



Summer 2021  
Vol. 41

## ***In Support of Caregivers***

***A Publication of the Caregivers' Resource Center and Alzheimer's Support Unit at the  
Tompkins County Office for the Aging***

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# Local Caregiver Support Services

Caregiver's Resource Center & Project Care Services

*Tompkins County Office for the Aging*

Amy Jackson 274-5486

Dawn Sprague 274-5499

***The Caregiver's Resource Center & Alzheimer's Support Unit*** offers family caregivers information, consultation services, workshops, this newsletter and a lending library of books on family caregiving topics. Stop by or call Amy for an appointment.

Volunteers with ***Project CARE*** offer caregivers a needed break and help in other ways as needed. We may also be able to arrange for paid home care services or short-term respite for stressed caregivers having difficulty paying for those services. Call Dawn to discuss your needs.

## **Caregiver Counseling**

*Family and Children's Services*

Ann Dolan 273-7494

A caregiver counselor will meet with family caregivers periodically in her office to help them work through complex caregiving issues or provide emotional support. Special circumstances may be considered for in-home service. No charge. Donations accepted.

## **Adult Day Program**

**There may be changes to this program due to COVID-19**

*Longview Adult Day Community*

Monday through Friday, 9am-3pm

Pamela Nardi 375-6323

Adult day programs offer older adults companionship along with planned social and recreational activities. It often provides a break from caregiving and time for other matters. Fee: \$60/day includes lunch and snack.

# Support Groups



**Most Support Groups are still meeting virtually.**

## **Family Caregiver Support Group**

**Every Tuesday at 11 am** online via Zoom, offered by the Tompkins County Office for the Aging. To register or for more information call Amy at 274-5486.

## **Caregiver Support Group**

**Last Thursday of every month at 5:30pm** online via Zoom through Brookdale Ithaca. For more information contact Lisa at 607-246-5094.

## **Alzheimer's Caregiver Groups**

**1st Wednesday of the month at 5:30pm** online via Zoom. For information, call the Alzheimer's Association at 1-800-272-3900.

**3rd Wednesday of the month at 12:30 pm** online via Zoom through Walden Place, Cortlandville. Call 607-756-8101 for information.

## **Cancer Caregiver Group**

**2nd Tuesday of the month, 5:30-7:00pm** online via Zoom through the Cancer Resource Center of the Finger Lakes. For family, friends and caregivers of individuals with Cancer. For information call 607-277-0960.

## **Parkinson's Caregivers Group**

For more information, call Carol Grove at 607-279-8257

## **Funding for Family Caregiver Respite**

The Tompkins County Office for the Aging has a limited amount of funding to help family caregivers afford to hire substitute care that enables them to take a break from caregiving, usually a few hours a week. We have some uncommitted funds available if you know a family caregiver who might want to take advantage of this opportunity.

### **Eligibility:**

**Title III E Respite:** This is federal funding that pays for respite service for family caregivers who are caring for an older adult (60 or older) who needs assistance with 2 or more ADL's (dressing, bathing, incontinence, transferring, toileting, eating) **OR** needs substantial supervision due to cognitive impairment (e.g., Alzheimer's or other dementia).

**Alzheimer's Respite Scholarships:** This is New York State funding granted to Tompkins County through the CNY Alzheimer's Association. This funding pays for respite service (at home or in a licensed care facility) to give a break to family caregivers of persons diagnosed with Alzheimer's or other dementia. Although neither program is means-tested, we do try to target these funds to those who find it difficult to privately hire enough substitute care.

### **To Apply or Inquire:**

Please encourage family caregivers to contact **Joanne Wilcox** or **Terry McCann** at **Tompkins County Adult and Long Term Care Services (607-274-5278)**. Due to the overall shortage of aides, or if clients prefer it, they may be able to use this funding to privately hire friends or relatives or aides listed with the Finger Lakes Independence Center (FLIC) through FLIC's Consumer Directed Personal Assistance Program (CDPAP).

# Caregiving: Roles and Tasks

Author: OncoLink Team, [OncoLink.org](https://www.oncolink.org), October 13, 2020

The job description for a caregiver can be overwhelming. The caregiver can be expected to manage the physical, practical, and emotional/spiritual needs of a loved one while continuing to manage his or her own life. In this article, we will explore a bit more about the roles and tasks of the caregivers, as well as how to strategize managing these tasks and roles and to set limits. The caregiver role is "fluid"; as your loved one's disease changes, so may your role. It is important to be flexible and to communicate clearly with your loved one about their care needs as they evolve.

