$10,351
CHATHAM	$69,275	$0	$52,431	$313,932	$317,047
CHATTAHOOCHEE	$0	$0	$1,690	$0	$15,353
CHATTOOGA	$11,450	$1,596	$10,689	$24,889	$29,894
CHEROKEE	$94,600	$3,861	$1,124	$18,461	$771,145
CLARKE	$66,853	$390	$23,477	$6,518	$284,934
CLAY	$0	$0	$457	$0	$4,529
CLAYTON	$57,350	$915	$39,207	$1,947	$210,541
CLINCH	$4,250	$996	$2,836	$0	$25,719
COBB	$148,600	$9,878	$50,183	$42,725	$790,359
COFFEE	$33,650	$7,951	$26,874	$22,515	$110,707
COLQUITT	$21,450	$0	$12,865	$9,279	$112,081
COLUMBIA	$13,300	$811	$2,547	$3,183	$141,646
COOK	$5,000	$0	$8,448	$1,920	$26,694
COWETA	$23,800	$3,981	$8,930	$937	$132,584
CRAWFORD	$600	$0	$35,218	$950	$36,327
CRISP	$10,050	$371	$19,739	$1,170	$95,239
DADE	$11,500	$12	$957	$1,663	$23,175
DAWSON	$6,050	$0	$797	$936	$25,280
DECATUR	$16,650	$0	$8,973	$4,044	$86,567
DEKALB	$166,250	$3,952	$245,648	$101,508	$788,666
DODGE	$8,250	$657	$5,523	$1,473	$41,461

FAMILY PRESERVATION SERVICES EXPENDITURES

STATE FISCAL YEAR 2018

COUNTY	CHILD AND FAMILY ASSESSMENT	EARLY INTERVENTION	HOMESTEAD	PARENT AIDE	PREVENTION OF OUT-OF-HOME PLACEMENT
DOOLY	$5,100	$0	$3,778	$1,378	$13,695
DOUGHERTY	$4,600	$20,544	$95,152	$22,605	$307,995
DOUGLAS	$34,500	$5,644	$58,544	$7,884	$67,635
EARLY	$1,800	$0	$1,826	$0	$7,694
ECHOLS	$1,200	$0	$2,595	$3,223	$4,174
EFFINGHAM	$14,500	$7,897	$39,058	$833	$68,763
ELBERT	$9,300	$170	$16,348	$0	$51,601
EMANUEL	$8,850	$1,365	$745	$0	$17,376
EVANS	$2,850	$0	$2,499	$0	$14,809
FANNIN	$11,200	$0	$0	$0	$30,921
FAYETTE	$10,600	$4,057	$16,779	$5,072	$57,917
FLOYD	$43,900	$0	$22,861	$43,799	$208,677
FORSYTH	$40,450	$0	$17,447	$12,700	$324,299
FRANKLIN	$13,300	$0	$0	$0	$6,730
FULTON	$109,500	$0	$55,114	$21,064	$938,275
GILMER	$7,600	$0	$285	$0	$62,965
GLASCOCK	$600	$0	$0	$0	$9,805
GLYNN	$16,100	$1,401	$5,167	$10,033	$85,459
GORDON	$57,475	$864	$0	$5,800	$105,010
GRADY	$11,950	$0	$3,310	$1,452	$76,955
GREENE	$6,900	$0	$1,558	$698	$30,002
GWINNETT	$71,650	$2,696	$51,677	$52,076	$751,432
HABERSHAM	$21,750	$0	$2,767	$543	$86,949
HALL	$75,150	$2,564	$19,702	$6,626	$481,525
HANCOCK	$5,000	$0	$1,796	$0	$14,675
HARALSON	$11,700	$2,582	$14,685	$2,610	$80,224
HARRIS	$4,850	$50	$1,360	$385	$46,680
HART	$4,500	$0	$0	$0	$3,581
HEARD	$2,150	$0	$3,748	$0	$11,500
HENRY	$37,000	$4,949	$77,720	$16,813	$543,017
HOUSTON	$26,150	$0	$50,571	$15,690	$94,438
IRWIN	$8,300	$1,182	$42,768	$12,924	$46,794
JACKSON	$32,575	$175	$9,291	$1,606	$159,404
JASPER	$6,250	$3,750	$13,084	$4,418	$75,446
JEFF DAVIS	$7,100	$437	$3,672	$2,368	$47,447
JEFFERSON	$7,800	$0	$0	$0	$31,413
JENKINS	$7,350	$0	$350	$0	$14,516
JOHNSON	$3,150	$179	$794	$0	$16,473
JONES	$11,950	$6,585	$128,066	$52,332	$149,406
LAMAR	$16,950	$658	$3,723	$949	$44,257
LANIER	$14,785	$4,798	$6,453	$879	$57,264
LAURENS	$19,875	$1,225	$4,544	$5,219	$80,398
LEE	$11,300	$0	$20,843	$3,482	$68,189
LIBERTY	$20,570	$852	$20,713	$5,039	$90,701
LINCOLN	$1,650	$1,907	$3,258	$1,284	$12,619
LONG	$9,400	$538	$4,266	$4,296	$32,969

FAMILY PRESERVATION SERVICES EXPENDITURES

STATE FISCAL YEAR 2018

COUNTY	CHILD AND FAMILY ASSESSMENT	EARLY INTERVENTION	HOMESTEAD	PARENT AIDE	PREVENTION OF OUT-OF-HOME PLACEMENT
LOWNDES	$35,450	$15,898	$44,521	$24,662	$268,873
LUMPKIN	$11,150	$0	$5,090	$350	$57,417
MACON	$3,500	$170	$0	$881	$10,072
MADISON	$8,500	$337	$1,614	$1,585	$41,051
MARION	$0	$0	$1,303	$0	$11,329
MCDUFFIE	$5,850	$214	$350	$368	$18,428
MCINTOSH	$7,700	$0	$736	$1,777	$23,261
MERIWETHER	$9,550	$0	$390	$245	$68,052
MILLER	$0	$0	$10,120	$0	$17,828
MITCHELL	$8,000	$413	$9,632	$5,537	$61,395
MONROE	$10,200	$5,802	$48,171	$70	$54,419
MONTGOMERY	$1,800	$2,177	$0	$0	$6,651
MORGAN	$16,850	$767	$1,307	$91	$68,693
MURRAY	$23,500	$0	$2,105	$1,312	$152,562
MUSCOGEE	$90,450	$0	$55,213	$9,181	$584,129
NEWTON	$24,875	$1,114	$61,407	$2,916	$132,869
OCONEE	$8,400	$0	$4,413	$245	$23,868
OGLETHORPE	$4,400	$468	$1,279	$0	$16,467
PAULDING	$29,450	$0	$0	$0	$213,577
PEACH	$7,950	$2,149	$48,445	$415	$74,692
PICKENS	$21,500	$0	$3,829	$399	$131,642
PIERCE	$9,730	$1,365	$6,083	$734	$53,733
PIKE	$3,650	$0	$910	$1,888	$22,684
POLK	$26,000	$3,091	$4,081	$3,245	$122,319
PULASKI	$3,500	$581	$402	$990	$11,710
PUTNAM	$5,700	$5,661	$27,952	$23,218	$56,508
QUITMAN	$3,700	$0	$2,571	$0	$10,323
RABUN	$7,400	$0	$0	$0	$32,116
RANDOLPH	$1,950	$0	$0	$0	$8,619
RICHMOND	$74,500	$936	$11,555	$625	$302,105
ROCKDALE	$26,250	$7,774	$60,464	$12,228	$277,748
SCHLEY	$1,300	$0	$0	$0	$12,171
SCREVEN	$9,375	$0	$1,050	$0	$19,976
SEMINOLE	$0	$0	$4,937	$0	$4,614
SPALDING	$25,700	$6,639	$34,080	$4,229	$190,084
STEPHENS	$15,150	$0	$224	$0	$47,570
STEWART	$2,300	$0	$9,518	$0	$7,517
SUMTER	$14,700	$0	$2,488	$754	$59,832
TALBOT	$0	$0	$0	$0	$6,948
TALIAFERRO	$0	$0	$476	$0	$764
TATTNALL	$5,550	$0	$7,218	$0	$35,571
TAYLOR	$1,575	$760	$1,829	$1,603	$9,006
TELFAIR	$6,900	$1,670	$7,317	$0	$25,996
TERRELL	$5,950	$0	$9,280	$4,003	$25,649
THOMAS	$10,050	$3,152	$10,594	$3,154	$42,798
TIFT	$24,625	$1,617	$39,724	$16,661	$92,319

FAMILY PRESERVATION SERVICES EXPENDITURES

STATE FISCAL YEAR 2018

COUNTY	CHILD AND FAMILY ASSESSMENT	EARLY INTERVENTION	HOMESTEAD	PARENT AIDE	PREVENTION OF OUT-OF-HOME PLACEMENT
TOOMBS	$17,690	$1,501	$148	$75	$51,388
TOWNS	$900	$0	$8,900	$556	$50,746
TREUTLEN	$2,150	$247	$1,810	$0	$10,634
TROUP	$43,900	$2,527	$29,240	$18,684	$160,066
TURNER	$3,350	$64	$11,311	$855	$16,472
TWIGGS	$6,500	$0	$8,044	$826	$29,824
UNION	$9,300	$0	$33,918	$2,912	$130,428
UPSON	$18,750	$0	$32,725	$6,267	$144,935
WALKER	$45,275	$8,512	$40,645	$9,379	$194,543
WALTON	$43,400	$628	$5,810	$5,061	$176,771
WARE	$26,125	$0	$5,500	$2,388	$66,430
WARREN	$1,200	$0	$0	$0	$1,045
WASHINGTON	$12,750	$439	$3,715	$963	$36,975
WAYNE	$16,525	$0	$1,404	$0	$37,763
WEBSTER	$0	$0	$751	$0	$2,925
WHEELER	$1,500	$525	$2,491	$0	$2,686
WHITE	$6,550	$0	$1,845	$3,579	$40,024
WHITFIELD	$51,300	$9,714	$7,545	$10,343	$155,971
WILCOX	$3,700	$319	$414	$530	$10,625
WILKES	$4,800	$760	$6,176	$6,630	$23,129
WILKINSON	$10,350	$0	$26,742	$8,738	$52,777
WORTH	$21,450	$0	$11,038	$7,474	$73,445
STATE TOTAL	**$2,987,568**	**$228,362**	**$2,547,241**	**$1,222,453**	**$16,417,795**

CHILD PROTECTIVE SERVICES (CPS)

