FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	Community Nurse Home Care, Inc
Project Title:	Senior Women Living Well (SWLW), a collaboration of Community Nurse Home Care (CNHC) and People Acting in Community Endeavors (PACE)
Annual Budget:	$12,798,064.00
Project Budget:	$48,950.00
Requested Amount:	$48,950.00
Targeted Funding Areas:	Trusted sources of knowledgeable advocates in community who will identify and connect us to women in need.

Statement of Need

Elderly women living at low income suffer health inequities negatively affecting living conditions, access to healthcare, and overall health status. Focusing aid programs to address these disparities can improve the health and well-being of this vulnerable population. We will aim to close the gap for those individuals who are unsure about how to obtain the needed services and care they require to live a healthy life.

The number of women aged 65 or older in New Bedford, Acushnet, Dartmouth, Fairhaven, and Westport total 18,626 and the average poverty rate of residents aged 65 or older in those same towns is 10.22%.

The need for assistance is present and we hope to provide these women with the tools they need to live independent, healthy lives

Project Description

CNHC and PACE seek to improve the independence and well-being of the underserved community of Greater New Bedford, specifically for low-income women over 65. These women may not qualify for home care services and require counseling in preventative health management and may need help with basic needs for crisis aversion. Together, we have designed a pilot program to meet the fundamental needs of ARAW-eligible women, providing a broad range of services needed to help optimize their quality of life by improving their health and well-being.

Take for example the case of Edna, a 67-year-old transient female who just relocated to New Bedford. While eating lunch at the Council on Aging (COA), Edna revealed with a staff member that she has been desperately in search of affordable housing, hasn't been able to get refills for her medication since she moved because she lost access to her physician and the meal at the COA is the only one she'll eat that day. The staff member immediately helps Edna make a phone call to the SWLW referral line at PACE.

The PACE SWLW navigator would assist Edna with securing subsidized housing and making sure she has health insurance. They will refer Edna to the food pantry to alleviate her food insecurity and then notify CNHC SWLW with Edna's contact information. The CNHC SWLW nurse will contact Edna to assess needs prior to visit. Once Edna is comfortably in her new housing, the CNHC SWLW Nurse will perform an in-home visit to Edna for her to help her find a new physician, provide education on the importance of med adherence as a preventative measure to help control her chronic high blood pressure disease and educate Edna about inexpensive healthy food options. She may also notice falling hazards around her home and make suggestions to remove those hazards. These new services that Edna was unaware of prior to the referral will result in her remaining

independent and at home with healthier lifestyle choices to promote well-being and improve quality of life.

Community Nurse Home Care and PACE will be piloting this coordination of services with ARAW-eligible women and will look to expand this program in the future to a broader population.

CNHC may provide a variable combination of the following services based on the needs of each individual:

- Emergency Preparation Counseling – ensuring individuals have essential supplies for inclement weather, such as medication (enough for a seven-day supply, management system), food, water, heat, and adequate oxygen if dependent.
- Vaccinations – education on importance and resources to get vaccinations
- Nutritional Reinforcement – preventive teaching on medically prescribed diets such as no added salt (NAS), cardiac, renal, and diabetic. Referral to dietician if appropriate.
- Healthcare preventive education and support – instruction on finding a PCP, getting annual exams, managing chronic disease such as diabetes and chronic hypertensive disease.
- Medication Reinforcement – importance of maintaining a current medication list, having follow up visits with physician and adherence with prescribed medications
- In Home Safety assessment – assessment and teaching for individuals with risk to increase safety in the home environment.
- Memory Loss Program (MLP) – dementia screening with report provided to Primary Care Physician (PCP); family support with referrals to community programs and support groups.
- Support for In-Home Telehealth visit - assistance with in-home physician telehealth appointment to facilitate the relay of information between physician and patient/caregiver
- Referral for Community Resources - referral to Adult Day programs, Councils on Aging, transportation, referral for respite programs.

PACE will provide the initial financial screening and after determination of qualification, a comprehensive assessment of needs to provide appropriate referrals to both their internal programs and CNHC. Services available from PACE include:

- Fuel Assistance – assists eligible households with the high costs of home heating during the winter months through financial assistance, discount programs, and financial counseling. https://paceinfo.org/programs/fuel-assistance/
- Housing Opportunity Center - provides rental assistance for individuals and families that are at risk of or experiencing homelessness through housing search assistance, case management, and referrals to other vital resources. Additional resources available for those effected by COVID-19. https://paceinfo.org/programs/housing-opportunity-center/
- Food Bank - provides the community with grocery and food items, including fresh food from local farms, supermarkets, and stores. https://paceinfo.org/programs/food-bank/
- Health insurance access - – application assistance to individuals and families exploring their health coverage options. The program assists with applications for MassHealth, Health Connector, and Medicare programs and can provide insurance counseling for the uninsured. In addition, PACE has on staff a SHINE advocate (Serving the Health Insurance Needs of Everyone) who provides free health insurance information and counseling to all Massachusetts residents with Medicare/Medicaid and their caregivers. https://paceinfo.org/programs/health-access/
- Income tax program – provides free tax preparation for eligible individuals and families. https://paceinfo.org/programs/vita-tax-preparation/

With these services in place, the beneficiaries will have the ability of attaining healthy, thriving lives and well-being, free of preventable disease, and meeting the fundamental hierarchy of basic needs to support a healthy lifestyle.

Methodology

Our marketing tools will be a postcard distributed to referral sources below, a web page with information to a referral form, and social media page. If enrollment is low, our public health nurse will spend some of the allocated time networking with referral sources to ensure understanding of the services provided.
Referrals will be sent through a website form, via email, or a phone call to a dedicated phone number with staff from PACE receiving first contact through all means. The PACE SWLW navigator will screen the potential recipient to ensure they meet the eligibility criteria, using a questionnaire provided by CNHC, identifying the needs of the participant.

If they meet the criteria, the navigator will then connect the participant to available services at PACE or CNHC. Each referral will be individualized based on needs.
We will encourage referrals from:

- Police and Fire Departments
- Councils on Aging
- Housing Authorities
- Wellness Centers
- PACE Staff
- ARAW
- Board of Health Agents

PACE Process:
Referrals will come into the PACE Health Access program and be screened by a staff member. The PACE SWLW Navigator will speak with the participant to determine the programming needed, using a provided questionnaire.

Once programming is determined, the Navigator will reach out to the appropriate PACE programs to connect the participant to a staff member in each program needed. The Navigator will send individuals contact and need information to the SWLW Program Manager at CNHC.

The PACE SWLW Navigator will follow up with the CNHC SWLW nurse for further referrals, if necessary, for each participant.

CNHC SWLW process:
Referral - once referral is received from the PACE SWLW navigator, a medical record will be initiated and our Public Health staff will reach out to the participant.
Intake – Public Health nurse will gather information, assess needs, schedule appointment for visit or arrange referral to appropriate services.
Visit – The Public Health nurse will complete an in-home visit to the referral, provide services and look for any other needs the referral may need.
Follow-up – phone call to beneficiary for follow-up; additional referrals if needed. Chart will be closed.
Reporting – CNHC SWLW Public Health Nurse will provide counts on types of visits provided with time spent.

Training our own respective staff on the services we can provide through both organizations and how to recognize eligible participants will be crucial.

Outcomes

Once the SWLW program is put in place, CNHC and PACE will inform the cities and towns' police and fire departments, Board of Health Agents, Councils on Aging, housing authorities, Wellness Centers, and the

ARAW. This will connect these women to much-needed resources, promoting financial stability and healthier medical outcomes.

There will be consistent communication and referrals placed between CNHC, PACE, and ARAW, with the expectation these women will live well and with dignity. PACE will ensure these women have access to safe housing and food; additionally, they will have the ability to remain safe in their homes with assessments and education provided by SWLW Public Health Nurse upon referral to CNHC.

They will reach optimal physical and emotional health by participating in their physical activity and enriched social interactions by the referrals to Councils on Aging programs or other support groups. Preventative health care will be optimized as they will have access to transportation for medical appointments, vaccine education and/or telehealth visits. This will prevent future hospitalizations.

With the new tools and skills they have learned from CNHC and ensuring basic needs are met though PACE, they will become more independent and proactive in their self-care. Along with any outside resources we may refer them to, we will provide these women what they need to live a happy, healthy, and active lifestyle.

Evaluation

PACE will collect basic demographic information including address, phone number, and DOB. PACE will use the qualifying information used in our Health Access Program to ensure that pilot participants fall into the qualifying guidelines for ARAW.