## Physical caregiving needs

While coping with an illness, acute or chronic, the individual requiring care may require physical, medically-based care, and management. As medical care has evolved, less care is being given in the hospital. Many patients are now sent home with high tech medical needs that, not long ago, would have been managed in a hospital. These needs can include tube feedings, chemotherapy, pain management, and wound care. There are also less medically intensive needs, including assistance with mobility and ambulation, repositioning, range of motion exercises, medication management, bathing, dressing, feeding, and supervision for safety.

Limit setting is extremely important in physical caregiving. There may be tasks that the caregiver feels uncomfortable with providing - it is important to voice your concerns about tasks that you feel you will not be able to perform, for whatever reason. For example, you have a bad back, but your family member requires lifting and repositioning. This is not a safe nor realistic role for the caregiver to play. The health care team can help you strategize for alternative plans and sources of assistance. It is of utmost importance to voice your own limitations to both the health care team and your loved one as care is being put into place. Communicate your needs, fears, and concerns so that safe, appropriate care can be arranged.

In many cases, you are being asked to become a nurse for your loved one. This can be a scary reality for the caregiver, but you are not alone. These services are always done in conjunction with and under the supervision of both the physician and a skilled home care agency. Caregivers can be taught (and re-taught) how to provide services to their loved one, how to troubleshoot, as well as when to call for help. Homecare agencies are on call 24 hours a day to provide you with guidance and support. You do not have to do it all on your own. Skilled nursing care, physical therapy, infusion, and wound care services are typically covered by insurance. See our article on "mobilizing help" for more information on home care services.

## **Practical caregiving needs**

Practical care needs involve assisting your loved one in the management of their daily life and can include paying bills, applying for disability, managing insurance claims, going to appointments, and assisting with medical decision making.

Overseeing financial tasks may require the appointing of a financial power of attorney. This is not something to be handled lightly. Consult with an attorney to draw up the necessary legal paperwork that affords protections to both you and your loved one. It is important to talk with your loved one about their financial situation, where supplies are located when bills are due, and how you both can work together to manage his or her personal finances.

As a caregiver, you may attend medical appointments with your loved one. In this role, you need to be present, take notes, ask questions, and assist your loved one in making decisions with the care team. Your loved one may want to appoint you as medical power of attorney or health care proxy so that in the event that he or she is unable to make decisions, you could make them on his or her behalf. Your social worker can help you with creating these documents.

It is important for the caregiver to stay organized. Start a binder or accordion file to keep all the related paperwork. The American Cancer Society offers a free, "Personal Health Manager" with tabs and folders to help organize everything from appointment calendars to medication lists to survivorship care plans. Keeping all paperwork necessary for caregiving in one place can be extremely helpful and alleviate the stress of looking for prescriptions, schedules, and legal documents.

You may also want to keep a separate folder for managing financial documents, such as disability applications and communication, insurance paperwork, and medical bills. This can help you and your loved one stay on top of needed paperwork and facilitate claims being paid on time. Discuss with your loved one where s/he keeps important documents including their will, living will, life insurance policies, property deeds, and car titles. If your loved one pays bills online, you may want to inventory user names and passwords as well as discuss with him/her if you can access these accounts on his or her behalf. It is important to spell this out in any financial power of attorney document to protect yourself and your loved one.

## **Emotional caregiving needs**

When faced diagnosis of cancer [or any other diagnosis], your loved one is riding a roller coaster of emotions. Whether you like it or not, you are along for that ride. Your loved one's feelings may change at the drop of the hat. Given your role as caregiver, you may be the one who hears the anger, dries the tears, laughs at a good joke, or hopes with him or her. What can be especially challenging for caregivers is that all of these emotions can happen in a very short period of time, making it hard to anticipate

and prepare for how to best support your loved one. At the same time, you need to support your own emotional needs.

