**Overview**

The Agency on Aging Northeastern Illinois is seeking applications from organizations interested in providing Aging and Disability Resource Network (ADRN) Access services. The Aging and Disability Resource Network (ADRN) consists of many entities working together to provide a no wrong door network of access to long-term support services (LTSS). The ADRN is visible, accessible, consumer focused, inclusive and supportive to facilitate ease of access into the system, no matter what the individual’s or family’s economic or social need. Organizations providing ADRN Access services receive the designation of “Core Partner” in the county they serve.

Core Partners in the ADRN serve as an integrated access point where consumers of all ages, incomes, and disabilities receive information and assistance, assessment of needs, options counseling, referral, assistance in completing applications and authorization of services where permitted and follow up to ensure referrals and services were received. Core Partners proactively engage in public outreach to promote awareness of the resources that are available. They also have formal linkages with key referral sources in a given community to ensure staff in these entities know about the functions of the ADRN and have up-to-date information and tools for quickly identifying and referring individuals to the ADRN.

In FY2020, the Agency on Aging will continue its work to collaborate with the Illinois Department on Aging, aging and disability service providers, as well as other local partners to work towards a “no wrong door” service system to provide streamlined access to LTSS. This system will also focus on developing dementia-capable no wrong door access for people with dementia and their caregivers through identification, information, assistance and referral.

The Agency on Aging has adopted an ADRN access service system model consisting of organizations that are designated as one of the following: Core Partner, Critical Pathway Partner or Additional Resource. This model will allow the ADRN to be seen as a major resource for health care systems and providers and will have the capacity to serve as a “front door” to the LTSS system that can quickly link their clientele to a full range of community services and supports.

**Core Partners** are defined as organizations that offer “no wrong door” access to services. These agencies act as coordinated points of entry to help individuals in Illinois identify community services available and assist with referral and follow up to access the services and supports chosen by the participant.

**Critical Pathway Partners** are defined as organizations that offer other critical services for community living such as:

* Medicaid waiver services for community based long term services and supports
* Assistance with transitions from hospitals, rehab centers, and long term care facilities, but do not offer all of the core services
* Community services that are vital to quality of life in the community
* Pre-Admissions Screening and Assessments
* Referrals to providers of behavioral healthcare and services for persons with developmental disabilities
* Collaboration with discharge planners and social work professionals in hospitals, public health departments, and federally qualified health centers

Examples of Critical Pathway Partners include hospitals, VA medical centers, nursing homes and other institutions, clinics, federally qualified health centers (health clinics for underserved areas and populations, e.g. Aunt Martha’s, VNA), health departments, developmental disability services, and mental health services.

**Additional Resources** are additional community organizations, identified by our Core Partners, that provide services to older adults and individuals with disabilities but do not meet Critical Pathway Partner criteria.

**Service Design**

To continue the goal of fostering an ADRN no wrong door access service system in Illinois, organizations will be funded to provide the following ADRN Access services:

1. IIIB INFORMATION AND ASSISTANCE (I&A)
2. IIIB OUTREACH
3. ADRN OPTIONS COUNSELING

ADRN Access service providers will be eligible to receive Flexible Community Services (FCS) funding and IIIB Residential and Repair funding. ADRN Access service providers must be Senior Health Insurance Program (SHIP) sites and will be eligible to receive SHIP/SHAP/MIPPA funding. This funding will be allocated on IDOA’s performance-based reimbursement system.