PACE will report referrals and CNHC will report which services were provided to the qualifying referrals and number of visits for each referral. CNHC will provide details that fall within HIPPA guidelines, and results of follow-up check-ins to ARAW quarterly.

Who will benefit?

This project will serve low-income women over the age of 65 in the Greater New Bedford area. PACE currently serves 2,594 women 65+ from the targeted cities/towns based on their database. Clients of PACE fall into the required income guidelines for ARAW programs. The census shows there are 18,626 elderly women living in this service area who may also be referred through other sources.

A broad range of services are available to optimize the quality of life for these women. These services can empower them to take control of their own care and help to maintain their independence.

Anticipating the population of baby boomers to grow over the next few years creates a larger population of women in this category. Providing education and necessary tools to live a standard quality of life will help prevent severe illness and control rising healthcare costs.

During the pilot of the program, PACE will not need to limit the referrals to their listed services due to their current capacity in already funded programming, however, CNHC will need to limit the number of participants who can be served. CNHC will reallocate some current CNHC staffing to accommodate approximately 100 participants for a one year timeframe, with a limit of 2 visits per individual, or a total of 200 visits.

Implementation Timeline

Launch planned for early April 2022. We will prepare marketing tools (postcard, website, and social media platform) at the end of February after notification of decision. We will begin outreach and education of staff in March. Finally, we will begin accepting referrals in May.

Qualifications

PACE is the local Community Action Agency designated to serve those living in poverty in the Greater New Bedford area. The nature of community action includes assessing the needs in the community and providing solutions in the form of programs and collaborations that can meet those needs. PACE offers 10 programs that address a variety of basic needs, from our Food Bank addressing food insecurity needs to our Fuel Assistance program offering benefits that assist with the payment of home heating bills, and our Housing Opportunity Center working to ensure people can retain stable housing. Through our Health Access program, PACE staff help to connect people to health insurance, assessing qualifications, and helping them complete the necessary paperwork to get insured. Staff in this program have experience determining eligibility and referring across the agency. It will be through the Health Access Program where referrals for this pilot will be processed.

CNHC is a long establish home care organization that has provided Public Health services to the towns of Acushnet and Fairhaven for many years. In fact CNHC began as the public health nurse for Fairhaven back in 1916. CNHC employs qualified staff equipped to serve this population. Most visits will be performed by the Public Health Nursing staff consisting of an LPN or RN. Memory Loss visits will be performed by a Certified Dementia Practitioner. Each clinician is skilled and/or licensed, allowing appropriate assessments and possible referrals to outside sources when applicable.

The Ask

Community Nurse Home Care and PACE will be using these funds to improve the lives of low-income individuals and as our pilot, focusing on elderly women in the community of Greater New Bedford. The funds for this project will be used to support staff time for both CNHC and PACE, from referral intake with PACE Navigator through the follow phone call and documentation by the nurse.

The PACE Navigator will provide the initial screening of referrals. The PACE Navigator's time doing the screening and If they meet the criteria to be an ARAW eligible recipient, they will be referred to the needed services.
If they need any of the CNHC's services listed above, the referral will be sent to the CNHC SWLW Program Manager, who will in turn assign the services. The SWLW Program Manager's time and the services are also included in the cost.
A maximum of 2 visits will be funded through the grant. If additional services are needed, they will be referred to other resources. CNHC will be limited to serving 100 individuals due to current resources' ability of providing 3-4 visits per week.

If they need PACE services listed above, the processing of the referral will be the only service the grant covers. All other PACE services are otherwise funded so the number served through PACE services will be unlimited.

The funds will also be used to create the necessary tools to referrals via the website, social media and creating and printing brochures. Outreach needed to access referrals will be done by the Public Health nurse networking with referral sources, with those hours subtracted from the visit allocation.

Training of staff for internal referrals will also be funded.

Future Funding/Sustainability

If this pilot is successful and there continues to be a high need in the community, CNHC will seek again funding from ARAW along with other funders to expand these services to additional populations for CNHC's and PACE's services.

Community Nurse Home Care, Inc
Senior Women Living Well (SWLW), a collaboration of Community Nurse Home Care (CNHC) and People Acting in Community Endeavors (PACE)

Project Budget $48,950.00
Budget Narrative Total funding for this pilot project will be coming from the ARAW grant.

CNHC Visits

Cost Per visit	$	150.00	includes fringe, admin costs and m
15 minute follow up	$	37.50	
number of visits per referal		2	
total cost per referal	$	337.50	
number of referals to be served		100	staff can manage 3-4 visits per we
Total Expense CNHC	$	33,750.00	
Training of staff	$	500.00	CNHC Social workers & PACE staff
Tracking tools (Casamba)	$	2,400.00	$200 x 12 months
Marketing Expenses			
Info card	$	800.00	printing and design
Website	$	1,000.00	programing and design
Social media	$	500.00	design and posting
Total Expense Marketing	$	2,300.00	
PACE expenses			
Total cost per year	$	7,905.00	Community Healthworker for 8 ho
Fringe	$	1,580.00	
Admin Cost	$	515.00	
Total Expense PACE	$	10,000.00	
Total Request	$	48,950.00	

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	New Bedford Art Museum (NBAM/ArtWorks!)
Project Title:	Creative Cares
Annual Budget:	$487,282.00
Project Budget:	$46,000.00
Requested Amount:	$46,000.00
Targeted Funding Areas:	Access to social engagement opportunities to combat loneliness and isolation.

Statement of Need

Building on its successful Creative Care program, NBAM will use its expertise as an arts learning center to provide art instruction, provide quality materials, and offer interdisciplinary yoga sessions to senior women in the New Bedford community to help combat loneliness and isolation.

Using art as a medium to connect and create, NBAM will use its knowledge of working with elder groups through previous partnerships with Community Nurse and Hospice Care, Autumn Glen Assisted Living Facility, and the MA/NH Chapter of the Alzheimer's Association.

Isolation and lack of meaningful social connections and continued learning experiences can be a challenge for senior women. NASEM says nearly one-fourth of adults aged 65 and older are considered to be socially isolated and that they are at increased risk because they are more likely to face factors like living alone, the loss of family or friends, chronic illness, and hearing loss.

Project Description

NBAM created a program designed specifically to engage senior women in meaningful art programming paired with yoga sessions, through direct delivery, with safety protocols in place. Taking place at locations determined by ARAW, NBAM will conduct classes both indoor and outdoor in conducive and constructive . The program incorporates physical movement, through an age-appropriate yoga practice, that sets the stage for centered art engagement and helps participants relax and enjoy art making.

Continuing to focus on underserved people in the community, including senior women, NBAM expanded its versatile artMOBILE and art kit distribution program to include these elder populations. By making the mobile art studios available and accessible, along with delivering art materials, NBAM has built on its outreach foundation of creating meaningful programming at facilities, community centers, and in outside settings. Paired with yoga sessions, participants are able to approach the activities in a more holistic way, exercising the mind and the body. The program will culminate in an exhibition of the participants artwork, and participants will also have the opportunity to see the museum in-person on three guided field trips where they can continue their exploration and learning experiences beyond the classes and kits.

Programs at senior facilities tackle physical and mental stimulation with activities and events- which is valuable.But motivating, dynamic classes and activities, taught by artists and professionals, can add another level of interest and involvement that goes beyond the daily programs and has proven to be a huge benefit: "weekly participatory art programs, reported: (A) better health, fewer doctor visits, and less medication usage; (B) more positive responses on the mental health measures; (C) more involvement in overall activities. (The Creativity and Aging Study- The Impact of Professionally Conducted Cultural Programs on Older Adults Final Report: April 2006)

NBAM recognizes and serves at-risk and isolated populations within the community, including; low-income seniors, vulnerable individuals, and people with disabilities- and it consciously strives to make direct, positive impacts by offering engaging programming that explores creativity and movement which are integral components of prolonging the effects of aging and intellect. Art can help break down barriers of isolation and connect people, and it's through this medium that NBAM seeks to bring these individuals. NBAM believes that each person has artistic and creative capabilities and that, when nurtured, can find unique and valuable expression. The Creative Care program endeavors to inspire and to open up possibilities while providing a foundation of skills and artistic development.

The Creative Care program will run from April 2022- March 2023 where artMOBILE will visit 2x/week for 10 weeks (5/spring & 5/fall) at 20 sites accompanied by 30 art kits per site. A total of 600 kits will be distributed via artMOBILE.