GEORGIA CHILD PROTECTIVE SERVICES

STATE FISCAL YEAR 2018

COUNTY	SUBSTANTIATED		UNSUBSTANTIATED		TOTAL CASES INVESTIGATED	SCREENED OUT	FAMILY SUPPORT	TOTAL CASES
	OPEN	CLOSED	OPEN	CLOSED				
APPLING	9	6	16	84	115	94	227	436
ATKINSON	9	4	7	28	48	19	43	110
BACON	18	4	6	23	51	30	109	190
BAKER	1	1	2	9	13	5	9	27
BALDWIN	49	26	50	161	286	181	210	677
BANKS	17	3	12	61	93	66	166	325
BARROW	56	28	20	113	217	190	582	989
BARTOW	16	10	61	239	326	325	909	1,560
BEN HILL	16	16	17	63	112	79	173	364
BERRIEN	20	17	13	52	102	59	177	338
BIBB	143	98	94	714	1,049	450	832	2,331
BLECKLEY	3	6	0	10	19	35	106	160
BRANTLEY	22	14	23	89	148	62	179	389
BROOKS	16	10	5	43	74	46	90	210
BRYAN	25	7	10	66	108	92	184	384
BULLOCH	42	19	10	135	206	127	288	621
BURKE	17	8	27	46	98	76	144	318
BUTTS	8	1	24	26	59	60	162	281
CALHOUN	5	1	4	6	16	10	19	45
CAMDEN	35	30	42	173	280	121	288	689
CANDLER	3	0	3	16	22	28	90	140
CARROLL	68	78	82	404	632	449	1,096	2,177
CATOOSA	78	36	36	239	389	278	493	1,160
CHARLTON	12	3	4	21	40	35	82	157
CHATHAM	187	127	173	997	1,484	714	1,246	3,444
CHATTAHOOCHEE	8	5	5	24	42	21	50	113
CHATTOOGA	55	16	25	84	180	50	222	452
CHEROKEE	140	51	173	395	759	674	1,107	2,540
CLARKE	84	65	78	223	450	337	717	1,504
CLAY	3	1	4	3	11	6	11	28
CLAYTON	130	114	126	1,130	1,500	1,189	1,761	4,450
CLINCH	12	5	2	23	42	19	41	102
COBB	119	91	185	1,193	1,588	1,893	3,517	6,998
COFFEE	51	31	34	203	319	111	266	696
COLQUITT	37	19	94	116	266	172	325	763
COLUMBIA	23	39	36	176	274	349	774	1,397
COOK	23	13	7	55	98	59	116	273
COWETA	21	28	56	179	284	336	707	1,327
CRAWFORD	5	2	21	37	65	24	68	157
CRISP	25	17	12	75	129	70	204	403
DADE	23	8	4	20	55	52	123	230
DAWSON	28	12	20	82	142	76	159	377
DECATUR	36	12	13	80	141	57	193	391

*Source: Georgia SHINES

GEORGIA CHILD PROTECTIVE SERVICES

STATE FISCAL YEAR 2018

COUNTY	SUBSTANTIATED		UNSUBSTANTIATED		TOTAL CASES INVESTIGATED	SCREENED OUT	FAMILY SUPPORT	TOTAL CASES
	OPEN	CLOSED	OPEN	CLOSED				
DEKALB	214	334	268	1,933	2,749	1,529	2,564	6,842
DODGE	19	5	1	36	61	59	167	287
DOOLY	8	3	1	17	29	28	53	110
DOUGHERTY	101	93	38	306	538	323	566	1,427
DOUGLAS	77	41	110	303	531	508	979	2,018
EARLY	2	1	4	12	19	24	105	148
ECHOLS	5	2	1	5	13	14	26	53
EFFINGHAM	48	8	11	105	172	157	369	698
ELBERT	16	5	18	48	87	51	169	307
EMANUEL	13	15	6	49	83	78	179	340
EVANS	7	0	2	4	13	28	67	108
FANNIN	18	1	22	75	116	73	216	405
FAYETTE	15	11	23	73	122	170	317	609
FLOYD	70	21	187	253	531	405	981	1,917
FORSYTH	81	48	74	224	427	302	663	1,392
FRANKLIN	8	1	35	43	87	117	226	430
FULTON	129	273	174	3,113	3,689	3,023	4,573	11,285
GILMER	15	11	17	81	124	60	206	390
GLASCOCK	0	2	7	8	17	11	27	55
GLYNN	31	26	22	193	272	227	498	997
GORDON	46	13	54	162	275	149	413	837
GRADY	26	26	13	79	144	78	183	405
GREENE	9	5	4	23	41	42	74	157
GWINNETT	101	82	140	1,106	1,429	2,058	3,603	7,090
HABERSHAM	50	17	27	91	185	117	267	569
HALL	164	80	96	521	861	512	1,063	2,436
HANCOCK	8	1	7	27	43	24	40	107
HARALSON	24	9	18	114	165	127	326	618
HARRIS	12	8	16	28	64	48	64	176
HART	8	5	31	37	81	53	135	269
HEARD	12	11	12	24	59	29	93	181
HENRY	121	99	129	635	984	1,182	1,572	3,738
HOUSTON	79	63	37	304	483	306	804	1,593
IRWIN	8	7	9	28	52	21	67	140
JACKSON	51	11	46	162	270	260	448	978
JASPER	24	11	4	55	94	52	125	271
JEFF DAVIS	5	14	8	61	88	61	178	327
JEFFERSON	9	4	9	18	40	47	94	181
JENKINS	12	2	0	11	25	26	63	114
JOHNSON	7	3	0	16	26	38	61	125
JONES	40	12	24	58	134	61	108	303
LAMAR	27	8	9	40	84	54	107	245
LANIER	13	5	6	39	63	51	102	216

*Source: Georgia SHINES

GEORGIA CHILD PROTECTIVE SERVICES

STATE FISCAL YEAR 2018

COUNTY	SUBSTANTIATED		UNSUBSTANTIATED		TOTAL CASES INVESTIGATED	SCREENED OUT	FAMILY SUPPORT	TOTAL CASES
	OPEN	CLOSED	OPEN	CLOSED				
LAURENS	36	31	2	94	163	157	329	649
LEE	6	8	39	105	158	91	138	387
LIBERTY	39	27	19	310	395	305	476	1,176
LINCOLN	11	5	1	10	27	14	42	83
LONG	15	12	4	67	98	68	127	293
LOWNDES	62	66	43	471	642	313	809	1,764
LUMPKIN	31	19	25	126	201	49	190	440
MACON	3	4	4	17	28	83	88	199
MADISON	22	6	20	95	143	95	259	497
MARION	8	1	5	20	34	31	58	123
MCDUFFIE	17	11	14	89	131	63	162	356
MCINTOSH	4	8	9	24	45	24	73	142
MERIWETHER	9	4	19	42	74	52	131	257
MILLER	1	1	3	3	8	15	46	69
MITCHELL	14	12	19	72	117	74	124	315
MONROE	28	18	14	76	136	54	125	315
MONTGOMERY	3	2	4	23	32	22	60	114
MORGAN	13	7	7	41	68	47	110	225
MURRAY	21	22	77	212	332	182	381	895
MUSCOGEE	115	81	136	715	1,047	1,111	1,537	3,695
NEWTON	41	31	43	277	392	327	593	1,312
OCONEE	8	8	10	45	71	62	112	245
OGLETHORPE	9	3	11	29	52	22	90	164
PAULDING	25	10	106	331	472	530	1,063	2,065
PEACH	16	13	26	59	114	42	105	261
PICKENS	22	23	38	88	171	107	230	508
PIERCE	27	8	2	85	122	47	137	306
PIKE	12	11	14	20	57	61	112	230
POLK	40	21	49	141	251	197	421	869
PULASKI	4	3	1	10	18	27	73	118
PUTNAM	20	5	7	49	81	62	93	236
QUITMAN	4	0	3	5	12	8	20	40
RABUN	32	8	5	46	91	51	94	236
RANDOLPH	3	1	10	20	34	21	28	83
RICHMOND	130	179	93	1,066	1,468	701	1,388	3,557
ROCKDALE	35	23	46	188	292	308	482	1,082
SCHLEY	5	1	4	7	17	20	40	77
SCREVEN	24	4	1	23	52	34	79	165
SEMINOLE	1	3	0	8	12	33	62	107
SPALDING	47	22	97	162	328	300	520	1,148
STEPHENS	22	12	26	88	148	88	212	448
STEWART	2	1	3	4	10	18	9	37
SUMTER	2	11	22	73	108	86	180	374

*Source: Georgia SHINES

GEORGIA CHILD PROTECTIVE SERVICES

STATE FISCAL YEAR 2018

COUNTY	SUBSTANTIATED		UNSUBSTANTIATED		TOTAL CASES INVESTIGATED	SCREENED OUT	FAMILY SUPPORT	TOTAL CASES
	OPEN	CLOSED	OPEN	CLOSED				
TALBOT	1	3	3	2	9	9	8	26
TALIAFERRO	1	0	0	4	5	2	3	10
TATTNALL	5	1	14	19	39	49	137	225
TAYLOR	5	2	5	16	28	16	34	78
TELFAIR	6	1	3	16	26	30	86	142
TERRELL	2	0	10	33	45	17	41	103
THOMAS	13	9	27	149	198	203	362	763
TIFT	26	20	21	135	202	131	304	637
TOOMBS	11	7	24	109	151	131	248	530
TOWNS	4	3	14	22	43	40	67	150
TREUTLEN	3	4	3	19	29	19	50	98
TROUP	66	56	99	207	428	226	466	1,120
TURNER	5	8	4	34	51	37	73	161
TWIGGS	15	4	8	11	38	15	21	74
UNION	22	7	40	64	133	56	137	326
UPSON	20	5	37	67	129	83	213	425
WALKER	72	29	77	285	463	343	654	1,460
WALTON	74	39	40	243	396	312	613	1,321
WARE	45	39	13	185	282	145	325	752
WARREN	6	1	1	11	19	4	29	52
WASHINGTON	26	6	9	37	78	51	113	242
WAYNE	20	6	8	100	134	144	352	630
WEBSTER	2	0	2	1	5	4	13	22
WHEELER	5	2	2	8	17	11	44	72
WHITE	44	11	28	131	214	72	214	500
WHITFIELD	35	11	135	374	555	343	686	1,584
WILCOX	5	1	2	9	17	21	62	100
WILKES	8	13	10	27	58	15	47	120
WILKINSON	21	8	6	15	50	27	29	106
WORTH	24	15	13	116	168	74	140	382
STATE TOTAL	**5,012**	**3,536**	**5,095**	**26,321**	**39,964**	**30,341**	**58,185**	**128,490**