Communication is key in supporting each other. It is important that you are able to share with your loved one your own feelings and emotions about the experience while continuing to be empathic with the situation. The rewards of providing this emotional support to your loved one should not be ignored. Your loved one is vulnerable, scared, and uncertain about the future. You have been asked to accompany them on this journey. You are committed to them. You are improving their quality of life. You are vital to their physical and emotional well-being. Relationships grow while providing care, but only if you can talk with each other about the experience, the stresses, the highs, and the lows and maintain a plan of action and support together. It is important to explore other avenues for social, emotional, and spiritual support for both you and your loved one. It bears repeating; you do not have to do this alone.

# Checklist: Emergency Preparedness for Seniors

By [Marlo Sollitto](#), [agingcare.com](#), Updated October 20, 2020

Emergency kits usually include standard supplies like non-perishable food, drinking water, batteries and first aid equipment. But, if you have an elderly or disabled relative living with you or nearby, there are some additional considerations to make when it comes to emergency preparedness for senior citizens.

Every area of the world is prone to certain dangerous events. Hurricanes, tornadoes, wildfires, earthquakes, landslides, floods and winter storms are real threats for millions of people each year. Planning and preparing for the possibility of severe weather or a natural disaster is crucial for safety and survival.

## What to Include in a Senior Emergency Kit

1. **Mobility Aids** - If your elder has limited mobility or is bedbound or wheelchair bound, make detailed plans for how they will get around and evacuate their home if necessary. For example, if your parent uses a motorized wheelchair to get around, be sure to have a manual wheelchair on hand as a backup.
2. **Durable Medical Equipment** - Most emergency shelters do not have durable medical equipment (DME) available on site, so seniors must bring their own. This includes therapeutic oxygen equipment, mobility aids, blood sugar monitors, CPAP devices, specialized cushions to prevent skin breakdown and any other portable DME your loved one requires to maintain their health.
3. **Visual Aids** - For a loved one who is blind or visually impaired, keep an extra cane by their bed and attach a whistle to it. Remind them to exercise caution when moving during or immediately after an emergency, as items in the home may have shifted and paths may have become obstructed. Be sure to include an extra pair of glasses or other necessary visual aids in your loved one's emergency kit.
4. **Personal Care Products and Sanitation Supplies** - Seniors often require specific supplies to ensure their personal hygiene and comfort. Stocking up on necessary items, such as incontinence supplies (e.g., adult briefs, pads, wet wipes, barrier creams, catheter and ostomy supplies), bathing products, latex gloves, toilet paper and commode liners, will help ensure their fundamental daily routine and quality of care change as little as possible during and after an emergency situation. Don't forget supplies like face masks, garbage bags, paper towels, disinfectant spray or wipes, hand sanitizer, etc.
5. **Hearing Aids** - Individuals who are hearing impaired should keep extra batteries for hearing aids with their emergency supplies. When not in use,



store hearing aids in a container in a designated space, such as the senior's nightstand, so they can be located quickly in the event of an emergency.

6. **ID, Legal and Health Information** - Keep copies of important identification and health documents on hand in an emergency folder for yourself and your care recipient. Bringing your driver's license or ID card and insurance cards is ideal, but copies are better than nothing. Other important papers to include in this file are copies of power of attorney (POA) documents, advance directives and a complete medication list. If you must evacuate, bringing copies of the deed or lease to one's home, insurance policies and similar papers may be a good idea as well.
7. **Prescription Medications** - Talk to your loved one's doctor about obtaining an extra week's supply of all their prescription medications. This will help your loved one stick to their regimen despite inclement weather and closed or inaccessible pharmacies. Just keep in mind that prescription and over-the-counter medications do have shelf lives. Dispose of any expired medications in emergency kits accordingly.
8. **First Aid Kit** - Include a complete first aid kit and manual in your emergency supplies bag.
9. **A Communication Plan** - Your family and friends may not be together when disaster strikes, so make a plan for how you will contact one another or determine a safe place where you all can meet if traveling is feasible. Keep in mind that roads may be unsafe and internet and phone lines may be down for some time, depending on the situation.
10. **Phone Numbers** - Make a list of important phone numbers for family, friends, local shelters and aid organizations, and your loved one's other care team members to include in your emergency file.
11. **An Emergency Care Plan** - If a senior receives in-home care services or resides at a long-term care facility, be sure to ask their care providers about their protocol for emergency situations. For example, find out up to what point home health aides will still come to your loved one's home to provide care or when, where and how your loved one's senior living facility evacuates residents. Don't forget to create backup plans to help you pivot quickly in changing circumstances.