Yoga sessions will be 2 hours per week for 6 weeks. Three field trips to NBAM, including transportation, will be guided by a museum coordinator and admission will be free.

On-site/Outdoor lessons will consist of 3x/week, for 20 weeks (4 sessions/5weeks) and the distribution of 12 kits per site, totaling 720 art kits.

A total of 1320 senior women will directly benefit from the Creative Care program.

Methodology

NBAM's project activities include providing purposefully curated art care kits to elder women served at select sites recommended by Coastline Elderly Services. Using a mobile art van, NBAM's artMOBILE, the art care kits will be brought directly to those we aim to serve, and distributed at pre-selected promoted times and dates. Each of these kits will feature a different arts-based project that will encourage cognitive thinking and motor skills through the use of quality art supplies, easy to follow lessons translated into English, Portuguese, and Spanish, along with age-appropriate materials to help with mindfulness and mobility.

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Outcomes

Providing access to social engagement and opportunities through our Creative Care program benefits the participants, but also the community at large. "Individuals and communities reap profound benefits from participating in arts programs, especially when those programs are led by professional teaching artists." (National Center for Creative Aging). By participating in programs like this, people can lead healthier lives and connect with themselves and others while actively staying involved.

The specific effects this project will address is: A- isolation and loneliness- participants will decrease these negative effects by joining the program; B-holistic health and well-being- creating and moving the body will help participants engage and internalize physical and mental benefits; and C: providing opportunities to build skills- learning a new medium, exploring a talent, nurturing a new interest all contribute to well-being.

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Evaluation

Evaluation will be a necessary and important part of learning how to improve, adjust and grow the program. NBAM will have surveys, and feedback -formal and informal- that both participants and caregivers will partake in sharing to evaluate and improve the program.

1. Administration Facility Evaluation: administrative and caregiver feedback and evaluation

2. Feedback from participants: the students/artists/participants will evaluate their experiences and provide insight to program development

3. Exhibit to Community (artist will display): Interaction and input from the community

4. Peer to Peer Critique and Feedback: critique and support by classmates

Who will benefit?

In New Bedford, 22.67% of females fall below the poverty line - slightly more than the national average. This program is designed to address these populations in purposeful programming. ARAW will determine locations that will benefit the elderly population best. We anticipate 1320 elderly women benefiting from the program both in in-person learning and through curated art care bag kits that will be distributed in the spring and fall.

Implementation Timeline

The Creative Care program will run from April 2022- March 2023 where artMOBILE will visit 2x/week for 10 weeks (5/spring & 5/fall) at 20 sites accompanied by 30 art kits per site. A total of 600 kits will be distributed via artMOBILE.

Yoga sessions will be 2 hours per week for 6 weeks. Three field trips to NBAM, including transportation, will be guided by a museum coordinator and admission will be free.

On-site/Outdoor lessons will consist of 3x/week, for 20 weeks (4 sessions/5weeks) and the distribution of 12 kits per site, totaling 720 art kits.

A total of 1320 senior women will directly benefit from the Creative Care program.

Yoga classes will be paired with hands-on indoor/outdoor sessions to help the mind and body warm-up for creative learning and exploring.

Qualifications

NBAM has been engaged in artMOBILE outreach for over 25 years. Involving more diverse groups of people to be able to access art programs and to be able to participate in self-care, has been at the center of NBAM's mobile art program since 1995. Each of the Art Museum's staff members is also an experienced art educator which allows them to bring a level of expertise to the development, administration, and evaluation of community-based programming. For this Creative Care initiative, a professional with extensive knowledge of the best and current practices for project implementation will be consulted. A trained art educator and yoga instructor with previous experience with elderly populations will conduct on-site activities.

NBAMs artMOBILE has been a successful outreach program for over 26 years. Beginning with young learners, it has evolved to serving underrepresented groups of people who don't have access to continued learning and exercise classes, expanding to reach elderly populations. Providing art classes and engagement to people of all abilities and ages is at the center of NBAM's mobile art program.

Each of the Art Museum's staff members is an experienced art educator which allows them to bring a level of expertise to the development, administration, and evaluation of community-based programming. For this Creative Care initiative, a professional with extensive knowledge of the best and current practices for project implementation will be consulted. A trained art educator and yoga instructor with previous experience with elderly populations will conduct on-site activities.

The Ask

NBAM is asking for funds for the Creative Care Program that will support 1320 elderly women: 1320 curated art kits, delivery and instruction in the spring and fall, yoga sessions, artist salaries, transportation/travel costs, exhibition expenses, staff and admin fees, marketing, and promotion.

Future Funding/Sustainability

NBAM anticipates continued growth of its Creative Care Program as it has been enthusiastically received and the interest exceeds what it can handle in terms of quality instruction. We know that other organizations that serve elderly populations are interested in this kind of programming. NBAM will inevitably establish the Creative Care program as a core offering to the community, and actively seek funding from a variety of sources as the need is critical and the Museum sees its involvement as a way to provide a valuable resource for a growing elderly population.

New Bedford Art Museum (NBAM/ArtWorks!)
Creative Cares

Project Budget $46,000.00
Budget Narrative The budget consists of curated art kits, delivery and instruction, outdoor supports, artist salaries, transportation/travel costs, exhibition expenses, staff and admin fees, marketing and promotion, and membership/transportation to access to Museum. The Creative Cares budget consists of Program Director, Art teacher and staff costs; art supplies/materials; yoga instruction; exhibition costs; mobile van costs; travel and admission to NBAM.

ARAW Budget	ARAW Budget	ARAW Budget	ARAW Budget	ARAW Budget	ARAW Budget	ARAW Budget	ARAW Budget	ARAW Budget	ARAW Budget	ARAW Budget	ARAW Budget				
April 2022 - March 2023															
		hourly rate	hours per week	total	weeks	total payroll									
	Program Director	23	2	46	35	$1,610.00									
	Executive Director	30	2	60	2	$120.00									
	Overhead/Admin					$7,666.72									
	Payroll tax: 15%					$1,370.10									
						$10,766.82	**ADMIN**								
artMOBILE - Curated Kit Delivery		hourly rate	hours per week	total	weeks	total payroll									
	Art Educator	20	6	120	10	$1,200.00									
	Art Educator	20	6	120	10	$1,200.00									
						$2,400.00	**EDUCATION PAYROLL**								
										artMOBILE - Curated Kit Delivery						
	Art Supply Kits and Handouts					$7,200.00				2	sites a week	One day - two locations			
	Van(s) insurance, maintenance					$3,000.00				10	weeks	5 weeks fall/5 weeks spring			
	Marketing and Promotion					$250.00				**20**	**sites total**				
						$10,450.00	**SUPPLY and OPERATIONS TOTAL**			30	kits per site				
										600	**total kits**				
On-Site Outdoor Classes		hourly rate	hours per week	total	weeks	total payroll				$12	per kit				
	Artist Faculty	25	8	200	20	$4,000.00	2-hour per site workshop			**$7,200**	**total cost**				
	Yoga Care Support	25	2	50	6	$300.00	stipend split among classes/15 min. per class								
						$4,300.00	**EDUCATION PAYROLL**								
	Art Supply Kits and Handouts					$10,800.00									
	Marketing and Promotion					$235.00				On-Site Outdoor Classes					
						$11,035.00	**SUPPLY and OPERATIONS TOTAL**			3	sites per week	2-3 days a week - locations may vary			
Program Exhibitions										20	weeks	4 sessions - 5 weeks per session - April 2022 to March 2023			
	Exhibitions Manager	22	16	352	2	$704.00				**60**	**sites total**				
	Exhibition Supplies					$1,300.00				12	kits per site				
	Marketing and Promotion					$500.00				**720**	**total kits**				
						$2,504.00	**SUPPLY and OPERATIONS TOTAL**			$15	per kit				
										$10,800	**total cost**				
Access															
	Free Timed Admission Tickets	665	passes	$5	per pass	$3,325									
	Travel to the Museum for Guided Tour	3	field trips	$407	round trip bus	$1,220									
						$4,545	**ACCESS TOTAL**								
						$38,333.60	*ignore - number used to calculate Overhead Admin 20%*								
						$46,000.32	**TOTAL PROGRAM COST**								

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	New Bedford Fishing Heritage Center
Project Title:	Herstory: Collecting the Stories of Women in the Fishing Community
Annual Budget:	$200,000.00
Project Budget:	$26,500.00
Requested Amount:	$20,000.00
Targeted Funding Areas:	Trusted sources of knowledgeable advocates in community who will identify and connect us to women in need.