*Source: Georgia SHINES

U.S. CENSUS

GEORGIA POPULATION

COUNTY	POPULATION 2010 CENSUS (April 2010)	POPULATION ESTIMATES (as of July 1, 2017)	RESIDENT TOTAL POPULATION NET CHANGE - APRIL 1, 2010 TO JULY 1, 2017	RESIDENT TOTAL POPULATION PERCENT CHANGE - APRIL 1, 2010 TO JULY 1, 2017
APPLING	18,236	18,521	285	1.56%
ATKINSON	8,375	8,342	-33	-0.39%
BACON	11,096	11,319	223	2.01%
BAKER	3,451	3,200	-251	-7.27%
BALDWIN	45,720	44,906	-814	-1.78%
BANKS	18,395	18,634	239	1.30%
BARROW	69,367	79,061	9,694	13.97%
BARTOW	100,157	105,054	4,897	4.89%
BEN HILL	17,634	16,996	-638	-3.62%
BERRIEN	19,286	19,186	-100	-0.52%
BIBB	155,547	152,862	-2,685	-1.73%
BLECKLEY	13,063	12,830	-233	-1.78%
BRANTLEY	18,411	18,731	320	1.74%
BROOKS	16,243	15,587	-656	-4.04%
BRYAN	30,233	37,060	6,827	22.58%
BULLOCH	70,217	76,149	5,932	8.45%
BURKE	23,316	22,522	-794	-3.41%
BUTTS	23,655	24,059	404	1.71%
CALHOUN	6,694	6,455	-239	-3.57%
CAMDEN	50,513	53,044	2,531	5.01%
CANDLER	10,998	10,797	-201	-1.83%
CARROLL	110,527	117,812	7,285	6.59%
CATOOSA	63,942	66,550	2,608	4.08%
CHARLTON	12,171	12,715	544	4.47%
CHATHAM	265,128	290,501	25,373	9.57%
CHATTAHOOCHEE	11,267	10,343	-924	-8.20%
CHATTOOGA	26,015	24,770	-1,245	-4.79%
CHEROKEE	214,346	247,573	33,227	15.50%
CLARKE	116,714	127,064	10,350	8.87%
CLAY	3,183	2,962	-221	-6.94%
CLAYTON	259,424	285,153	25,729	9.92%
CLINCH	6,798	6,727	-71	-1.04%
COBB	688,078	755,754	67,676	9.84%
COFFEE	42,356	43,014	658	1.55%
COLQUITT	45,498	45,835	337	0.74%
COLUMBIA	124,053	151,579	27,526	22.19%
COOK	17,212	17,277	65	0.38%
COWETA	127,317	143,114	15,797	12.41%
CRAWFORD	12,630	12,295	-335	-2.65%
CRISP	23,439	22,736	-703	-3%
DADE	16,633	16,285	-348	-2.09%
DAWSON	22,330	24,379	2,049	9.18%
DECATUR	27,842	26,716	-1,126	-4.04%

GEORGIA POPULATION

COUNTY	POPULATION 2010 CENSUS (April 2010)	POPULATION ESTIMATES (as of July 1, 2017)	RESIDENT TOTAL POPULATION NET CHANGE - APRIL 1, 2010 TO JULY 1, 2017	RESIDENT TOTAL POPULATION PERCENT CHANGE - APRIL 1, 2010 TO JULY 1, 2017
DEKALB	691,893	753,253	61,360	8.87%
DODGE	21,796	20,730	-1,066	-4.89%
DOOLY	14,918	13,737	-1,181	-7.92%
DOUGHERTY	94,565	89,502	-5,063	-5.35%
DOUGLAS	132,403	143,882	11,479	8.67%
EARLY	11,008	10,296	-712	-6.47%
ECHOLS	4,034	3,936	-98	-2.43%
EFFINGHAM	52,250	59,982	7,732	14.80%
ELBERT	20,166	19,109	-1,057	-5.24%
EMANUEL	22,598	22,530	-68	-0.30%
EVANS	11,000	10,775	-225	-2.05%
FANNIN	23,682	25,322	1,640	6.93%
FAYETTE	106,567	112,549	5,982	5.61%
FLOYD	96,317	97,613	1,296	1.35%
FORSYTH	175,511	227,967	52,456	29.89%
FRANKLIN	22,084	22,820	736	3.33%
FULTON	920,581	1,041,423	120,842	13.13%
GILMER	28,292	30,674	2,382	8.42%
GLASCOCK	3,082	3,062	-20	-0.65%
GLYNN	79,626	85,282	5,656	7.10%
GORDON	55,186	57,089	1,903	3.45%
GRADY	25,011	24,819	-192	-0.77%
GREENE	15,994	17,281	1,287	8.05%
GWINNETT	805,321	920,260	114,939	14.27%
HABERSHAM	43,041	44,567	1,526	3.55%
HALL	179,684	199,335	19,651	10.94%
HANCOCK	9,429	8,561	-868	-9.21%
HARALSON	28,780	29,256	476	1.65%
HARRIS	32,024	33,915	1,891	5.90%
HART	25,213	25,794	581	2.30%
HEARD	11,834	11,730	-104	-0.88%
HENRY	203,922	225,813	21,891	10.73%
HOUSTON	139,900	153,479	13,579	9.71%
IRWIN	9,538	9,410	-128	-1.34%
JACKSON	60,485	67,519	7,034	11.63%
JASPER	13,900	13,964	64	0.46%
JEFF DAVIS	15,068	15,025	-43	-0.29%
JEFFERSON	16,930	15,648	-1,282	-7.57%
JENKINS	8,340	8,767	427	5.12%
JOHNSON	9,980	9,788	-192	-1.92%
JONES	28,669	28,470	-199	-0.69%
LAMAR	18,317	18,599	282	1.54%
LANIER	10,078	10,425	347	3.44%

GEORGIA POPULATION

COUNTY	POPULATION 2010 CENSUS (April 2010)	POPULATION ESTIMATES (as of July 1, 2017)	RESIDENT TOTAL POPULATION NET CHANGE - APRIL 1, 2010 TO JULY 1, 2017	RESIDENT TOTAL POPULATION PERCENT CHANGE - APRIL 1, 2010 TO JULY 1, 2017
LAURENS	48,434	47,330	-1,104	-2.28%
LEE	28,298	29,470	1,172	4.14%
LIBERTY	63,453	61,386	-2,067	-3.26%
LINCOLN	7,996	7,880	-116	-1.45%
LONG	14,464	19,014	4,550	31.46%
LOWNDES	109,233	115,489	6,256	5.73%
LUMPKIN	29,966	32,873	2,907	9.70%
MACON	21,875	21,498	-377	-1.72%
MADISON	14,333	14,106	-227	-1.58%
MARION	14,740	13,314	-1,426	-9.67%
MCDUFFIE	28,120	29,302	1,182	4.20%
MCINTOSH	8,742	8,450	-292	-3.34%
MERIWETHER	21,992	21,049	-943	-4.29%
MILLER	6,125	5,838	-287	-4.69%
MITCHELL	23,498	22,292	-1,206	-5.13%
MONROE	26,424	27,113	689	2.61%
MONTGOMERY	9,123	9,031	-92	-1.01%
MORGAN	17,868	18,412	544	3.04%
MURRAY	39,628	39,782	154	0.39%
MUSCOGEE	189,885	194,058	4,173	2.20%
NEWTON	99,958	108,078	8,120	8.12%
OCONEE	32,808	38,028	5,220	15.91%
OGLETHORPE	14,899	14,877	-22	-0.15%
PAULDING	142,324	159,445	17,121	12.03%
PEACH	27,695	27,099	-596	-2.15%
PICKENS	29,431	31,588	2,157	7.33%
PIERCE	18,758	19,307	549	2.93%
PIKE	17,869	18,217	348	1.95%
POLK	41,475	42,085	610	1.47%
PULASKI	12,010	11,201	-809	-6.74%
PUTNAM	21,218	21,730	512	2.41%
QUITMAN	2,513	2,358	-155	-6.17%
RABUN	16,276	16,602	326	2%
RANDOLPH	7,719	7,075	-644	-8.34%
RICHMOND	200,549	201,800	1,251	0.62%
ROCKDALE	85,215	90,312	5,097	5.98%
SCHLEY	5,010	5,213	203	4.05%
SCREVEN	14,593	13,953	-640	-4.39%
SEMINOLE	8,729	8,292	-437	-5.01%
SPALDING	64,073	65,380	1,307	2.04%
STEPHENS	26,175	25,890	-285	-1.09%
STEWART	6,058	5,985	-73	-1.21%
SUMTER	32,819	29,847	-2,972	-9.06%

GEORGIA POPULATION

COUNTY	POPULATION 2010 CENSUS (April 2010)	POPULATION ESTIMATES (as of July 1, 2017)	RESIDENT TOTAL POPULATION NET CHANGE - APRIL 1, 2010 TO JULY 1, 2017	RESIDENT TOTAL POPULATION PERCENT CHANGE - APRIL 1, 2010 TO JULY 1, 2017
TALBOT	6,865	6,249	-616	-8.97%
TALIAFERRO	1,717	1,628	-89	-5.18%
TATTNALL	25,520	25,334	-186	-0.73%
TAYLOR	8,906	8,142	-764	-8.58%
TELFAIR	16,500	15,989	-511	-3.10%
TERRELL	9,315	8,729	-586	-6.29%
THOMAS	44,720	44,779	59	0.13%
TIFT	40,118	40,598	480	1.20%
TOOMBS	27,223	26,999	-224	-0.82%
TOWNS	10,471	11,506	1,035	9.88%
TREUTLEN	6,885	6,740	-145	-2.11%
TROUP	67,044	69,786	2,742	4.09%
TURNER	8,930	7,961	-969	-10.85%
TWIGGS	9,023	8,174	-849	-9.41%
UNION	21,356	23,459	2,103	9.85%
UPSON	27,153	26,135	-1,018	-3.75%
WALKER	68,756	68,939	183	0.27%
WALTON	83,768	91,600	7,832	9.35%
WARE	36,312	35,871	-441	-1.21%
WARREN	5,834	5,303	-531	-9.10%
WASHINGTON	21,187	20,313	-874	-4.13%
WAYNE	30,099	29,817	-282	-0.94%
WEBSTER	2,799	2,605	-194	-6.93%
WHEELER	7,421	7,952	531	7.16%
WHITE	27,144	29,453	2,309	8.51%
WHITFIELD	102,599	104,658	2,059	2.01%
WILCOX	9,255	8,800	-455	-4.92%
WILKES	10,593	9,892	-701	-6.62%
WILKINSON	9,563	8,959	-604	-6.32%
WORTH	21,679	20,533	-1,146	-5.29%