## **Creating an Emergency Plan Helps Keep You Safe and Calm**

If your aging relative has Alzheimer's or another form of dementia, know that even seniors who are cognitively impaired have an innate understanding that something is wrong in emergency situations. Explain what is happening in easy-to-understand terms, but don't expect them to remember specific details. Validate their concerns but try to keep them as calm as possible. Provide clear direction without being condescending or losing patience.

Creating a comprehensive emergency plan and disaster supplies kit is crucial for ensuring you and your family are well prepared for potentially dangerous situations. Not only do these things help you practically and logistically, but they also help you feel more confident and therefore calmer.

For more tips on how to prepare for common emergencies and types of natural disasters that are specific to your area, visit the [Red Cross website](#).

# Hospital Discharge Planning: A Guide for Families and Caregivers

by Family Caregiver Alliance, [caregiver.org](http://caregiver.org) (n.d.)

A trip to the hospital can be an intimidating event for patients and their families. As a caregiver, you are focused completely on your family member's medical treatment, and so is the hospital staff. You might not be giving much thought to what happens when your relative leaves the hospital.

Yet, the way this transition is handled—whether the discharge is to home, a rehabilitation (“rehab”) facility, or a nursing home—is critical to the health and well-being of your loved one. Studies have found that improvements in hospital discharge planning can dramatically improve the outcome for patients as they move to the next level of care.

Patients, family caregivers, and healthcare providers all play roles in maintaining a patient's health after discharge. And although it's a significant part of the overall care plan, there is a surprising lack of consistency in both the process and quality of discharge planning across the healthcare system.

This Fact Sheet will look at the keys to a successful transition from hospital to home, explain some important elements, offer suggestions for improving the process, and provide caregivers with checklists to help ensure the best care for a loved one. If you are a caregiver, you play an essential role in this discharge process: you are the advocate for the patient and for yourself.

## What Is Discharge Planning?

Medicare states that discharge planning is “a process used to decide what a patient needs for a smooth move from one level of care to another.” Only a doctor can authorize a patient's release from the hospital, but the actual process of discharge planning can be completed by a social worker, nurse, case manager, or other person. Ideally, and especially for the most complicated medical conditions, discharge planning is done with a team approach.

In general, the basics of a discharge plan are:

- Evaluation of the patient by qualified personnel
- Discussion with the patient or his representative
- Planning for homecoming or transfer to another care facility
- Determining whether caregiver training or other support is needed
- Referrals to a home care agency and/or appropriate support organizations in the community
- Arranging for follow-up appointments or tests

The discussion needs to include the physical condition of your family member both before and after hospitalization; details of the types of care that will be needed; and whether discharge will be to a facility or home. It also should include information on whether the patient's condition is likely to improve; what activities he or she might need help with; information on medications and diet; what extra equipment might be needed, such as a wheelchair, commode, or oxygen; who will handle meal preparation, transportation and chores; and possibly referral to home care services.

### **Why Is Good Discharge Planning So Important?**

Effective discharge planning can decrease the chances that your relative is readmitted to the hospital, and can also help in recovery, ensure medications are prescribed and given correctly, and adequately prepare you to take over your loved one's care.

Not all hospitals are successful in this. Although both the American Medical Association and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) offer recommendations for discharge planning, there is no universally utilized system in US hospitals. Additionally, patients are released from hospitals "quicker and sicker" than in the past, making it even more critical to arrange for good care after release.

Studies have shown that as many as 40 percent of patients over 65 had medication errors after leaving the hospital, and 18 percent of Medicare patients discharged from a hospital are readmitted within 30 days. This is not good for the patient, not good for the hospital, and not good for the financing agency, whether it's Medicare, private insurance, or your own funds. On the other hand, research has shown that excellent planning and good follow-up can improve patients' health, reduce readmissions, and decrease healthcare costs.

Even simple measures help immensely. For example, you should have a telephone number(s) accessible 24 hours a day, including weekends, for care information. A follow-up appointment to see the doctor should be arranged before your loved one leaves the hospital. Since errors with medications are frequent and potentially dangerous, a thorough review of all medications should be an essential part of discharge planning. Medications need to be "reconciled," that is, the pre-hospitalization medications compared with the post-discharge list to see that there are no duplications, omissions, or harmful side effects.