Statement of Need

Many elderly women in Greater New Bedford are directly connected to the story of commercial fishing through work or family ties. Much of this significant history remains undocumented and the women are rapidly aging. Moreover, many of the ethnic, religious, and industry-based organizations and events that once created a sense of community for women in the fishing industry no longer exist. Consequently, older women who worked in the fishing industry and widows whose husbands, fathers, and sons were fishermen are often isolated and lonely, a condition exacerbated by the pandemic. Additionally, and particularly as we age, all of us want to know that who we are and what we do in our lives matters. This project aims to combat social isolation and validate the lived experience of these women, many of whom are low income and/or immigrants.

Project Description

This will be a multiphase project serving existing ARAW clients and casting a wider net to identify ARAW eligible women from the local fishing community. The activities proposed are designed to provide social experiences which encourage life review, create opportunities for lasting friendships, and validate the lives and experiences of the participants, positioning them as valuable keepers of history.

Phase One:

Fishing Heritage Center staff and volunteers will visit senior centers and low-income senior housing facilities to present Finest Kind, the Center's 20-minute orientation film to groups of women. Following the film, the FHC presenter will lead a discussion and sharing session, encouraging the women to share any related memories with the group. The women will also be invited to complete a short survey to determine whether they have any connection to the fishing industry, whether they would be interested in visiting the Fishing Heritage Center, and whether they would be willing to be interviewed at a later date. Also, during this phase, Center staff will do targeted outreach to the fishing community (including social service, religious, and cultural organizations) to identify additional women who may be ARAW eligible and interested in participating.

Phase Two:

Four to six groups of 10-20 women from senior centers and low-income senior housing facilities will visit the Fishing Heritage Center. During a 90-minute visit they will take a guided tour of the Center's exhibits. They will watch Pearl of the Atlantic, a 1963 film about New Bedford's then burgeoning scallop industry. And they will have time to socialize with one another and enjoy coffee and pastries. Women who were not previously surveyed in the visits to senior housing will be invited to complete a short survey to determine their ARAW eligibility, whether they have any connection to the fishing industry, whether they would be interested in volunteering at the FHC, and whether they would be willing to be interviewed at a later date. Eligible women will be invited to learn more about ARAW and potential benefits.

Phase Three:
The Center will outreach to local high schools and colleges to recruit a group of young women to participate in the project as oral history interviewers. These women will attend a workshop to learn basic oral history methodology, the use of digital recording equipment, and become familiar with the practice of life review therapy.

Phase Four:
The young women will conduct interviews with the older women. Interviews will be completed in one or two sessions at a mutually agreeable location (most likely the older woman's home). Interviewees will be photographed and any historical photographs or documents that the older women share will be scanned.

Phase Five:
Interviews will be transcribed and young women will develop digital profiles of the older women. Copies of the transcripts and photographic portraits will be given to each of the interviewees. Profiles will be shared in a culminating event or series of events held at location(s) to be determined. Participating women will be invited to become FHC volunteers. Eligible women will be invited to learn more about ARAW and potential benefits.

Addressing the need:
Oral history projects create an opportunity for participants to engage in life review. In 1963, psychiatrist and aging expert Robert Butler, MD, explained that reminiscence is a universal and naturally occurring mental process. Reminiscing allows older adults to identify past accomplishments and maintain a balanced perspective that integrates the full spectrum of life experience. Therapeutic results from life review include reduced depression, increased life satisfaction, self-acceptance, bonding, catharsis, and reconnecting with family and friends. [Haight, B. K. (2007). The life review: Historical approach. In J. A. Kunz & F. G. Soltys (Eds.), Transformational reminiscence: Life story work (pp. 67–81). Springer Publishing Co.]

As the National Academy of Sciences noted "Social isolation and loneliness are serious yet underappreciated public health risks that affect a significant portion of the older adult population. Approximately one-quarter of community-dwelling Americans aged 65 and older are considered to be socially isolated, and a significant proportion of adults in the United States report feeling lonely." [National Academies of Sciences, Engineering, and Medicine. 2020. Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System. Washington, DC: The National Academies Press]

Visits to the Fishing Heritage Center will provide important opportunities for social connection and in particular, the chance to engage with others who have shared similar experiences. Additionally, the program will offer participants the opportunity to become Fishing Heritage Center volunteers. In the five years since the Center opened, volunteers have quite literally created a community among themselves. Center staff offer regular trainings for volunteers including guest speakers and field trips to learn more about the fishing industry.

The Center provides volunteers with meaningful ways to contribute. While not all volunteers have a direct connection to the fishing community, those who do are particularly valuable because they can engage visitors by sharing their lived experience. They can also help educate FHC volunteers and staff about aspects of the fishing community and its history.

Methodology
Programs at senior centers and senior housing complexes will engage women in social activities. Required

resources: portable projector and screen and refreshments. We may also need a simple microphone and speaker. Though we hope to have an informal gathering, elders often need sound amplification.

Visits to the Fishing Heritage Center provide an intimate setting where members of the fishing community see themselves, their community, and their history reflected in the exhibits. The exhibits which tell the story of the fishing community past, present, and future, are both evocative and comforting. Those who have worked or lived in the fishing community look at photographs and film clips and listen to audio excerpts of workers past and present are reminded of aspects of their own lives. The exhibits have also been a consolation to fishing family members who have lost someone at sea and are looking for a way to recall their loved one and remember or gain insight into that person's life. Required resources: rental of handicapped-accessible bus or van to transport the seniors; refreshments

A half-day, oral history workshop will provide the cohort of students with hands-on experience using the recording equipment and training in best practices for successfully interviewing seniors. During the workshop we will also co-create a list of potential questions to be used in the interviews. In addition, the workshop will include a presentation by a gerontologist about the value of life review therapy. Required resources: stipend for presenter(s), refreshments.

Oral history interviews: We will make arrangements for mutually agreed upon locations for the interviews. The center owns high-quality digital recorders. Required resources: lapel microphones, batteries, and a portable scanner.

Culminating event(s): We plan to gather program participants and guests to share the results of the project and offer an opportunity for comradery among the women. Resources needed: handicapped-accessible transportation, refreshments, and venue rental.

Outcomes

The Center's staff, board, and volunteers have well-established, trusted relationships with the fishing community formed over the course of the past two decades. These relationships will enable the Center to identify and connect ARAW to women in need from the fishing community including women from a variety of immigrant communities. The programs we propose are designed to provide social engagement opportunities that will combat loneliness and isolation including both group activities and one-on-one intergenerational opportunities for life review. Additionally, as discussed earlier, the life review that is a natural part of participating in an oral history interview has beneficial therapeutic effects known to combat depression in older people. We are hopeful that some of the women will elect to become FHC volunteers which would offer continuing opportunities for social engagement.

The activities proposed in this project will provide women who are connected to the local fishing industry through work or family ties with access to social engagement opportunities by offering programs at senior centers and in low-income senior housing facilities. Field trips with transportation and free admission to the Fishing Heritage Center are planned so the women can view the Women's Work exhibit and participate in related programming. The intergenerational oral history project will engage the older women in life review, provide validation of their lives and experiences. Additionally, the young women involved in conducting the interviews will gain an appreciation of the work and lives of the older women while practicing the interpersonal skills of close listening and empathy. The oral history interviews produced will further the FHC's ongoing efforts to preserve and document the history of the fishing community, adding previously unheard stories. These oral histories will be incorporated into digital profiles of the women interviewed and will be added to the FHC's archive as well as the archives at UMASS Dartmouth and NOAA Voices from the Fisheries.

The Fishing Heritage Center may also gain new volunteers and women who become volunteers will gain a community.

Evaluation

The project will provide introductory programs at 8-10 sites, and engage groups of 10-20 women from each site in visits to the Fishing Heritage Center. We will train 6-8 young women to conduct the oral history interviews, and conduct and transcribe a minimum of 24 oral history interviews.

Project activities will be documented and observations will be collected from project participants, staff at senior housing and Fishing Heritage Center, and interviewers. Project participants will be asked to complete a survey at the beginning of the project and at the project's conclusion.

Measures of success will include the number of women who participate in the project, numbers of programs delivered at senior centers and senior housing facilities, the number of groups who visit the Center, and the number of interviews conducted and transcribed. Additionally, the number of women referred for services to ARAW and other service providers and the number of women who become volunteers at the Fishing Heritage Center will be tracked. Results from the pre- and post-visit surveys will be analyzed. Equally important, anecdotal information reported by staff at senior centers and the Fishing Heritage Center and the interviewers will be an important indicator of the impact of the programs and oral history interviews in combating loneliness and depression.