POVERTY IN THE 2010 CENSUS

COUNTY	ALL AGES BELOW POVERTY LEVEL		AGES 5 AND UNDER BELOW POVERTY LEVEL		AGES 5-17 BELOW POVERTY LEVEL		MEDIAN HOUSEHOLD INCOME IN 2010
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	
APPLING	4,435	24.70	484	38.80	958	29.20	0
ATKINSON	2,262	27.40	286	49.40	760	44.30	0
BACON	2,466	23.20	330	43.70	671	31.20	0
BAKER	634	19.50	34	26.80	93	17.60	0
BALDWIN	11,610	27.80	857	39.90	2,293	36.00	0
BANKS	2,629	14.30	205	21.80	559	16.90	0
BARROW	9,829	13.20	880	16.40	2,736	18.80	0
BARTOW	14,417	14.20	1,203	18.20	3,639	19.40	0
BEN HILL	5,139	30.40	463	40.80	1,418	43.90	0
BERRIEN	4,445	23.70	389	35.00	952	28.20	0
BIBB	39,473	26.70	5,108	47.50	10,434	38.80	0
BLECKLEY	2,591	23.00	181	26.70	643	33.90	0
BRANTLEY	3,970	21.80	387	36.20	843	25.30	0
BROOKS	3,641	23.60	337	39.00	998	41.40	0
BRYAN	4,897	14.10	510	21.00	1,213	15.70	0
BULLOCH	20,153	30.40	1,398	34.80	3,336	31.80	0
BURKE	6,504	29.20	667	42.60	2,080	49.20	0
BUTTS	4,892	23.50	565	43.50	964	27.20	0
CALHOUN	1,474	32.20	121	55.00	345	38.50	0
CAMDEN	6,413	12.70	708	18.40	1,869	21.00	0
CANDLER	3,341	31.50	359	55.00	872	41.60	0
CARROLL	20,705	18.60	1,879	25.80	5,328	26.40	0
CATOOSA	7,045	10.80	707	19.60	1,536	13.10	0
CHARLTON	2,719	23.10	247	34.20	599	34.90	0
CHATHAM	47,119	17.30	4,846	26.50	11,039	25.60	0
CHATTAHOOCHEE	1,139	15.00	190	20.80	240	16.10	0
CHATTOOGA	5,152	22.50	424	34.20	1,166	28.10	0
CHEROKEE	22,072	9.40	2,489	17.20	4,814	10.60	0
CLARKE	38,618	34.10	2,391	35.40	5,986	41.60	0
CLAY	1,230	41.40	143	70.10	309	60.80	0
CLAYTON	58,701	21.90	8,016	38.70	17,448	31.60	0
CLINCH	2,641	39.50	329	55.40	494	40.80	0
COBB	79,127	10.90	7,338	15.40	18,975	14.50	0
COFFEE	9,348	23.90	1,098	38.00	2,490	32.70	0
COLQUITT	11,444	25.40	1,493	46.50	3,097	35.30	0
COLUMBIA	12,269	8.60	868	9.60	2,846	10.30	0
COOK	4,099	24.20	362	33.20	954	29.10	0
COWETA	15,900	11.60	1,863	21.60	3,888	14.90	0
CRAWFORD	2,207	18.10	191	29.40	440	22.30	0
CRISP	7,025	31.20	692	46.90	1,588	38.30	0
DADE	2,619	17.50	172	23.70	523	22.70	0
DAWSON	2,729	11.80	299	23.60	465	13.00	0
DECATUR	6,233	24.10	653	36.10	1,348	28.00	0

POVERTY IN THE 2010 CENSUS

COUNTY	ALL AGES BELOW POVERTY LEVEL		AGES 5 AND UNDER BELOW POVERTY LEVEL		AGES 5-17 BELOW POVERTY LEVEL		MEDIAN HOUSEHOLD INCOME IN 2010
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	
DEKALB	127,299	17.60	15,631	30.00	31,860	27.00	0
DODGE	4,229	22.20	250	22.50	1,037	33.60	0
DOOLY	2,837	23.20	156	28.90	678	32.90	0
DOUGHERTY	26,759	30.50	2,790	45.10	7,247	45.90	0
DOUGLAS	19,690	14.20	2,363	26.80	4,556	16.30	0
EARLY	2,812	27.50	297	44.60	778	41.40	0
ECHOLS	1,130	28.20	98	46.00	199	21.60	0
EFFINGHAM	5,405	9.60	561	14.50	1,395	12.40	0
ELBERT	4,246	22.40	480	41.80	935	30.80	0
EMANUEL	6,329	29.20	719	48.20	1,704	41.70	0
EVANS	2,657	26.00	326	41.10	755	37.50	0
FANNIN	3,806	15.80	86	9.90	637	20.00	0
FAYETTE	6,907	6.30	445	9.30	1,577	7.40	0
FLOYD	16,774	18.10	1,590	27.10	3,984	24.10	0
FORSYTH	13,643	6.50	1,286	9.80	3,324	7.10	0
FRANKLIN	5,503	25.40	533	40.10	1,034	29.30	0
FULTON	156,519	16.00	15,804	25.40	37,981	22.80	0
GILMER	5,520	18.80	651	41.30	1,445	33.20	0
GLASCOCK	339	11.50	10	7.10	54	9.70	0
GLYNN	15,773	19.20	1,794	37.00	3,973	28.90	0
GORDON	10,466	18.80	1,093	30.60	3,049	29.20	0
GRADY	6,284	25.40	705	41.60	1,775	39.40	0
GREENE	3,623	21.90	354	36.00	761	34.00	0
GWINNETT	107,267	12.10	11,221	18.60	31,974	17.40	0
HABERSHAM	7,114	17.20	630	24.90	1,604	21.90	0
HALL	30,634	16.10	3,650	28.60	8,775	23.50	0
HANCOCK	1,804	30.00	155	59.20	527	53.60	0
HARALSON	5,064	18.00	391	22.50	1,297	26.10	0
HARRIS	2,382	7.30	163	10.40	400	7.00	0
HART	4,642	18.80	424	30.40	830	21.20	0
HEARD	1,975	17.40	145	22.40	461	24.00	0
HENRY	24,638	11.40	2,414	19.50	7,030	15.70	0
HOUSTON	24,745	16.70	2,783	27.50	6,357	22.70	0
IRWIN	2,204	24.50	106	25.90	587	36.00	0
JACKSON	7,898	12.50	809	19.70	1,454	12.00	0
JASPER	2,623	19.40	84	10.80	680	28.90	0
JEFF DAVIS	3,079	20.60	426	42.90	715	23.40	0
JEFFERSON	4,162	26.90	570	52.00	1,091	40.30	0
JENKINS	2,720	30.70	445	70.20	541	35.40	0
JOHNSON	2,037	21.50	296	54.50	408	29.40	0
JONES	4,001	14.20	378	25.00	980	18.60	0
LAMAR	3,525	20.80	319	32.30	795	28.80	0
LANIER	2,875	28.70	309	44.60	528	28.10	0

POVERTY IN THE 2010 CENSUS

COUNTY	ALL AGES BELOW POVERTY LEVEL		AGES 5 AND UNDER BELOW POVERTY LEVEL		AGES 5-17 BELOW POVERTY LEVEL		MEDIAN HOUSEHOLD INCOME IN 2010
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	
LAURENS	12,683	27.30	1,485	46.80	2,856	33.60	0
LEE	3,281	11.60	380	20.70	909	15.40	0
LIBERTY	9,931	16.60	1,628	26.00	2,192	19.40	0
LINCOLN	1,773	23.00	273	63.90	300	27.80	0
LONG	3,530	20.00	406	29.80	984	26.80	0
LOWNDES	27,410	25.00	2,859	35.90	5,368	28.30	0
LUMPKIN	6,052	20.10	272	20.00	829	18.50	0
MACON	5,503	26.00	812	54.10	1,705	41.30	0
MADISON	2,829	20.30	302	48.50	435	23.40	0
MARION	3,364	28.60	334	55.40	703	34.40	0
MCDUFFIE	4,977	17.60	375	23.00	1,187	24.40	0
MCINTOSH	1,952	23.10	199	43.50	465	33.50	0
MERIWETHER	4,735	22.70	327	28.10	1,059	32.10	0
MILLER	1,332	23.30	111	32.10	387	38.90	0
MITCHELL	5,438	27.10	554	44.40	1,434	37.90	0
MONROE	3,415	13.30	179	12.80	422	10.30	0
MONTGOMERY	1,593	19.50	155	33.00	364	25.10	0
MORGAN	2,374	13.40	280	29.50	497	16.00	0
MURRAY	7,026	18.00	680	28.60	1,897	26.00	0
MUSCOGEE	41,295	21.70	4,839	32.80	10,325	30.40	0
NEWTON	17,328	16.70	1,879	27.50	4,909	23.30	0
OCONEE	2,476	6.90	243	12.90	735	9.50	0
OGLETHORPE	2,543	17.60	199	25.80	764	32.10	0
PAULDING	14,716	9.70	1,119	11.30	4,228	13.40	0
PEACH	4,685	18.70	486	32.50	1,060	24.20	0
PICKENS	2,964	9.80	145	10.20	506	10.70	0
PIERCE	3,994	21.00	357	30.70	1,004	27.50	0
PIKE	2,148	12.30	188	25.00	442	12.80	0
POLK	7,781	19.00	879	32.80	2,318	29.40	0
PULASKI	2,143	21.80	135	42.50	631	40.10	0
PUTNAM	3,425	16.20	389	38.10	557	18.10	0
QUITMAN	488	22.80	26	29.50	146	51.20	0
RABUN	3,259	20.30	145	21.70	698	33.40	0
RANDOLPH	2,449	35.10	400	78.00	610	56.00	0
RICHMOND	46,692	24.20	4,961	36.00	12,541	38.10	0
ROCKDALE	14,232	16.30	1,916	36.60	3,552	20.80	0
SCHLEY	1,148	22.20	104	37.30	319	30.50	0
SCREVEN	3,092	22.60	302	35.70	793	36.70	0
SEMINOLE	2,149	25.50	192	39.90	570	41.90	0
SPALDING	13,624	21.60	1,429	36.20	3,723	32.80	0
STEPHENS	4,504	18.10	212	14.70	1,187	27.90	0
STEWART	1,640	41.50	156	78.80	352	57.10	0
SUMTER	9,560	33.40	934	49.80	2,828	54.90	0