Under the best of circumstances, the discharge planner should begin his or her evaluation when the patient is admitted to the hospital.

## **The Caregiver's Role in the Discharge Process**

The discharge staff will not be familiar with all aspects of your relative's situation. As caregiver, you are the “expert” in your loved one's history. While you may not be a medical expert, if you've been a caregiver for a long time, you certainly know a lot about the patient and about your own abilities to provide care and a safe home setting.

The discharge planners should discuss with you your willingness and ability to provide care. You may have physical, financial, or other limitations that affect your caregiving capabilities. You may have other obligations such as a job or childcare that impact the time you have available. It is extremely important to tell hospital discharge staff about those limitations.

Some of the care your loved one needs might be quite complicated. It is essential that you get any training you need in special care techniques, such as wound, feeding tube or catheter care, procedures for a ventilator, or transferring someone from bed to chair.

If your loved one has memory problems caused by Alzheimer's disease, stroke, or another disorder, discharge planning becomes more complicated, and you will need to be a part of all discharge discussions. You may need to remind the staff about special care and communication techniques needed by your loved one. Even without impaired memory, older people often have hearing or vision problems or are disoriented when they are in the hospital, so that these conversations are difficult to comprehend. They need your help.

If you or your family member are more comfortable speaking in a language other than English, an interpreter is needed for this discussion on discharge. Written materials must be provided in your language as well. Studies have shown that numerous, and sometimes dangerous, errors can be made in home care when language is not taken into account at discharge.

Because people are in a hurry to leave the hospital or facility, it's easy to forget what to ask. We suggest you keep the questions summarized below (on pages 5–6 of the printout) with you, and request that the discharge planner take the time to review them with you.

### **Getting Help at Home**

Listed below are common care responsibilities you may be handling for your family member after he or she returns home:

- Personal care: bathing, eating, dressing, toileting
- Household care: cooking, cleaning, laundry, shopping
- Healthcare: medication management, physician's appointments, physical therapy, wound treatment, injections, medical equipment and techniques
- Emotional care: companionship, meaningful activities, conversation.

Community organizations can help with services such as transportation, meals, support groups, counseling, and possibly a break from your care responsibilities to allow you to rest and take care of yourself. Finding those services can take some time and several phone calls. The discharge planner should be familiar with these community supports, but if not, your local senior center or a private case manager might be helpful. (See the Resources section at the end of this Fact Sheet.) Family and friends also might assist you with home care.

If you need to hire paid in-home help, you have some decisions to make. Unfortunately, these hiring decisions are often made in a hurry during hospital discharge. You might be handed a list of agencies, with instructions to decide which to use—but often without further information. This is another good reason discharge planning should start early—as caregiver, you'll have time to research your options while your loved one is cared for in the hospital. Think about both your needs as a caregiver and the needs of the person you are caring for, including language and cultural background.

You have a choice between hiring an individual directly or going through a home care or home health care agency. Part of that decision may be affected by whether the help will be “medically necessary” i.e., prescribed by the doctor, and therefore paid for by Medicare, Medicaid, or other insurance. In that case, they will most likely determine the agency you use. In making your decisions, consider the following: home care agencies take care of all the paperwork for taxes and salary, substitutes will be available if the worker is sick, and you may have access to a broader range of skills. On the other hand, there may be a more personal relationship if you hire an individual directly, and the cost is likely to be lower. In either case, try to get recommendations for hiring from acquaintances, nurses, social workers, and others familiar with your situation.

## **Discharge to a Facility**

If the patient is being discharged to a rehab facility or nursing home, effective transition planning should ensure continuity of care, clarify the current state of the patient's health and capabilities, review medications, and help you select the facility to which your loved one is to be released.

Too often, however, choosing a facility can be a source of stress for families. You may have very little time and little information on which to base your decision. You might simply be given a list of facilities, and asked to choose one. To help, a private geriatric care manager (for whom you will pay an hourly fee) or a social worker can offer much needed advice and support. There are also online sources of information (see the Resources section of this Fact Sheet) that rate nursing homes, for example.