Who will benefit?

Our project will focus on ARAW eligible women including women living in greater New Bedford who are connected to the fishing community. The project will also engage young women who are attending local high schools and/or colleges.

According to the 2020 United States Census, Greater New Bedford (including Dartmouth, Acushnet and Fairhaven) has a population of 95,348 which is about 51% female. Sixteen percent of the population (or roughly 15,255 people) is over 65. Fifty-nine percent of the population is White, 9% Black, 2% Asian, and 21% Hispanic. The census does not provide clear statistics for Cape Verdean and multi- racial respondents. Almost 20% of Greater New Bedford's population is foreign born with 36.8% who speak a language other than English at home. Seventy-six percent have graduated high school, but only 17% have a bachelor's degree. The median household income is $47,305, about half that of state median of $85,843. Sixteen percent of seniors in Greater New Bedford are living below the poverty line.

While New Bedford is currently the highest value fishing port in the country due primarily to scallop prices, this was not the case prior to 2000. The women we plan to engage in this project were involved in the industry at a time when it was much less lucrative and now, in their twilight years, many of these women are low income. As the fishing community is ethnically diverse, including many immigrants, we anticipate serving this population as well.

Implementation Timeline

April – May
Outreach to community partners to explain project
Outreach to identify elderly women with ties to the fishing community (multilingual flyers created, press release sent, social media posting)

May -June

Programs presented at senior centers and senior housing facilities

June -August
Group visits to FHC

September
Outreach to area high schools

October
Oral history interviews conducted

October-December
Oral History Workshop conducted

November-January
Oral history interviews transcribed
Women photographed

January-March
Digital profiles created

March
Culminating event planned

April
Culminating event presented

Qualifications

The Center's staff, board, and volunteers have well-established, trusted relationships with the fishing community. Many volunteers are themselves fishing family members.

The Center's board includes several fishing business owners, a maritime social scientist, an archivist, and a fishing community social service provider.

The Center has collaborated with a number of social service agencies and ethnic associations which will support our outreach to project participants. Likewise, the Center will rely on well-established relationships with area high schools, Bristol Community College, and UMASS Dartmouth to recruit a cohort of young women to conduct the interviews.

The Fishing Heritage Center and its predecessor the Working Waterfront Festival, have collected hundreds of oral histories over the past two decades. Executive Director Laura Orleans who has a master's degree in folklore from the University of North Carolina at Chapel Hill, has led oral history workshops and conducted ethnographic interviews for the Massachusetts Cultural Council, National Park Service, and Library of Congress. The Fishing Heritage Center has incorporated oral histories in the production of films, books, and exhibits. For example, the Center recently developed a major exhibit called "Women's Work" exploring the roles of women in the fishing community historically and today which incorporates oral history excerpts from interviews with over seventy women from fishing communities in Maine, Massachusetts, and Rhode Island.

The Ask

ARPA funding would be used to support staff time coordinating this project including community outreach; planning, scheduling, and presenting programs; training volunteers and student interviewers; overseeing the oral history project; promoting the entire project; and reporting to ARAW. Additional funds will be used to pay for transportation of women from senior housing to the Fishing Heritage Center, refreshments for programs, supplies and equipment, printing, stipends for presenters, student interviewers and photographer, and cost to rent a venue for the culminating event.

Future Funding/Sustainability

The proposed project would be a new program for the Fishing Heritage Center. If we are able to support this initial pilot program with ARAW funds, we would envision continuing to offer onsite and Center-based programs for senior centers and senior housing facilities. We would seek private funds (Bank Charitable Foundations and corporate sponsorships) to support transportation and administration costs. We are also hopeful that some of the women who participate in this project will become Fishing Heritage Center volunteers which would involve them in ongoing social engagement with other volunteers, Center staff, and the visiting public. The oral histories collected as part of this project will become part of the Center's archive and will be shared through future exhibits and publications.

New Bedford Fishing Heritage Center
Herstory: Collecting the Stories of Women in the Fishing Community

Project Budget
$26,500.00

Budget Narrative
The proposed project builds on the Center's ongoing Women's Work project which was funded through a combination of private donations and government grants. The Center has raised considerable funds in the past to support its projects through a combination of foundation and government grants and corporate support. The Center is confident that it will be able to raise the additional funds needed to carry out this project. Requested and received funds are as follows:

Wicked Cool Places – Pending request of $5000
Women's Fisheries Network – Donation received $1500
Women's Fund Southcoast – intend to apply if invited

Herstory
Project Budget

Expenses	Amount	Notes
Staff Time	$ 14,000.00	Executive Director 15-20%; Community Engagement 10-15%
Workshop Presenter Stipends	$ 500.00	
Transportation	$ 4,000.00	van rental 8 trips @ $500
Photographer	$ 1,500.00	20 portraits @ $75/ea.
Student Stipends	$ 2,500.00	10 stipends of $250
Equipment	$ 1,250.00	portable projector, screen, scanner, microphone
Supplies	$ 750.00	stamps, batteries, paper, toner
Marketing/Outreach	$ 500.00	printing, translation
Refreshments	$ 1,000.00	
Venue Rental	$ 500.00	
TOTAL	**$ 26,500.00**	

Income	Amount	Status	Notes
ARAW	$ 20,000.00	pending	
Wicked Cool Places	$ 5,000.00	pending	
Women's Fisheries Network	$ 1,500.00	secured	
TOTAL	**$ 26,500.00**		

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	New Bedford Police Department
Project Title:	NBPD assisting elderly female residents
Annual Budget:	
Project Budget:	$20,000.00
Requested Amount:	$20,000.00
Targeted Funding Areas:	Trusted sources of knowledgeable advocates in community who will identify and connect us to women in need.

Statement of Need
The New Bedford Police Department is applying for a grant which will help them to reach out to elderly women within the community. The program will help them to feel safer, less isolated, and put them in closer touch with critical resources.

Project Description
The department will partner with Coastline Elderly and conduct outreach visits with elderly women living alone. Coastline will gather names and addresses of women to be visited. On select evenings, a police officer and a coastline representative will make their way to the residence, provide them with a hot-meal and some much-needed company. While on our visit to their homes, we will talk to them about how we can help them feel safer and how we can help accomplish weekly tasks such as grocery shopping, installing smoke detectors if needed, and anything else they might need help with.

Methodology
We, along with Coastline Elderly, will conduct outreach visits with elderly women who live alone. We will provide them with hot meals from Market Basket, who are also collaborating with us. We will talk to them about how we can help them feel safer and how we can help accomplish weekly tasks such as grocery shopping, installing smoke detectors if needed, and anything else they might need help with.

Outcomes
We seek to provide these women with a sense of security, to provide them with comfort for their well-being, to provide them with hot meals for their health, to have a conversation with them to combat loneliness and isolation, and to assist them in any way they need.

Evaluation
We will meet regularly with Coastline Elderly to determine the effectiveness of our strategies. We will also seek input from the elderly women that we visit.

Who will benefit?
Elderly residents with the help of the NBPD, Coastline Elderly (NB) and Market Basket, who has agreed to collaborate with the department.

Implementation Timeline
We have already done a trial run and visited three elderly women.

Qualifications

We seek to put these women at ease by allowing them to share their concerns with a local police officer who can address them and put them in touch with vital resources. Particularly with the last 18 months of COVID-related quarantine, the isolation in the homes of these women is palpable. We want to provide them with a sense of security, and to let them know that someone is looking out for them. With this grant, we could provide them with whatever essentials they need for a greater sense of well-being.

The Ask

The money will allow us to pay overtime costs to police officers who belong to the outreach team, which currently visits those affected by drug addiction, post-overdose along with a drug counselor and pastor.

Future Funding/Sustainability

The city of New Bedford places a high level of value on caring for the constituents. However, there is no guarantee we can continue without financial assistance.

New Bedford Police Department
NBPD assisting elderly female residents

Project Budget
$20,000.00

Budget Narrative
The department will partner with Coastline Elderly and conduct outreach visits with elderly women living alone. Coastline will gather names and addresses of women to be visited. On select evenings, a police officer and a coastline representative will make their way to the residence, provide them with a hot meal or groceries from Market Basket whom we have also collaborated with, and some much-needed company. While on our visit to their homes, we will talk to them about how we can help them feel safer and how we can help accomplish weekly tasks such as grocery shopping, installing smoke detectors if needed, and anything else they might need help with.