POVERTY IN THE 2010 CENSUS

COUNTY	ALL AGES BELOW POVERTY LEVEL		AGES 5 AND UNDER BELOW POVERTY LEVEL		AGES 5-17 BELOW POVERTY LEVEL		MEDIAN HOUSEHOLD INCOME IN 2010
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	
TALBOT	1,070	16.90	70	28.20	137	16.50	0
TALIAFERRO	571	31.00	37	54.40	107	48.00	0
TATTNALL	4,553	23.70	566	39.90	1,455	37.70	0
TAYLOR	2,285	28.20	188	44.20	410	31.80	0
TELFAIR	3,608	27.70	364	55.70	789	35.80	0
TERRELL	3,047	35.30	403	67.70	827	53.00	0
THOMAS	8,580	19.50	773	26.80	1,909	24.80	0
TIFT	10,725	27.80	1,553	54.70	2,672	37.20	0
TOOMBS	6,532	24.40	768	38.70	1,387	26.40	0
TOWNS	1,516	14.70	69	16.90	275	24.70	0
TREUTLEN	1,347	21.00	166	35.90	324	33.30	0
TROUP	14,430	21.30	1,622	35.80	3,381	26.90	0
TURNER	2,137	27.90	238	48.60	671	45.10	0
TWIGGS	2,244	27.30	148	34.40	306	26.70	0
UNION	2,788	12.80	369	48.70	531	18.90	0
UPSON	5,817	22.70	771	47.80	1,132	27.50	0
WALKER	11,523	17.20	824	21.70	2,856	25.40	0
WALTON	11,200	12.80	1,134	21.20	2,931	17.60	0
WARE	8,240	24.80	1,005	43.10	2,320	38.60	0
WARREN	1,427	26.80	97	35.30	329	37.80	0
WASHINGTON	5,074	27.10	491	41.60	1,253	36.90	0
WAYNE	5,863	21.30	587	29.50	1,277	25.20	0
WEBSTER	509	19.50	23	25.00	138	26.50	0
WHEELER	1,780	29.30	198	58.60	370	38.00	0
WHITE	4,981	17.70	445	35.20	1,305	28.20	0
WHITFIELD	19,710	19.20	2,340	33.30	5,478	26.90	0
WILCOX	1,491	21.80	187	40.40	338	26.90	0
WILKES	2,595	26.50	261	51.40	665	44.80	0
WILKINSON	2,112	23.30	78	15.30	583	36.50	0
WORTH	4,447	21.50	353	27.70	1,206	33.50	0
STATE TOTAL	**1,746,894**	**17.77**	**187,887**	**28.80**	**437,178**	**24.16**	**46,252**

License Type	Date Received	Agency Name	Agency Representative	Agency/Agency Representative's Address	Agency/Agency Representative's Phone Number	Rule #	Reason for Waiver	Approved	Attorney Yes/No	Approval Date	Conditions of Approval
Child Placing Agency	1/2/2018	Community Connections, Inc.	Kimberly Brown	2300 West Park Place Boulevard, Stone Mountain, Georgia 30087	770-465-0604	290-9-2-.07(5)(a)(9)(ii)(V)	The agency submitted a waiver application for the rule which states children over three years of age of different sexes shall not share a bedroom.	Approved	No	1/25/2018	1. The agency will maintain a homelike environment for children in care and develop service plans that address their emotional, medical, social and developmental needs. 2. The agency will provide a living environment that is safe and appropriate for children under the age of six. The agency will ensure that the foster family installs a monitoring system, such as a baby monitor, in the foster children's bedroom in an effort to monitor the bedroom when the foster children are alone. 3. The agency will conduct a monthly home visit with both children present and document the notes of the placement supervision in the respective files. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Placing Agency	1/25/2018	An Open Door Adoption Agency, Inc.	Walter Gilbert	218 East Jackson Street, Thomasville, Georgia 31792	229-228-6339	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule that requires the casework supervisor to hold a master's degree and have a minimum of two years of experience in a Child Placing Agency.	Approved	No	2/22/2018	1. The approved casework supervisor must obtain 24 hours of annual training related to the type of residents served by the agency. 2. The casework supervisor must receive monthly supervision by a master's level staff member that should be documented in his/her personnel file. 3. The casework supervisor shall receive an annual employee evaluation completed by the director and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

License Type	Date Received	Agency Name	Agency Representative	Agency/Agency Representative's Address	Agency/Agency Representative's Phone Number	Rule #	Reason for Waiver	Approved	Attorney Yes/No	Approval Date	Conditions of Approval
Child Placing Agency	1/11/2018	Choices For Life of Georgia, LLC.	Sara Riley	2200 North Patterson Street, Valdosta, Georgia 31602	229-244-1707	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule that requires the casework supervisor to hold a master's degree and have a minimum of two years of experience in a Child Placing Agency.	Approved	No	2/22/2018	1. The employee must obtain 24 hours of annual training related to the type of residents served in the program, including training in writing home study evaluations and service plans. 2. The employee must receive monthly supervision completed by the director which is documented in his/her personnel file. 3. The agency must document an annual employee evaluation on the employee completed by the director and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Caring Institution	1/25/2018	Morningstar Children & Family Services, Inc.	Jessica Lynn	1 Youth Estate Drive, Brunswick, Georgia 31525	912-267-3700 x 2121	290-2-5-.08(6)(b)1	The agency submitted a waiver application for the rule that requires the human service professional to hold a bachelor's degree and have a minimum of two years of experience in the field of child care.	Approved	No	2/26/2018	1. The employee must obtain at least 32 hours of annual training related to the type of residents served in the facility. 2. The employee must receive bi-monthly supervision that is documented and maintained in his/her personnel file by a master's level staff member. The supervision shall include a review of all assessments and service plans completed by the human service professional. 3. The facility must document an annual employee evaluation on the employee completed by his/her supervisor and maintained in his/her personnel file. 4. This waiver is contingent upon the facility maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.
Child Caring Institution	1/25/2018	Skyland Trails	Beth Finnerty	2830 Dresden Drive, Atlanta, Georgia 30341	404-322-6133	290-2-5-.05(8)	The agency submitted a waiver application for the rule which states no licensed child caring institution shall provide room board and watchful oversight to more than 16 residents on its premises.	Approved	No	2/26/2018	1. The facility shall be limited to twenty-six residents at one time. 2. The facility must maintain a qualified director and human service professional. There shall be at least one human service professional for every 16 residents in care. 3. This waiver is contingent upon the facility maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.

License Type	Date Received	Agency Name	Agency Representative	Agency/Agency Representative's Address	Agency/Agency Representative's Phone Number	Rule #	Reason for Waiver	Approved	Attorney Yes/No	Approval Date	Conditions of Approval
Child Placing Agency	1/31/2018	Trinity J & D, LLC	Janice Walker	2505 Mississippi Avenue, Savannah, Georgia 31404	912-443-3799	290-9-2-.03(4,5,6)(b,c,d,e,f,g,h,i,j,k,l); 290-9-2-.03(9)(a)	The agency submitted a waiver renewal application for the rules which state that a Child Placing Agency shall be incorporated in the state of Georgia as a nonprofit and the rules as they relate to the functions of the board of directors and financing of the agency.	Approved	No	3/26/2018	1. The agency must submit evidence that it remains registered to conduct business in the state of Georgia. The agency must remain active with Georgia's Secretary of State office. 2. The agency shall not expand it's scope of services as a Child Placing Agency beyond arranging foster care placements. The agency will not provide adoption services. 3. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Maternity Home	2/6/2018	The Living Vine, Inc.	Emily Thomas	535 East 54th Street, Savannah, Georgia 31405	912-352-9998	290-2-29-.18(2)	The facility submitted a waiver application for the rule which states that a basic maternity home providing second chance home services shall conduct a preplacement assessment during which the home and legal custodian shall determine whether the home can meet the known needs of the resident.	Approved	No	3/29/2018	1. The facility shall complete an assessment for the residents detailing of the appropriateness of maintaining the placement. The facility shall assess the educational and vocational skills, daily living skills and discharge plans for the resident and her children. 2. The facility shall maintain a homelike environment for all nursery age residents and toddlers and ensure that the service plans address the emotional, educational, medical, social, and developmental needs of the mother and her children. 3. The facility shall document an assessment and service plan for the resident and her children within 15 days of placement. 4. This waiver is contingent upon the facility maintaining substantial compliance with the rules and regulations governing Maternity Homes.

License Type	Date Received	Agency Name	Agency Representative	Agency/Agency Representative's Address	Agency/Agency Representative's Phone Number	Rule #	Reason for Waiver	Approved	Attorney Yes/No	Approval Date	Conditions of Approval
Child Placing Agency	2/13/2018	Faithbridge Foster Care, Inc.	Kris Isom	4400 North Point Parkway, Suite 210, Alpharetta, Georgia 30022	678-690-7100	290-9-2-.07(2)	The agency submitted a waiver for the rule which states a foster home shall not place more than six children under the age of 19.	Approved	No	3/27/2018	1. The agency will maintain a homelike environment for these children and develop service plans that address their emotional, educational, medical, social and developmental needs. 2. The agency will provide a living environment that is safe and appropriate for children under the age of six. 3. The agency will not allow children of different sexes over the age of three to share a bedroom. 4. The agency must provide appropriate supervision to the foster family and children. The agency will conduct monthly visits to the foster home in which the foster children are observed interacting with the foster family. 5. The facility will ensure that appropriate staffing and supervision is maintained at all times. 6. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Caring Institution	2/16/2018	Grace for Family Kids Family, LLC	Jocelyn Cesar Fulwood	1244 Dharahn Drive, Hinesville, Georgia 31313	912-318-2980	290-2-5-.08(3)(a)	The facility submitted a waiver application for the rule that states the director shall possess a master's degree from an accredited college or university in the area of social science, social work, childhood education, or business administration and two years of related work experience.	Approved	No	3/26/2018	1. The staff must obtain 32 hours of annual training related to the type of residents served in the program which shall be documented and maintained in his/her personnel file. 2. The director must receive quarterly supervision by the owners which shall be documented and maintained in his/her personnel file. This supervision shall include an evaluation of his/her job duties and an evaluation of the program's operations. 3. The director must receive an annual employee evaluation completed by the owners which shall be documented and maintained in his/her personnel file. 4.The facility must maintain a qualified human service professional at all times. 5. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.

License Type	Date Received	Agency Name	Agency Representative	Agency/Agency Representative's Address	Agency/Agency Representative's Phone Number	Rule #	Reason for Waiver	Approved	Attorney Yes/No	Approval Date	Conditions of Approval
Child Caring Institution	2/16/2018	Lighthouse of Columbus, Inc.	Patrena Patrick	6634 Forrest Road, Columbus, Georgia 31907	706-442-7783	290-2-5-.08(3)(a)	The facility submitted a waiver application for the rule that states the director shall possess a master's degree from an accredited college or university in the area of social science, social work, childhood education, or business administration and two years of related work experience.	Approved	No	3/26/2018	1. The staff must obtain 32 hours of annual training related to the type of residents served in the program which shall be documented and maintained in his/her personnel file. 2. The director must receive quarterly supervision by the owners which shall be documented and maintained in their personnel file. This supervision shall include an evaluation of his/her job duties and an evaluation of the program's operations. 3. The director must receive an annual employee evaluation completed by the owners which shall be documented and maintained in his/her personnel file. 4. The facility must maintain a qualified human service professional at all times. 5. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.
Child Placing Agency	2/19/2018	Connecting Heart, Inc.	Latrice Stowe	5538 Old National Highway, Suite 150, College Park, Georgia 30349	404-518-5149	290-9-2-.07(5)(a)(6)(v)	The agency submitted a waiver application for the rule which states that a screening for venereal disease for prospective foster parent(s) and children 16 years of age and older living in the foster home shall be completed.	Approved	No	3/22/2018	There are no specific conditions of approval imposed.