Organizations designated as an ADRN Access service provider will be required to perform the following activities:

1. Cost Per Unit Analysis
   1. Organization will work toward keeping each service’s cost per unit in line with the regional average. See Appendix A.
2. Coordination:
   1. Have a working relationship and a written agreement with the county specific disability-related information provider Core Partner (Center for Independent Living) to coordinate and where possible to co-locate services.
   2. Have a working relationship and/or written agreement with county specific Critical Pathways Partners and Additional Resources, as defined above, to coordinate and where possible to co-locate services.
3. Staffing:
   1. Dedicate at least 1 staff position to coordinate and provide ADRN Access Services.
   2. At least 1 staff person will have certification from the Alliance of Information & Referral Systems (AIRS). New applicants will demonstrate ability to obtain certification within 1 year of becoming the ADRN Access Services Core Partner – sooner if staff meet eligibility criteria to take the certification exam (<https://www.airs.org/i4a/pages/index.cfm?pageID=3309>).
   3. At least 1 staff person will have Senior Health Insurance Program (SHIP) Counselor certification. New applicants will demonstrate ability to obtain certification within 6 months of becoming the ADRN Access Services Core Partner.
4. Training:
   1. Participate in ADRN meetings and trainings held by the Agency on Aging.
   2. Participate in SHIP trainings held by IDOA.
   3. Providers are encouraged to participate in Make Medicare Work trainings held by AgeOptions (<http://www.ageoptions.org/services-and-programs_makemedicarework.html>).
5. Adhere to the Agency on Aging General Service Requirements and the program specific requirements as well as reporting requirements for these services. Visit the Agency on Aging website ([www.ageguide.org](http://www.ageguide.org)) for Service Standards and information on reporting requirements.

**ADRN Access Package Narrative**

Applicant Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person Name, Phone & Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In a clear and concise narrative, respond to each of the following items. Please review Appendix B, the program rubric, for guidance and scoring information.

**Program Planning**

1a. Describe how your organization assessed the service area and the target population to be served. Include your plan to target services to those in greatest economic and social need as outlined in the Older Americans Act including: Persons 75+, older adults living alone, older adults identified as minority, at or below poverty level, limited English speaking and other hard-to-reach older adults. See Appendix C.

1b. Describe your organization’s previous experience with these types of services. Describe any other experience serving older persons and persons with disabilities.

**Program Design & Delivery**

2a. Describe your organization’s plan to provide **I&A services**. Include when and where (locations, times, days of week) and how (methods of delivery) the service will be delivered.

2b. Describe your organization's proposed **Outreach** **services** including when and where activities will be provided. Describe how referrals and follow up will be handled on behalf of Outreach participants.

2c. Describe your organization's plan to provide **Options Counseling services**. Include when and where (locations, times, days of week) and how (method of delivery) the service will be delivered. Describe your organization’s plan to ensure a person-centered approach to service delivery.

2d. Complete the staffing chart based on the application(s) your organization is completing. See Appendix D. **(One completed staffing chart per organization is all that is necessary.)**

2e. Describe how your organization will maintain and offer current information on services and resources available to support older adults, persons with disabilities and caregivers.

2f. Describe how client information and documentation will be maintained. **New applicants:** provide a sample data collection form (e.g. Intake Form) or describe the types of participant data to be collected.

**Program Operations**

3a. Describe your plan for staff (and if applicable, volunteer) screening, training, supervision and retention for ADRN services.

3b. Describe your process to evaluate ADRN services delivery, including client satisfaction and outcomes. Describe a scenario where your organization used feedback to improve programs and services.

3c. Describe how your organization provides services that are culturally competent and responsive to diverse populations. In addition, include your plan to provide barrier-free access to inquirers who speak languages other than English; inquirers with hearing or speech impairments; and for persons with disabilities at the facility (or facilities) where ADRN services are provided.

**Outreach and Coordination within the Community**

4a. Describe the public awareness efforts your organization will undertake to assure that older adults, caregivers, and the public know about ADRN services and how to access them.

4b. Describe how your organization will coordinate with other service providers in your community. At a minimum, the plan will include how your organization will:

* Coordinate and make referrals to the local Care Coordination Unit (CCU) and Managed Care Organizations (MCOs).
* Have a working relationship and written agreement with the local Center for Independent Living (CIL) to coordinate, and where possible, to co-locate services.
* Have a working relationship and/or written agreement with other community service providers (Critical Pathway Partners and Additional Resources) to coordinate, and where possible, to co-locate services.