BUDGET NARRATIVE

Category A. Personnel

Name:	Poisition	Estimated Rate of Pay	Rate	# of hours	TOTAL COST	FUNDING REQUESTED
various	various	56.0224	hourly	357	$ 20,000.00	$ 20,000.00

Narrative:

For 12 officers that would be part of this elderly outreach, the average overtime rate would be 56.0224. They will need to work over 350 hours in order to cover the time needed to pick up hot meals, spend time with the residents, and to help them with whatever they may need from us. This would total out to $20,000 needed in funds.

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	South Coast LGBTQ Network, Inc
Project Title:	Aging Well
Annual Budget:	$95,025.00
Project Budget:	$49,920.00
Requested Amount:	$49,920.00
Targeted Funding Areas:	Trusted sources of knowledgeable advocates in community who will identify and connect us to women in need.

Statement of Need

The South Coast LGBTQ+ Network will address the reluctance to engage in and support needed by LGBTQ+ women to access resources and services for basic needs and overall wellness. During a study Health Disparities Among LGBT Adults and the Role of Nonconscious Bias, nearly 15 percent of older LGBT adults were fearful of accessing health care services outside the LGBT community and 13 percent reported being denied or provided with inferior care as a result of their sexual orientation or gender identity. A Fenway Health report indicates that LGBT older adults were more than twice as likely to report paying for housing or food in the past year. Sage reports that LGBT older adults are twice as likely to live alone, making them vulnerable to social isolation. The South Coast LGBTQ+ Network will remove barriers to access to services and reduce isolation supporting the wellness of aging LGBT women.

Project Description

The Aging Well program will create a safe space for LGBTQ+ elders to connect to caring support and services through a variety of means. There are five components of the Aging well program: case management, friendly visitors, workshops/trainings, social opportunities, community engagement and safety. The South Coast LGBTQ+ Network is a recognized and respected organization making it relevant in providing LGBTQ+ aging women with supportive services.

Case management services will be provided by an individual with a bachelor's degree and either significant lived or professional experience supporting the LGBTQ+ community. Case management services will provide an initial screening/survey to determine the individuals' areas of needs and interest. Areas that will be included in the initial survey are safety, social opportunities, engagement in routine and follow up health care, supportive family, financial stability, access to transportation and comfort and access to technology. An individualized plan will be developed based on their identified needs and interests. Case Managers will visit program participants a minimum of monthly but more often as appropriate.
Friendly Visitors will be supporting LGBTQ+ women in their home and throughout the community. Each program participant with identify their level of engagement with friendly visitors. There will be opportunities for visits in the home, phone calls, transportation and support for community events, assistance with technology, crafts, and other activities. The friendly visitor will visit as often as weekly. Friendly visitors can also provide support through phone calls for those who are concerned with home visiting due to health or other concerns.

Pen Pal group will be an option for ongoing communication through written word. A pen pal group is in the process of being organized. This was developed through interest of a youth looking to reduce isolation for LGBTQ+ elders who are unable or fearful of leaving their home. Pen pal participants will be provided with stationery and postage to allow participation at no cost. This provides connection to other without needed

access to technology or leaving the home.

Workshops and trainings will be provided to both participants and the community. Participants will have access to workshops/trainings based on interest. These workshops will include topics such as technology, healthy cooking, financial planning, and community resources.

Trainings will be provided to community organizations serving the aging population. These trainings will be geared to creating welcoming and safe environment for service providers. Some examples of target audience are nursing homes, day programs, home visiting health care professionals, physician offices and assisted living facilities. These trainings will cover topics such as understanding vocabulary related to sexual orientation and gender identity. Supporting LGBTQ+ aging individuals and their unique history with discrimination and creating welcoming environments. A study published in Journal of Homosexuality found that 73% of LGBTQ older adults living in the community believed that discrimination exists in assisted living facilities (from both staff and residents), and 34% would hide their sexual orientation if they had to move to such a facility. This indicates the need for ongoing training to support those who need to enter facilities to remain connected to their family without fear of discrimination and to receive equality in health care.

Social interactions and minimizing feelings of loneliness and depression is a priority of the Aging Well program. LGBTQ older adults are more likely to live alone than heterosexuals. According to AARP, LGBTQ adults aged 50-95 are at greater risk of social isolation. This may be due to a number of factors. According to Services and Advocacy for Gay, Lesbian, Bi-Sexual & Transgender Elders (SAGE), one facto may be that older LGBTQ people are three to four times less likely to have children, a key support network for older adults. Aging Well participants will have opportunities to engage in activities organized by the program and those that are self-identified. Examples of social events include weekly yoga classes, monthly game day, craft/art activities, book clubs, monthly intergenerational brunch, and other events organized as participant interest is expressed.
Both friendly visitor and case managers will provide participants with information regarding community events. These events could be held at senior centers, community organizations, holiday events, pride celebrations, local fairs and other events. Every effort will be made to ensure participants have access to social and community events that support participant happiness and reduce isolation.

A key component to services for participants is transportation. Aging Well will provide access to transportation, not only for needed medical and mental health support, but also to social and community events. Transportation as a barrier to engagement is detrimental to the aging population's social opportunities and over wellbeing.

Safety is a priority for all individuals. Ensuring access to personal supplies needed to ensure safety will be a priority. Case managers will provide support in securing individualized supplies needed for activities of daily living that promote safety through health insurance and other community organizations. In the event these supplies are not immediately accessible through community organizations, resources and health insurance, Aging Well will make every effort to provide access to these materials. An example may be purchasing a week supplies of incontinence products, ensure or rental of equipment on a short-term basis.
Overall wellness of LGBTQ women will be supported through self-identified goals of the participant. The Aging Well program will implement activities promoting wellness for LGBTQ+ aging women through creating a safer, welcoming environment promoting continued engagement in wellness activities, socialization, financial stability, technology access and safety. The South Coast LGBTQ+ Network is a recognized and respected organization making it relevant in providing LGBTQ+ aging women with supportive services.

Methodology

The South Coast LGBTQ+ Network's Aging Well program will be an advocate for LGBTQ+ aging women in the Greater New Bedford Area. This program will be successful due to the extensive partnership with community organizations across the area. The combination of these collaborations with area organizations and the expertise of the professionals employed at The South Coast LGBTQ+ Network who will leading the Aging Well program will ensure successful engagement of aging LGBTQ+ women who otherwise would not access services and support due to fear.

The foundation of the program is in home visiting, socialization, and community engagement. Through these things overall well being of aging LGBTQ+ women will improve based on engagement with an organization recognized as the LGBTQ+ provider in the area. Aging Well will implement programming on an individual level with an understanding that approaches to support may need to be adjusted to meet the changing needs of the community.

Activities that will encourage program participation will be announcing the program in locations that will reach the targeted audience of LGBTQ+ aging women who haven't previously connected to supportive services. Examples are posting in senior centers, rehabilitation centers, assisted living facilities and other locations that aging individuals and their family members visit.

Collaboration with community organizations is crucial in the success of connecting LGBTQ-aging women to services. Aging well employees have developed long standing relationships with organizations that are welcoming and inclusive. They will continue to develop new relationships with all those providing service to the aging population continuing to break down barriers to engagement and reducing fear of LGBTQ+ aging individuals of discrimination and maltreatment. Aging well will encourage community partners to provide all older women with take away information regarding the program that will allow them to reach out for support in privacy. This eliminates the need to disclose sexual orientation or gender identity information when they may not feel it is safe to do so.

To support the objective of reducing isolation and depression several actions will be taken. Case Managers and Friendly Visitors will organize opportunities for social interaction that is in alignment with participant interest. Workshops will be scheduled to increase access to and comfort level with the use of technology. This will increase access to telehealth and friends and family. Technology also offers connection to news, games and videos that can increase activity.

The Aging Well program is designed to support LGBTQ+ aging individuals by meeting them where they are at, respecting their goals and understanding their unique needs as an aging LGBTQ+ women in a world that may have not been so welcoming and supportive throughout their lives.

Outcomes

The projected outcomes for the aging well program include increased socialization, increased financial stability, increased safety, increase sense of connection to community and increased safety. It is expected that 100% of program participants will indicate they have a safe and reliable resource from the Aging Well program that supports them with identifying necessary resources and connecting them to inclusive services.