License Type	Date Received	Agency Name	Agency Representative	Agency/Agency Representative's Address	Agency/Agency Representative's Phone Number	Rule #	Reason for Waiver	Approved	Attorney Yes/No	Approval Date	Conditions of Approval
Child Placing Agency	2/22/2018	Faithbridge Foster Care, Inc.	Kris Isom	4400 Northpoint Parkway, Suite 210, Alpharetta, Georgia 30022	678-690-7118	290-9-2-.07(5)(a)(9)(ii)(V)	The agency submitted a waiver application for the rule which states children over the age of three years of age of different sexes shall not share a bedroom.	Approved	No	3/27/2018	1. The agency will maintain a homelike environment for these children and develop service plans that address their emotional, educational, medical, social and developmental needs. 2. The agency will provide a living environment that is safe and appropriate for children. The agency will ensure that the foster family installs a monitoring system, such as a baby monitor, in the foster children's bedroom. 3. The agency will ensure that the foster children are provided their own bed or crib to sleep. 4. The agency will conduct monthly home visits and develop goals and objectives to assist the foster family in providing a positive transition of the foster children moving to their separate bedrooms. 5. This waiver is contingent upon the facility maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Placing Agency	2/23/2018	Normal Life, Inc..-Macon	Miles Williams	105 Preston Court, Macon, Georgia 31210	478-741-9745 ext. 212	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule which requires the casework supervisor to have at least a master's degree and document a minimum of two years of experience in a Child Placing Agency.	Approved	No	3/29/2018	1. The employee must obtain 24 hours of annual training related to the type of residents served in the program, including training in writing home study evaluations and service plans. 2. The employee must receive monthly supervision completed by the director which is documented in his/her personnel file. 3. The agency must document an annual employee evaluation on the employee completed by the director and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Caring Institution	3/7/2018	Liberty County Children's Home, Inc. DBA Gabriel's House	James Osteen	6145 E. Oglethorpe Highway, Midway, Georgia 31320	912-884-4545	290-2-5-.18(2)(a)	The facility applied for a waiver renewal for the rule which states boys and girls shall sleep in separate areas.	Approved	No	4/10/2018	1. The facility will maintain a homelike environment for these children and develop service plans that address their needs. 2. The facility will provide a living environment that is safe and appropriate for children under the age of six. 3. The facility will provide a living environment that is safe and appropriate for children under the age of six. 4. The facility must ensure that residents of different sexes are provided their own bed or crib. 5. The facility will not allow children of different sexes over the age of three to share a bedroom. 6. The facility will ensure appropriate staffing and supervision is maintained. 7. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.
Child Caring Institution	3/7/2018	Liberty County Children's Home, Inc. DBA Gabriel's House	James Osteen	6145 E. Oglethorpe Highway, Midway, Georgia 31320	912-884-4545	290-2-5-.09(2)(a)	The facility applied for a waiver renewal for the rule which states a child under the age of six shall not be admitted to an institution unless that child is a part of a sibling group with at least one of the siblings being six years of age or older and will reside at the institution.	Approved	No	4/10/2018	1. The facility will maintain a homelike environment for these children and develop service plans that address their needs. 2. The facility will provide a living environment that is safe and appropriate for children under the age of six. 3. The facility will only admit residents under the age of six who are a part of a sibling group. A waiver request must be submitted prior to placement of any child under the age of six who is not part of a sibling group. 4. The facility must maintain a qualified human service professional and ensure appropriate staffing and supervision is maintained. 5. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.

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Child Placing Agency	3/28/2018	Uphold Homes, Inc.	Leah Delanoy	109 E. Water Street #8, Bainbridge, Georgia 39817	229-205-4588	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule which requires the casework supervisor to have at least a master's degree and document a minimum of two years of experience in a Child Placing Agency.	Approved	No	5/17/2018	1. The staff must obtain at least 24-hours of annual training related to the type of residents served in the program, including training in writing home study evaluations and service plans. The agency shall maintain and document training in his/her personnel file. 2. The staff member shall receive monthly supervision and oversight by the board of directors which shall be documented and maintained in his/her personnel file. 3. The agency must document an annual employee evaluation for the staff member completed by the board of directors that is maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Placing Agency	3/29/2018	Hope Bridge Child Placing Agency, Inc.	Tracy Thompson	1200A Riverside Drive, Macon, Georgia 31201	478-390-1172	290-9-2-.04(9)(a)	The applicant submitted a waiver application for the rule which requires the casework supervisor to have a master's degree and document a minimum of two years of experience in a Child Placing Agency	Approved	No	5/17/2018	1. The staff must obtain at least 24-hours of annual training related to the type of residents served in the program, including training in writing home study evaluations and service plans. The agency shall maintain and document training in his/her personnel file. 2. The staff member shall receive monthly supervision and oversight by the board of directors which shall be documented and maintained in his/her personnel file. 3. The agency must document an annual employee evaluation for the staff member completed by the board of directors that is maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Placing Agency	4/2/2018	Camp Rock of Georgia, Inc.	John Andrew Boswell	P.O. Box 1528, Valdosta, Georgia 31603	229-834-3517	290-9-2-.04(7)(b)	The agency submitted a waiver for the rule which states that the director shall have as a minimum a Bachelor's degree and two years administrative experience in the field of human services.	Approved	No	5/15/2018	1. The director approved must receive monthly supervision from an advisor who has documented experience working in a Child Placing Agency. This supervision shall be documented and maintained in his/her personnel file. 2. The director must receive quarterly supervision from the board of directors that shall be documented and maintained in his/her personnel file. This supervision shall consist of a review of his/her job duties and the agency's operations. He/she shall also receive an annual employee evaluation from the board of directors. 3. The agency must maintain a masters-level case work supervisor at all times. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Caring Institution	4/2/2018	Never Too Late, Inc.	Rob Andrew	1178 College Street, Monticello, Georgia 31064	706-435-7200	290-2-5-.08(3)(a)	The facility submitted a waiver for the rule which states the director may possess a bachelor's degree and four years of work experience or a master's degree and two years of work experience.	Approved	No	5/15/2018	1. The director must obtain 32-hours of annual training that shall be documented and maintained in his/her personnel file. 2. The director must received quarterly supervision from the board of directors that shall be documented and maintained in his/her personnel file. This supervision shall consist of a review of his/her job duties and a review of the program operations. 3. The employee must receive an annual performance evaluation completed by the board of directors that is documented and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.

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Child Placing Agency	4/19/2018	Safe Haven Around the Clock Youth Services, Inc.	Carolyn Cheathem	2800 Northside Crossing, Macon, Georgia 31210	478-201-0572	290-9-2-.04(9)(a)	The applicant submitted a waiver application for the rule which requires the casework supervisor to have a master's degree and document a minimum of two years of experience in a Child Placing Agency	Approved	No	5/15/2018	1. The employee must receive monthly supervision and oversight from the director which must be documented in his/her personnel file. 2. The employee must obtain at least 24 hours of annual training related to the type of residents served in the agency, including training in writing home study evaluations. 3. The employee must receive an annual performance evaluation completed by the director that is maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Placing Agency	4/23/2018	Ena-Necco, Inc.-Valdosta	Stephen Johnston	1990 Lakeside Parkway, Suite 350, Tucker, Georgia 30084	229-269-1941	290-9-2-.04(9)(a)	The applicant submitted a waiver application for the rule which requires the casework supervisor to have a master's degree and document a minimum of two years of experience in a Child Placing Agency	Approved	No	5/17/2018	1. The employee must obtain 24 hours of annual training related to the type of residents served by the agency, including training in writing home study evaluations and service plans. 2. The employee must receive monthly supervision completed by the director and documented and maintained in his/her personnel file. 3. The employee must receive an annual performance evaluation completed by the director that is maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Caring Institution	4/24/2018	The Mercy House, Inc.	Mary Baker	3512 Norwich Street, Brunswick, Georgia 31520	912-222-3551	290-2-5.08(3)(a)	The facility submitted a waiver for the rule which states the director may possess a bachelor's degree and four years of work experience or a master's degree and two years of work experience.	Approved	No	5/15/2018	1. The director must obtain 32-hours of annual training that shall be documented and maintained in his/her personnel file. 2. The director must receive quarterly supervision from the board of directors that shall be documented and maintained in his/her personnel file. This supervision shall consist of a review of his/her job duties and a review of the program operations. 3. The employee must receive an annual performance evaluation completed by the board of directors that is documented and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.
Child Placing Agency	5/29/2018	Kindred Family Services, Inc.	Dianne Kelly	4845 Collins Lake Dr., Mableton, Georgia 30126	404-822-8867	290-9-2-.07(5)(a)(6)(v)	The agency submitted a waiver application for the rule which states that a screening for venereal disease for prospective foster parent(s) and children 16 years of age and older living in the foster home shall be completed.	Approved	No	6/25/2018	There are no specific conditions of approval imposed.