Convenience is a factor—you need to be able to easily get to the facility—but the quality of care is very important, and you may have to sacrifice your convenience for

the sake of better care. The list of questions below will give you direction as you start your search for a facility.

## **Paying for Care After Discharge**

You might not be aware that insurance, including Medicare, does not pay for all services after a patient has been discharged from the hospital. However, if something is determined by the doctor to be “medically necessary,” you may be able to get coverage for certain skilled care or equipment. You will need to check directly with the hospital, your insurer, or Medicare to find out what might be covered and what you will have to pay for. Keep careful records of your conversations.

## **What if You Feel It’s Too Early for Discharge?**

If you don't agree that your loved one is ready for discharge, you have the right to appeal the decision. Your first step is to talk with the physician and discharge planner and express your reservations. If that isn't enough, you will need to contact Medicare, Medicaid, or your insurance company. Formal appeals are handled through designated Quality Improvement Organizations (see the Resources section). You should know that if the QIO rules against you, you will be required to pay for the additional hospital care. The hospital must let you know the steps to take to get the case reviewed.

## **Improving the System**

As we have mentioned throughout this Fact Sheet, discharge planning is an inconsistent process that varies from hospital to hospital. Who does it, when it's done, how it's done, what kind of follow-up is mandated, and whether caregivers are assessed for their ability to provide care and included as respected members of the discussion are all elements that differ from setting to setting.

In general, hospitals make money only when beds are occupied, so in many cases, discharge and transitional care planning become “orphan” services that produce no revenue. Despite its benefits, which clearly increase the well-being of patients and caregivers, discharge/transition planning is often not given the attention it deserves, and indeed, ineffectual planning often serves to add to patients' and caregivers' stress. Discussions among experts on improving transitional care and discharge planning have centered on improvements that emphasize education and training, preventive care, and including caregivers as members of the healthcare team. Some studies have revealed that surprisingly simple steps can help. For example, sending the summary of care to the patient's regular doctor increases the likelihood of effective follow-up care. Likewise, telephone calls from knowledgeable professionals to patients and caregivers within two days after discharge help anticipate problems and improve care at home. Broader recommended changes in practice and policy include:



- Formally recognize the role families and other unpaid caregivers play, include them as part of the healthcare team, and assess their capabilities and willingness to provide care.
- Coordinate care across sites, from hospital to facility to home. Improve communication between hospital and community-based services.
- Develop better educational materials, available in multiple languages, to help patients and caregivers navigate care systems and understand the types of assistance that might be available to them, both during and after a hospital stay.
- Improve training for healthcare staff, including ways to respond to language, culture, and literacy differences.
- Simplify and expand eligibility for public programs. Make transitional care a Medicare benefit; change reimbursement policies to cover more home-based care in addition to institutional care. Reward hospitals and physicians that improve patient well-being and reduce readmissions to hospitals.

## **Conclusion**

Multiple studies have explored the importance of effective discharge planning and transitional care, and have highlighted the very real benefits in improved patient outcomes and lower rehospitalization rates. Several pilot programs have illustrated those benefits, but until healthcare financing systems are changed to support such innovations in care, they will remain unavailable to many people. Caregivers, patients, and advocates are continuing their efforts to alter our healthcare system to make discharge planning a priority. With our graying population, these changes are ever more necessary.



# Personal Emergency Response Systems



TOMPKINS COUNTY  
OFFICE FOR THE AGING

*Aging Better, Together*

Are you concerned about the safety of a family member or a friend? Are you, or someone you know, at risk for falling in their home? Tompkins County Office for the Aging can help!

We contract with Doyle Medical Monitoring to provide Personal Emergency Response Systems (PERS) to residents of Tompkins County. Standard pricing starts at \$25 a month and there is no installation, cancellation, or service call fee. When you get a PERS through our office, an Outreach Worker will visit your home, install and test the device, and explain how it works. With our Personal Emergency Response Systems, you will receive personalized in-home service, peace of mind, services and connections from a local agency, and 24/7 monitoring service. Call the Office for the Aging today at 607-274-5482 to speak with an Outreach Worker about our devices!



Security for your life.™

Did you know living with isolation in long-term care can have serious consequences?

Check in regularly with your family and friends residing in Nursing Homes and know who to call if you are concerned for their mental, emotional, and/or physical well-being.