Through the support of the LGBTQ+ case manager, an expected outcome will be 80% of participants have resources supporting their financial stability. Case managers will support connection to resources and completion of applications to receive financial support from available resources as needed by the participant. 100% of participants will indicate increased opportunities to social and community activities. Identification of activities and removing barriers, such as transportation to attending will be addressed increasing access to

social and community activities. Participation in social and community events will include those organized by the Aging Well program and self-identified opportunities.

Participants will report a decrease of isolation and loneliness of 70%. Friendly visitors will provide access to social events, in person and remote access to activities and family/friend connections and engage in activities with participants that encourage communication and socialization.

The South Coast LGBTQ+ Network is launching a monthly intergenerational brunch. The first monthly intergenerational brunch is scheduled for December 12 with an expected attendance of 25 elders and 25 younger community members. Participants in the Aging Well program will report an increase of access to social activities with younger community members.

Participants engaged in the Aging well program and are not receiving routine healthcare at intake will increase engagement in health services by 50%. It is expected that the support of an LGBTQ+ case manager will increase trust in accessing inclusive, high-quality healthcare for program participants. Additionally, transportation to appointments will be provided as needed and when other safe options are not available. Participants in need of mental health services will report a 75% increase in access to affirming, inclusive and quality mental/behavioral health services. Case managers will provide support in identifying and connecting participants to appropriate behavioral and mental health supports.

Participants interested in engaging in technology use will report 50% increase in confidence in using and access to technology. Group opportunities for education on use of technology will be made available that are presented in a manner that is inclusive of older learners. Individual support can be provided in home on technology use by friendly visitors and/or case managers.

Participants will have increased access to wellness events. Aging well participants will have access to programs in the community such as Yoga that runs each Friday. Additional wellness activities will be made available based on participant interest.

The Aging Well program will address areas of need and has targeted outcome expectations. The outcomes will promote socialization, stability, decrease in loneliness, access to technology support, intergenerational connection, access to wellness activities all through the support of LGBTQ+ trained case managers and friendly visitors.

Evaluation

The South Coast LGBTQ+ Network monitors ongoing success of programs. Progress is measured using data sets at intake and data sets at discharge. Examples of information gathered are housing stability, engagement in healthcare, engagement in mental health services, access to and understanding of technology, supports needed to live as independently as possible, social and community activity and barriers to engagement.

Program success will be measured by progress towards goals on Individual Service Plans that will be reviewed monthly. Participant satisfaction surveys will be available at each workshop/training and social event organized by the Aging Well program. The Network will conduct an annual evaluation of the Aging Well program that includes both employee and participant reviews. Every individual that participated in the Aging Well program and family members of participants will receive a survey. Employees will provide feedback on program implementation, progress towards goals and areas of improvement. These surveys will be compiled and used as a guide for adjusting services as appropriate.

Additional, input will be requested through a community partner satisfaction survey. This survey will gather

input from community partners on areas of success in our collaboration and areas of continued growth. This will allow opportunities for discussion and evaluation of current performance. The South Coast LGBTQ+ Network actively seeks opportunities for growth and improving quality of programming. These practices will continue in the Aging Well program.

Who will benefit?

The Aging Well program will support LGBTQ+ women who are elderly, low income and who are residents of the City of New Bedford and the surrounding towns of Acushnet, Dartmouth, Fairhaven and Westport. Elderly women will be the primary beneficiaries of the project with families being secondary beneficiaries. This program will reach LGBTQ+ aging women who are in need of resources and are reluctant to seek support due to fear of rejection, discrimination, and substandard care.

LGBT women who have limited access to transportation will benefit from the project providing increased access to community and social events as well as medical appointments. There may be older LGBTQ women who prefer not to leave home. These women will have access to in home friendly visitors to provide social connection. There may still be others who are hesitant to allow support in their home. For these individuals, remote opportunities will be available and there will be opportunity for pen pal interaction. Women will be more able to live as independently as possible with the resources and support needed. Families will benefit through the reassurance that their family member has access to trusted supports increasing overall wellness and reducing risk of isolation and depression.

The South Coast LGBTQ+ Network will provide services to LGBTQ women in need in The Greater New Bedford area ensuring access to basic needs, wellness activities and social/community events.

Implementation Timeline

The South Coast LGBTQ+ Network has had significant success with launching new programs and engaging participants. Upon notification of award The South Coast LGBTQ+ Network will begin designing outreach materials and will be prepared to provide community partners with materials for distribution on April 1, 2022. The Aging Well program be announced on social media platforms and our website on April 1, 2022, highlighting the funding support of The Association for the Relief of Aged Women.

The South Coast LGBTQ+ Network employs experienced case managers, who are licensed social workers able to implement services immediately. Additional positions would be posted immediately, and appropriate and experienced candidates would be hired and trained. Additionally, volunteer opportunities for friendly visitors would be posted and using our current volunteer pool would assess interest.

Monthly social events would be scheduled beginning the month of June. These events will change focus based on participant interest. Technology training would begin immediately on an individual basis and based on interest.

In collaboration with community organizations, targeted elder serving agencies would be targeted to receive training. The Aging Well program will reach out to elder serving organizations and offer free training. It is expected that one training a month will occur September, October, November, January, February and March. This will supply five community organizations with free LGBTQ+ inclusivity training.

In February 2022, a satisfaction survey will be distributed to both participants and community partners. The results of these surveys will be complied with results available by April 15, 2022.

The final narrative grant report will be submitted by the expected date.

Qualifications

The South Coast LGBTQ+ Network is qualified to provide programming to LGBTQ+ elders given extensive experience in supporting the LGBTQ+ community across the South Coast of Massachusetts. The South Coast LGBTQ+ Network has been providing support to the community since 2014.

The South Coast LGBTQ+ Network consists of a team of professionals with considerable lived and professional experience. The Executive Director of The South Coast LGBTQ+ Network holds a master's degree in human and social services, a bachelor's in psychology and completed a certificate program in Behavioral Health in Aging through Boston University. The Executive director also holds a license in social work. The Executive director has significant experience managing programs providing services to families, those experiencing homelessness and those with substance use disorders.

The South Coast LGBTQ+ Network employs two licensed social workers providing case management services. Each case manager brings a variety of knowledge and experience to the team. One case manager has a bachelor's degree in psychology and is enrolled in a Master of Social Work program at Bridgewater University. This case manager has experience with case management as well as providing oversight to a team supporting youth in residential placement. The second case manager holds a bachelor's degree in humanities and social sciences. This case manager brings an array of experiencing overseeing youth programs and providing case management to elderly individuals in the Greater New Bedford Area.

The South Coast LGBTQ+ Network currently has two mentors. These mentors have significant lived and professional experience supporting individuals across the age spectrum. One mentor holds a bachelor's degree in political science and women & Gender studies. This mentor has significant experience supervising teams serving diverse populations. The second mentor has an associate degree in business and extensive experience serving diverse populations.

The South Coast LGBTQ+ Network is a certified service enterprise organization holding a Points of Light certificate. This certification shows our commitment to volunteer services and expertise in leveraging skills of volunteers to increase social impact and strengthen communities. The South Coast LGBTQ+ Network values volunteers and provides comprehensive training to ensure competence in providing support to the LGBTQ+ community.

Additionally, The South Coast LGBTQ+ Network is committed to collaboration. Community partners are integral to the success of support provided to the LGBTQ+ community. Some examples of community partners are Coastline Elderly Services, Bristol Elder Services, Fairhaven Council on Aging, SouthCoast Fair Housing, YWCA, The Women's Center, UMass Dartmouth, United Way and The Lenny Zakim Fund. These collaborations provide comprehensive supports for those assisted by The South Coast LGBTQ+ Network.

The South Coast LGBTQ+ Network is experienced in providing case management and mentoring support to LGBTQ+ youth, young adults, and families. Given the credentials of the professionals employed by The South Coast LGBTQ+ Network it is evident the team has the passion, knowledge, experience, and skillset to bring services to LGBTQ+ older women in the Greater New Bedford area.

The Ask

The South Coast LGBTQ+ Network will utilize funds from the Association for the Relief of Aged Women to improve overall well being for aging LGBTQ+ women living in New Bedford, Acushnet, Dartmouth, Fairhaven, and Westport. These funds will be used to employee case managers and friendly visitors with experience supporting the LGBTQ community and the unique needs of the community. These professionals have in depth knowledge of how being an LGBTQ+ individual can impact ability and willingness to engage in services due to

historical treatment of individuals who are LGBTQ. Funds will be used to provide temporary support for personal and safety products in the event they aren't immediately available and without them basic needs are not met. Funds will be used to provide transportation for social events, community events, mental health, and medical appointments.