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Child Placing Agency	6/17/2018	Health Connect of America, Inc.	Holly Davis	100 Glendalough Court, Tyrone, Georgia 30290	615-567-6726	290-9-2-.03(6)(c)	The agency submitted a waiver application for the rule which states the Board shall refrain from direct administration or operation of the agency either through individual members or committees, except in emergencies.	Approved	No	7/24/2018	1. The agency must provide evidence annually that the agency remains registered to do business in the State of Georgia with an identified agent for service and that the agency remains in good standing with Georgia's Secretary of State's Office. 2. The agency must not expand its scope of services as a child placing agency beyond arranging foster care placements. The agency shall not provide adoption services. 3. The agency's leadership staff will meet quarterly to review and act upon all operational reports and evaluations of the agency. The agency must maintain a copy of these minutes and must make them available to the licensing staff upon request. 4. The agency's governing body will meet at least annually to review and act upon all operational reports and evaluations for the Georgia program. 5. The agency will provide a copy of its annual financial report audit completed by a Certified Public Accountant. 6. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Placing Agency	6/17/2018	Health Connect of America, Inc.	Holly Davis	100 Glendalough Court, Tyrone, Georgia 30290	615-567-6726	290-9-2-.03(7)	The agency submitted a waiver application for the rule which states the board members shall have no direct or indirect financial interest in the assets, leases, business transactions, or in current professional services of the agency. Any potential conflict of interest shall be declared by a board member and the minutes shall record declaration and abstention from the vote when a conflict exists.	Approved	No	7/24/2018	1. The agency must provide evidence annually that the agency remains registered to do business in the State of Georgia with an identified agent for service and that the agency remains in good standing with Georgia's Secretary of State's Office. 2. The agency must not expand its scope of services as a child placing agency beyond arranging foster care placements. The agency shall not provide adoption services. 3. The agency's leadership staff will meet quarterly to review and act upon all operational reports and evaluations of the agency. The agency must maintain a copy of these minutes and must make them available to the licensing staff upon request. 4. The agency's governing body will meet at least annually to review and act upon all operational reports and evaluations for the Georgia program. 5. The agency will provide a copy of its annual financial report audit completed by a Certified Public Accountant. 6. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Placing Agency	6/17/2018	Health Connect of America, Inc.	Holly Davis	100 Glendalough Court, Tyrone, Georgia 30290	615-567-6726	290-9-2-.03(9)(a-c),(e)	The agency submitted a waiver application for the rules which state the Board shall be composed of at least five (5) members; at least one of the board members shall be a bona fide resident of Georgia; provision shall be made for systematic rotation of board members through a plan of overlapping terms of office; and employees and paid consultants of the agency shall not serve as members of the board.	Approved	No	7/24/2018	1. The agency must provide evidence annually that the agency remains registered to do business in the State of Georgia with an identified agent for service and that the agency remains in good standing with Georgia's Secretary of State's Office. 2. The agency must not expand its scope of services as a child placing agency beyond arranging foster care placements. The agency shall not provide adoption services. 3. The agency's leadership staff will meet quarterly to review and act upon all operational reports and evaluations of the agency. The agency must maintain a copy of these minutes and must make them available to the licensing staff upon request. 4. The agency's governing body will meet at least annually to review and act upon all operational reports and evaluations for the Georgia program. 5. The agency will provide a copy of its annual financial report audit completed by a Certified Public Accountant. 6. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Placing Agency	6/17/2018	Health Connect of America, Inc.	Holly Davis	100 Glendalough Court, Tyrone, Georgia 30290	615-567-6726	290-9-2-.03(4),(5)	The agency submitted a waiver application for the rule which states Child Placing Agencies shall be incorporated as a nonprofit under Georgia law and that each agency shall have a board of directors.	Approved	No	7/24/2018	1. The agency must provide evidence annually that the agency remains registered to do business in the State of Georgia with an identified agent for service and that the agency remains in good standing with Georgia's Secretary of State's Office. 2. The agency must not expand its scope of services as a child placing agency beyond arranging foster care placements. The agency shall not provide adoption services. 3. The agency's leadership staff will meet quarterly to review and act upon all operational reports and evaluations of the agency. The agency must maintain a copy of these minutes and must make them available to the licensing staff upon request. 4. The agency's governing body will meet at least annually to review and act upon all operational reports and evaluations for the Georgia program. 5. The agency will provide a copy of its annual financial report audit completed by a Certified Public Accountant. 6. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Placing Agency	6/18/2018	Abiding Love Adoption Agency, Inc.	Carrie Murray-Nellis	5500 Frederica Road, Saint Simons Island, Georgia	912-596-8778	290-9-2-.06(3)(d)(9)(V)	The agency submitted a waiver application for the rule which states if a pool is present in the home then it shall be fenced and locked and meet all community ordinances.	Approved	No	7/26/2018	1. The agency must complete a safety plan for both family and children in the home. The plan must be signed by the agency, adoptive parents and children and documented and maintained in respective files. 2. The agency must ensure that the adoptive parents install a tamper proof pool guard alarm system. The agency must also ensure that the adoptive parents install alarms and chimes leading to the outside of the home. 3. All children placed in the home must successfully complete water safety and swimming lessons that is documented and maintained in their files. 4.This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

License Type	Date Received	Agency Name	Agency Representative	Agency/Agency Representative's Address	Agency/Agency Representative's Phone Number	Rule #	Reason for Waiver	Approved	Attorney Yes/No	Approval Date	Conditions of Approval
Child Placing Agency	6/20/2018	Benchmark Family Services, Inc.- Macon	Santoria Williams	4509 Knight Road, Macon, Georgia 31220	770-210-8745	290-9-2-.04(9)(a)	The applicant submitted a waiver application for the rule which requires the casework supervisor to have a master's degree and document a minimum of two years of experience in a Child Placing Agency	Approved	No	7/24/2018	1. The employee must obtain at least 24 hours of annual training related to the type of residents served in the facility. 2. The employee shall receive monthly supervision completed by the director. 3. The agency shall document an annual employee evaluation completed by the director and maintained in the employee's personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Caring Institution	5/10/2018	Lambs of Love Outreach, Inc.	Adraine Holly	1471 Brewer Avenue, Columbus, Georgia 31903	706-221-1546	290-2-5-.08(3)(a)	The facility submitted a waiver for the rule which states the director may possess a bachelor's degree and four years of work experience or a master's degree and two years of work experience.	Approved	No	6/28/2018	1. The director must obtain 32-hours of annual training that shall be documented and maintained in his/her personnel file. 2. The director must receive quarterly supervision from the board of directors that shall be documented and maintained in his/her personnel file. This supervision shall consist of a review of his/her job duties and a review of the program operations. 3. The employee must receive an annual performance evaluation completed by the board of directors that is documented and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.
Child Caring Institution	5/10/2018	Chris 180, Inc. Ellenwood-Sherwood	Cindy Simpson	1017 Fayetteville Road, Atlanta, Georgia 30316	770-731-2616	290-2-5-.08(6)(b)1	The agency submitted a waiver application for the rule that requires the human service professional to hold a bachelor's degree and document a minimum of two years of experience in the field of child care.	Approved	No	6/28/2018	1. The employee shall receive monthly supervision and oversight from the director. This supervision shall include a review of all assessments and service plans written by the employee. 2. The employee must obtain at least 32 hours of annual training related to the type of residents served in the facility. 3. This waiver is contingent upon the agency demonstrating substantial compliance with the rules and regulations governing Child Caring Institutions.

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Child Placing Agency	7/2/2018	Giving Children A Chance, LLC	Heather Lynn	201 Vaughan Drive, Alpharetta, Georgia 30009	770-255-1018	290-9-2-.07(5)(a)(9)(ii)(V)	The agency submitted a waiver application for the rule which states children over the age of three years of age of different sexes shall not share a bedroom.	Approved	no	7/25/2018	1. The agency will complete a safety plan for the foster family and children. This plan shall be sighed by all parties and maintained in all respective files. 2. The foster parents must increase supervision for the siblings sharing a room. Night-time supervision shall include the use of a monitoring system such as a baby monitor and door alarm. 3. The placing county must remain supportive of the placement. 4. The agency must conduct monthly home visits and provide appropriate foster care services as needed. 5. This waiver is contingent upon the agency effectively demonstrating substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Placing Agency	7/16/2018	National Mentor, LLC-GA Mentor-Albany	LaToya Bostic	2200 Watergate Court, Albany, Georgia 31707	229-435-6601	290-9-2-.04(9)(a)	The applicant submitted a waiver application for the rule which requires the casework supervisor to have a master's degree and document a minimum of two years of experience in a Child Placing Agency	Approved	No	8/13/2018	1. The employee must obtain at least 24 hours of annual training related to the type of residents served in the facility. 2. The employee shall receive monthly supervision completed by the director. 3. The agency shall document an annual employee evaluation completed by the director and maintained in the employee's personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Caring Institution	7/20/2018	Fresh Start for Boys, LLC	Sonya Lee	5007 Old Waynesboro Road, Hephzibah, Georgia 30815	706-751-2223	290-2-5-.08(6)(b)1	The applicant submitted a waiver application for the rule which requires the casework supervisor to have a master's degree and document a minimum of two years of experience in the field of child care.	Approved	No	8/13/2018	1. The employee must obtain at least 32 hours of annual training related to the types of residents served at the facility. 2. The employee must receive monthly supervision by the director that is documented and maintained in his/her personnel file. This supervision shall include a review of the assessments and service plans written by the employee. 3. The employee must receive an annual employee evaluation completed by the director that is documented and maintained in his/her personnel file. 4. This waiver is contingent upon the facility maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.
Child Placing Agency	7/30/2018	National Mentor, LLC-GA Mentor-Albany	LaToya Bostic	2200 Watergate Court, Albany, Georgia 31707	229-435-6601	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule which requires the casework supervisor to have at least a master's degree and document a minimum of two years of experience in a Child Placing Agency.	Approved	No	8/13/2018	1. The employee must obtain at least 24 hours of annual training related to the type of residents served in the facility. 2. The employee shall receive monthly supervision completed by the director. 3. The agency shall document an annual employee evaluation completed by the director and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Outdoor Child Caring Program	8/1/2018	Second Nature Blue Ridge, LLC	Vanessa Allen	236 File Street, Clayton, Georgia 30525	706-212-2037	290-2-7-.05(6)	The facility submitted a waiver renewal for the rule which states outdoor child caring programs shall not accept a camper for care until a psychological or psychiatric evaluation and intake study has been completed.	Approved	No	8/31/2018	1. Residents accepted and enrolled in the program must enter the Earth Phase. A staff member must always maintain visual contact with the new residents and document this observation in the resident's file. 2. Residents accepted and enrolled in the program must receive a psychological or psychiatric evaluation within two weeks of placement. This evaluation shall assess the resident for the appropriateness of participating in an outdoor child caring program. Documentation of this evaluation must be maintained in the resident's file. 3. This waiver is contingent upon the program maintaining substantial compliance with the rules and regulations governing Outdoor Child Caring Programs.