Chemung, Schuyler, and Tompkins County  
Long Term Care Ombudsman:

607-274-5498

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"WE ARE DEEPLY CONCERNED  
THAT RESIDENTS ARE CUT OFF  
FROM LOVED ONES AND VICE  
VERSA. ... FAMILIES PROVIDE  
VITAL MONITORING AND OFTEN  
ESSENTIAL CARE."

—LONG TERM CARE COMMUNITY COALITION



# Project CARE



TOMPKINS COUNTY  
OFFICE FOR THE AGING

*Aging Better, Together*

Project CARE is a **friendly visitor program** in Tompkins County for Seniors age 60 and over. Project CARE provides companionship to Seniors by having a volunteer make a weekly visit. Project CARE can be a great comfort to Seniors by providing in-home support and companionship, especially to frail or homebound older adults, those that are socially isolated, as well as family caregivers.

## **Weekly visiting:**

Many Seniors in our community greatly benefit from a weekly visit. Visits provide a caring bond, especially to those who are socially isolated. Volunteers can provide conversation, support, organize calendars/paperwork, play games, go for a walk, read to their Senior, polish nails, do a puzzle together, and much more.

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***If you are interested in having a Project CARE friendly visitor please contact Dawn Sprague at NY Connects Tompkins County Office for the Aging by phone @ (607)274-5499 or email @ [dsprague@tompkins-co.org](mailto:dsprague@tompkins-co.org) to discuss this opportunity further.***

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# The Registry at FLIC



The Registry is a compiled list of private pay aides who have been screened through a face to face interview with the Registry Coordinator at FLIC. References are provided and verified to make sure the aide has the necessary skills and compassion that are important for someone to have when taking care of people in their homes. The Registry also contains a list of skilled nurses varying from pediatrics to palliative care.

For more information **contact Teri Reinemann at 272-2433.**

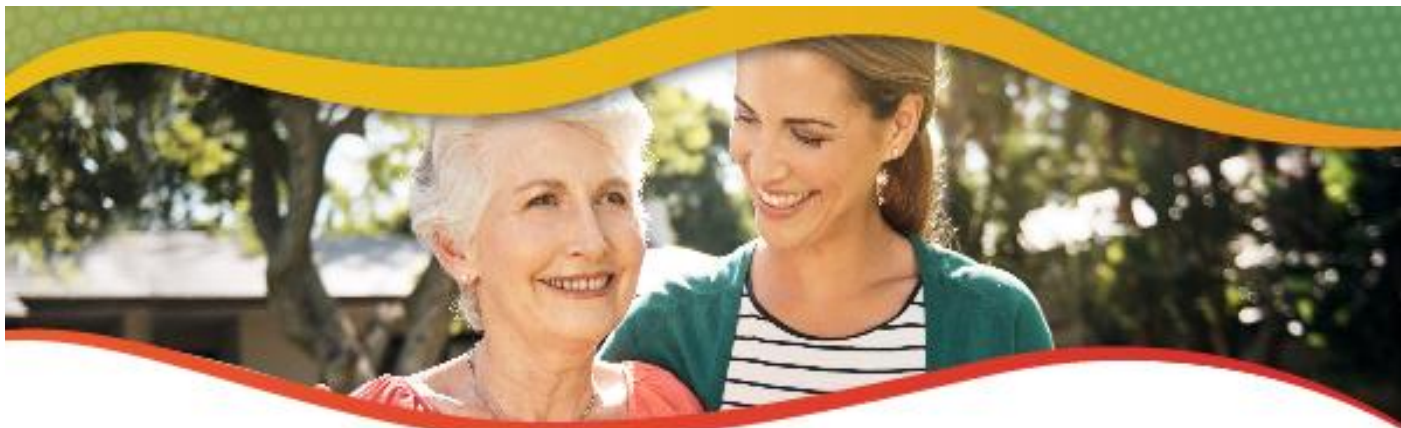
*The Registry program is made possible through funding from the Tompkins County Office for the Aging and the New York State Office for the Aging.*

# NEWS AND NOTES



TOMPKINS COUNTY  
OFFICE FOR THE AGING

*Aging Better, Together*



## The Caregiver Resource Center at the Office for the Aging

**We are still providing support to family caregivers remotely.**

**Powerful Tools for Caregivers Classes**—there are two upcoming classes, one this summer, and one this fall! Contact our office to sign up!

**Caregiver Workshops**—Previously scheduled workshops with the Alzheimer's Association have been changed to an online format. Watch for other workshops coming up as well!

**Caregiver Supportive Group Discussion**—We are currently holding remote caregiver supportive group discussion weekly, and welcome any family caregiver to join us. Contact us to discuss!

**Caregiver Library** - We loan out books on caregiving. We can mail you a book from our library, or you can pick it up! Reach out for the list of available books.

**Caregiver Counseling** - We are available by phone to help caregivers navigate services available in our community.

**For more information about these services please contact the Caregiver Resource Center at the Tompkins County Office for the Aging. We'll be glad to help you!**

**Phone: 607-274-5486**

**Email: [ajackson@tompkins-co.org](mailto:ajackson@tompkins-co.org)**

**Visit our website for COVID-19 resources: <https://tompkinscountyny.gov/cofa/cofa-COVID>**



# POWERFUL TOOLS FOR CAREGIVERS

Managing Stress and Improving Self-Care



TOMPKINS COUNTY  
OFFICE FOR THE AGING  
*Aging Better, Together*



## FEELING OVERWHELMED?

• Caring for someone with illnesses such as dementia, heart disease, Parkinson's disease, stroke, or chronic cancer can be stressful physically, emotionally, and financially.

## JOIN OUR NEXT COURSE!

Thursdays  
July 15th to August 19th  
Via Zoom

OR

Thursdays  
September 19th to  
October 14th  
In-Person (COVID Permitting)

Tompkins County Office for the Aging 214 W. MLK Jr. / State St. Ithaca, NY 14850  
607 - 274 - 5482

## Home Energy Assistance Program (HEAP)

Summer is just around the corner, but there are still plenty of cold nights ahead. As you may know, keeping a home warm can be costly at times, but there are programs to assist heaters during the colder months. The Home Energy Assistance Program (HEAP) provides assistance with fuel and utility expenses for income-eligible homeowners and renters. Under HEAP, eligible clients can also receive a benefit to have their furnace cleaned and tuned as well as repaired or replaced. The current HEAP income guidelines are as follows:

Household Size:	Monthly Income Maximum:
1	\$2,610
2	\$3,413
3	\$4,216

Does your care receiver or someone else that you know fit these criteria? If so, please give our office a call at 607-274-5482 for more information. The Tompkins County Office for the Aging processes HEAP applications for those who are over 60 or receive SSD/SSI and do not receive Food Stamps. All other applicants would call the Department of Social Services at 607-274-5264. The HEAP benefit to assist with a clients' fuel/utility expense has been extended to August 30, 2021. The benefit to assist with a clean and tune/repair or replacement will be available until September 30, 2021. Our office is always taking new applications and assisting those in need of help, please feel free to give our office a call for more information or to apply. Here's to warm and comfortable homes!

***You can always contact the Office for the Aging for information and referral on Caregiver and Long-Term Care services at 274-5482.***

If you would like to be taken off our mailing list, or if you would like to be taken off our mailing list but added to our Email list, please contact us!

**Thank you!!**

**The Caregivers' Resource Center and Alzheimer's Support  
Unit**

Please call or visit us at the  
**Tompkins County Office for the Aging**  
214 W. Martin Luther King, Jr./State Street, Ithaca

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### **Websites of Interest to Family Caregivers:**

**Tompkins County Office for the Aging:** [www.tompkinscountyny.gov/cofa](http://www.tompkinscountyny.gov/cofa)

- Click on “Local Resources for Older Adults” to access our Tompkins County Resource guides.

**Family Caregiver Alliance:** [www.caregiver.org](http://www.caregiver.org)

**CaringBridge:** [www.caringbridge.org](http://www.caringbridge.org)

**Caregiver Action Network:** [www.caregiveraction.org](http://www.caregiveraction.org)

**AARP Caregiver Resource Center:** [www.aarp.org/home-family/caregiving](http://www.aarp.org/home-family/caregiving)

**Next Step in Care:** [www.nextstepincare.org](http://www.nextstepincare.org)

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Ithaca, NY 14850