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Outdoor Child Caring Program	8/1/2018	Second Nature Blue Ridge, LLC	Vanessa Allen	236 File Street, Clayton, Georgia 30525	706-212-2037	290-2-7-.05(8)	The facility submitted a waiver renewal for the rule which states outdoor child caring programs shall include a discussion regarding the placement with the camper and his/her parents or placement agency and it shall include a visit to the camp.	Approved	No	8/31/2018	1. The program must ensure that the intake process includes a discussion of the program with both the resident and his/her parent(s) or guardian and shall be documented in the resident's file. 2. The program must document a visit to the camp by both the resident and parent/guardian in the resident's file. Any parent or guardian opting not to visit the camp as a part of the intake process must sign a waiver indicating that he/she does not wish to visit the camp. 3. This waiver is contingent upon the program demonstrating substantial compliance with the rules and regulations governing Outdoor Child Caring Programs. 4. This waiver will expire August 31, 2019.
Child Placing Agency	8/7/2018	United Methodist Children's Home, Inc.	Suzette Roberts	1967 Lakeside Parkway, Building 400, Tucker, Georgia 30084	404-327-5841	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule which requires the casework supervisor to have at least a master's degree and document a minimum of two years of experience in a Child Placing Agency.	Approved	No	8/31/2018	1. The employee must obtain at least 24 hours of annual training related to the type of residents served in the agency including writing home study evaluations. This training must be maintained in his/her file. 2. The employee must receive monthly supervision and oversight from the director that must be documented and maintained in his/her personnel file. 3. The agency must document an annual performance evaluation for the employee, completed by the director, that is documented and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Caring Institution	9/12/2018	AMIkids Savannah River, Inc.	C.S.Weiss	626 Old River Road, Sylvania, Georgia 30467	912-829-5300	290-2-5-.08(6)(b)1	The applicant submitted a waiver application for the rule which requires the casework supervisor to have a master's degree and document a minimum of two years of experience in the field of child care.	Approved	No	9/26/2018	1. The employee must obtain at least 32 hours of annual training related to the type of residents served by the facility. 2. The employee must receive monthly supervision, documented and maintained in his/her personnel file, by the director. This supervision shall include a review of the assessments and service plans written by the employee. 3. The employee must receive an annual performance evaluation completed by the director that is documented and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.
Child Placing Agency	9/20/2018	Community Connections, Inc.	Kimberly Boykin	2300 West Park Place Boulevard, Stone Mountain, Georgia	770-465-9644	290-9-2-.07(5)(a)(9)(ii)(IV)	The agency submitted a waiver for the rule which states that no child over the age of one shall sleep in a room with an adult in a foster home.	Approved	No	11/14/2018	1. The agency must conduct monthly foster home visits to ensure the child's placement in the home is appropriate and does not pose a threat to the health and safety to any of the children in care. 2. The child is not allowed to sleep in the same bed with the foster parent. The agency will ensure that the child is provided with his/her own bed or crib to sleep. 3. All updates and any changes to the family shall be documented in an amended home study report and a copy maintained in both the foster parent's and child's file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Outdoor Child Caring Program	10/4/2018	Second Nature Blue Ridge, LLC	Laura Fuqua	236 File Street, Clayton, Georgia 30525	770-212-2037	290-2-7-.05(5)	The facility submitted a waiver for the rule which states the outdoor child caring program shall not admit a camper who has not had a dental examination by a licensed dentist within six months prior to admission.	Approved	No	11/14/2018	1. The facility must conduct a thorough review of the resident's dental history prior to admission and document the history in the intake evaluation. 2. The facility will document an interview of both the resident and custodian regarding any existing dental issues in the resident's file. 3. The facility must request and document all dental records for the past year in the resident's file. 4. Dental examinations must be scheduled and completed by a licensed dentist within 30 days of admission and documented in the resident's file. 5.This waiver is contingent upon the facility maintaining substantial compliance with the rules and regulations governing Outdoor Child Caring Programs.
Child Placing Agency	10/9/2018	Faithbridge Foster Care, Inc.	Kris Isom	4400 North Point Parkway, Suite 210, Alpharetta, Georgia 30022	678-690-7118	290-9-2-.07(2)	The agency submitted a waiver application for the rule which states no more than six children under the age of 19 may reside in a foster home.	Approved	No	11/14/2018	1. The agency must conduct monthly foster home visits to ensure that the child's placement in this home is appropriate and does not pose a threat to the health and safety to any children in care. 2. The agency must maintain a homelike environment for the child and develop a service plan that addresses the child's emotional, educational, medical, social and developmental needs. 3. The foster parent(s) will not allow children of different sexes over the age of three to share a bedroom. 4. All updates and any changes to the family shall be documented in an amended home study report and a copy maintained in both the foster parent's and foster child's file. 5. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Placing Agency	10/30/2018	Great Heights Foster Care, Inc	Nancy Tuttle	3340 Peachtree Road, Building 100, Suite 1800, Atlanta, Georgia 30326	770-334-9373	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule which requires the casework supervisor to have at least a master's degree and document a minimum of two years of experience working in a Child Placing Agency.	Approved	No	11/21/2018	1. The employee shall obtain at least 24 hours of annual training related to the type of residents served in the program, including training in writing home study evaluations. 2. The employee must receive monthly supervision completed by the director that must be documented in his/her personnel file. 3. The agency must document an annual performance evaluation on the employee completed by the director and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Placing Agency	11/1/2018	National Mentor Healthcare, LLC-GA Mentor-Macon	Crystal Smith	120-B Osigian Boulevard, Suite 100, Macon, Georgia 31088	478-333-2971	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule which requires the casework supervisor to have at least a master's degree and document a minimum of two years of experience working in a Child Placing Agency.	Approved	No	11/21/2018	1. The employee must received monthly supervision by the director that must be documented in his/her file. 2. The employee must obtain 24 hours of annual training related to the type of residents served by the agency. This training must be maintained in his/her file. 3. The agency shall document an annual performance evaluation for the employee that is completed by the director. The evaluation shall be maintained in the employee's personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Child Placing Agency	11/8/2018	Lighthouse Therapeutic Foster Care, Inc.	Kerri Hooper	35 Mountain Street, Ringgold, Georgia 30736	706-944-1637	290-9-2-.07(5)(a)(9)(ii)(IV)	The agency submitted a waiver for the rule which states that no child over the age of one shall sleep in a room with an adult in a foster home.	Approved	No	11/26/2018	1. The agency will conduct monthly foster home visits to ensure the child's placement in this home is appropriate and does not pose a threat to the health and safety of any children in care. 2. The child is not allowed to sleep in the same bed with the foster parent. The agency will ensure that the child is provided with his/her own bed or crib to sleep. 3. All updates and any changes to the family shall be documented in an amended home study report and a copy shall be maintained in both the foster parent's and child's file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Placing Agency	11/8/2018	Abiding Love Adoption Agency, Inc.	Carrie Murray-Nellis	5500 Frederica Road, Saint Simons Island, Georgia	912-596-8778	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule which requires the casework supervisor to have at least a master's degree and document a minimum of two years of experience working in a Child Placing Agency.	Approved	No	11/26/2018	1. The employee must received quarterly supervision by the board of directors that must be documented in his/her file. 2. The employee must obtain 24 hours of annual training related to the type of residents served by the agency. This training must be maintained in his/her file. 3. The agency shall document an annual performance evaluation for the employee that is completed by the board of directors and maintained in his/her personnel file. 4. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.

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Maternity Home	11/9/2018	Innovative Housing Residential Services, Inc.	Cheryl Wilcox	7462 Holly Court, Riverdale, Georgia 30274	770-364-6196	290-2-29-.16(5)	The facility submitted a waiver for the rule which states that a resident shall not remain in the home for more than eight weeks after delivery once she has been medically discharged.	Approved	No	11/27/2018	1. The facility shall complete an updated assessment for detailing the appropriateness of maintaining the placement. The assessment shall document any issues or concerns and vocational skills, daily living skills and discharge plans. 2. The facility shall document a 30-day individual service plan which includes goals and objectives based on the assessment of the resident. 3. The facility must submit a change request form and second chance home policies and procedures by January 11, 2019, to amend the facility's current license type. 4. This waiver is contingent upon the maternity home maintaining substantial compliance with the rules and regulations governing Maternity Homes.
Child Caring Institution	10/9/2018	Kidspeace National Centers of Georgia, Inc.	Louis Shagawat	101 Kidspeace Drive, Bowdon, Georgia 30108	404-322-6133	290-2-5-.05(8)	The facility submitted a waiver for the rule which states that no licensed child caring institution shall provide room, board and watchful oversight to more than sixteen residents on its premises.	Approved	No	12/5/2018	1. The facility will increase its capacity by five residents until the requested increase of twenty residents has been reached. 2. The facility shall be limited to a total of eighty residents at one time. 3. The facility shall maintain the staff to client ratio as indicated per their Office of Provider Management contract. 4. The facility must maintain a human service professional for every sixteen residents in care. 5.This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Caring Institutions.

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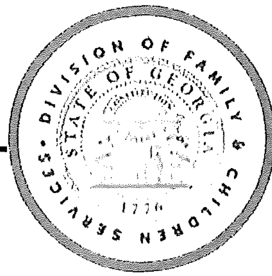
Child Placing Agency	11/23/2018	Faithbridge Foster Care, Inc.	Kris Isom	4400 Northpoint Parkway, Suite 210, Alpharetta, Georgia 30022	678-690-7118	290-9-2-.07(2)	The agency submitted a waiver application for the rule that states no more than 6 children under the age of 18 shall reside in a foster home.	Approved	No	12/19/2018	1. The agency will conduct monthly foster home visits to ensure the placement in this home is appropriate and does not pose a threat to the health and safety of any children in care. 2. The agency will develop a service plan to address each child's emotional, educational, medical, social and developmental needs. 3. The agency will not allow children of different sexes over the age of three to share a bedroom. 4. All updates and any changes to the family shall be documented in an amended home study report and a copy shall be maintained in both the foster parent's and each child's file. 5. This waiver is contingent upon the agency maintaining substantial compliance with the rules and regulations governing Child Placing Agencies.
Child Placing Agency	11/27/2018	National Mentor Healthcare, LLC-GA Mentor-Albany	LaToya Bostic	2200 Watergate Court, Albany, Georgia 31707	229-435-6601	290-9-2-.04(9)(a)	The agency submitted a waiver application for the rule which requires the casework supervisor to have at least a master's degree and document a minimum of two years of experience working in a Child Placing Agency.	Approved	No	12/19/2018	1. The employee must receive monthly supervision from the director that shall be documented in his/her personnel file. This supervision should include a review of the home study evaluations approved by the staff. 2. The employee must obtain at least 24 hours of annual training related to the type of residents served by the agency. This training must be maintained in his/her personnel file. 3. The employee shall receive an annual performance evaluation completed by the director that is documented and maintained in his/her personnel file. 4. This waiver is contingent upon the agency demonstrating substantial compliance with the rules and regulations governing Child Placing Agencies.



NATHAN DEAL
GOVERNOR

VIRGINIA PRYOR
DIRECTOR

Maltreatment Type Report

Report Parameters

Start Date: 07/01/2017
End Date: 06/30/2018
County: All

Maltreatment Type: All
Relationship: All
Maltreator: Adult

Maltreatment Type	Count
Physical Abuse	819
Sexual Exploitation	17
Sexual Abuse	356
Neglect	4902
Child Endangerment	2275
This section provides the total number of Maltreatment Types received by CPSIS based on the Date, Maltreator and Relationship parameters selected.	