Other funds will be used to secure training and workshops for both participants in the program and elder serving organizations. Technology training and support will also support socialization and activity that may not be currently available due to lack of access of comfort level with use. These workshops will both directly and indirectly support program participants. Additionally, the training programs for community organizations may have positive impact on future services provided to LGBTQ+ women who engage with them in the future whether they have accessed support from Aging Well.

The South Cost LGBTQ+ Network's, Aging Well program aims to service the most vulnerable LGBTQ+ aging women with a comprehensive program increasing socialization, overall health and financial stability.

Future Funding/Sustainability

The South Coast LGBTQ Network will actively pursue funding to ensure continuation of the Aging Well Program. The South Coast LGBTQ Network will continue to identify funding sources and community partners. Through grant writing and general donations Aging Well will continue to provide needed support to LGBTQ+ aging women across the Greater New Bedford Area. In the event that there is a reduction in funding sources, The South Coast LGBTQ+ Network will access its significant pool of volunteers to support LGBTQ+ aging women until additional funding sources are secured. Additionally, The South Coast LGBTQ+ Network will collaborate with community partners to ensure LGBTQ+ aging women in need of support have the resources necessary. Supporting the older LGBTQ+ community is one of the primary missions of The South Coast LGBTQ+ Network.

South Coast LGBTQ Network, Inc
Aging Well

Project Budget
$49,920.00

Budget Narrative
The South Coast LGBTQ+ Network is requesting funds to launch the Aging Well Program. The total budget for this program is $49,920. The funds will be utilized to support LGBTQ+ aging women across The Greater New Bedford Area. Total salaries requested are $30,732. This includes case management at 12 hours a week for 52 weeks. Friendly visitors at 15 hours a week for 52 weeks and Program manager at 2 hours a week for 52 weeks. Total fringe requested is 12% at $3,688.

Funds requested for travel total $3,000. This will support mileage reimbursement for employees transporting participants to events and the use of other transportation for participants as necessary.

Printing costs requested is $300. This will cover the cost of printing materials for posting in community locations. Postage in the amount of $300 will support mailing documents for participants and supporting participation in the pen pal program.

Technology funds will cover training and technology purchases totaling $3500. These funds include purchasing tablets and internet access that is not accessible by other means.
Office supplies will total $500. This includes purchasing of general office supplies such as pens, paper, folder, pencils, staples, highlighters, etc.

Marketing funds in the amount of $200 will be used to promote awareness on social media platforms.

Participant expenses totaling $4,000 will be used to purchase necessary personal items to support safety and activities of daily living. These funds will be used when other resources are not readily available or there are one-time expenses not typically covered. Costs for workshops will also be accessed through Participant expenses.

Community training supplies totaling $500. These funds will support materials for training. Each session will utilize $100 of funds.

Social events funds will allow a budget of $275 per month for group activities. These funds will be utilized to purchase supplies and nutritious food.

Personnel	Funds Requested
Salaries	30732
Fringe	3688
Non Personnel	
Travel	3000
Printing	200
Postage	300
Techonology	3500
Office Supplies	500
Marketing	200
Participant Expenses	4000
Community Trainings	500
Social Events	3300
Total	49920

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	Zeiterion Performing Arts Center
Project Title:	ARAW Volunteer Usher Corps
Annual Budget:	$3,000,000.00
Project Budget:	$48,400.00
Requested Amount:	$38,000.00
Targeted Funding Areas:	Access to social engagement opportunities to combat loneliness and isolation.

Statement of Need

A 2020 report from the National Academies of Sciences, Engineering and Medicine states that ¼ of adults over 65 are socially isolated. The coronavirus and its lasting social effects has only intensified the need for community engagement and volunteerism for adults over 65.

Project Description

The Z is currently working with the ARAW to establish an Intergenerational Mentorship Program which partners ARAW participants with a teenager or young adult to attend performances in dance, music, theatre and beyond. This program is seasonal in nature and while we hope bonds will last far beyond the year we recognize the need to create a continued pipeline of engagement. The Zeiterion Usher Corps are the warm and welcoming ambassadors who help to make enjoyable, memorable experiences for all who pass through The Z doors. ARAW members will be transported, recruited, and trained to be part of this community of volunteers! As ushers they will work and attend Z shows, celebrate with their peers in quarterly social outings, give back to the community with the Z Usher Fund, and interact with Z patrons of all ages.

Methodology

ARAW participants will be chosen in April 2021 and will then have the opportunity to take ten hours of technical training on computer usage and social media before being connected with their Teen Ambassador in October. Together each ARAW member and her teen will attend 8 performing arts events from live theatre to comedy shows, take one creative classroom, attend at least 2 mentor only events, keep a social media channel actively updated, and attend a special wrap party event.

We're tackling this from a three-pronged approach:

- Recruitment – maintaining relationships with current ARAW participants, targeting and build out of up to 20 additional ARAW members
- Training – community building through skill-based learning in technology, safety, equity, accessibility, education, and patron relations
- Retention – combating isolation and long-term engagement through regular community interaction; social events, charitable giving (through the Z Usher Community Fund), and full access to the Z calendar to self-select shows to work

Outcomes

The Intergenerational Performing Arts Membership tackles three key indicators; the creation of intergenerational programming, opportunities for engagement, training and support for ARAW women in using technology and social media, and innovative initiatives which address loneliness and isolation among older women in our community.

Our ARAW program will tackle two targeted funding areas:
Access to social engagement opportunities to combat loneliness and isolation
- Innovative initiatives which address loneliness and isolation among older women in our community
- Opportunities for engagement, training and support for ARAW eligible women in using technology and social media.

Establishment of safety and stability to foster optimal health and well-being.
- Increased participation in physical activity, wellness and/or self-care programs for ARAW eligible women

Evaluation

Innovative initiatives which address loneliness and isolation among older women in our community:
- 60% of existing ARAW members (re: Intergenerational Mentorship) will return as Ushers
- Usher and attend Z shows
  - 70% of women will work 6 or more shows

Opportunities for engagement, training and support for ARAW women in using technology and social media:
- At least 10 hours of training in technology will be made available to ARAW woman
  - 70% of women will attend at least 7 hours of training
- A social media account will be created for Ushers to connect, but also to share their experiences
  - 60% of Ushers will post to social media at least 3 times

Increased participation in physical activity, wellness and/or self-care programs for ARAW eligible women:
- ARAW woman will gain physical strength and mobility from volunteering at shows
  - 70% of women will volunteer at least 6 performances
- ARAW woman will gain a permanent community
  - 60% of women will agree (per survey) that the program improved community connection

Who will benefit?

Adults over 65
Patrons of the Zeiterion Performing Arts Center whose experience is enriched by our Front Line Ushers.

Implementation Timeline

March-April 2022 – recruitment of current ARAW members
April – June 2022 – recruitment of other ARAW members
July 2022 – first usher training
August 2022 – second usher training
September 2022 – third usher training
October 2022 – begin show-based training
December 2022 – Z Usher Community Fund Charitable Giving – choose and announce
January 2023-March 2023 – retention events; social and trainings (dates TBD based on Usher wants/needs)

Qualifications

It is the mission of the Zeiterion to entertain, educate, and inspire through the performing arts. Creating lively, engaging and, most importantly, social spaces is our responsibility. We're proud to carve out a space where our most vulnerable populations can gather and connect.

It is the mission of the Zeiterion to entertain, educate, and inspire through the performing arts. Creating lively, engaging and, most importantly, social spaces is our responsibility. We're proud to carve out a space where our most vulnerable populations can gather and connect. Our Usher Corps is well established with new

members being trained every year and has a history of retention - more than one Usher has been with us over 20 years!

The Ask

The Usher Corps is the backbone of the Z's volunteer engagement. Partnering with the ARAW (1) creates a continuous pipeline of engagement and interaction with ARAW participants while combating social isolation and promoting technology fluency and (2) scales a training and retention program to support the growth and preservation of the Usher program for all future volunteers

Future Funding/Sustainability

Ushers currently dedicate more than 15,000 hours annually. We will continue to run this program without funding. Funding would support scaling training and retention and build a direct pipeline access to ARAW participants

Zeiterion Performing Arts Center
ARAW Volunteer Usher Corps

Project Budget
$48,400.00
Budget Narrative
Total: $48,400 Staff Time – Director of Community Engagement, 200 hours x $27 = $5,400 ($2,700 existing contribution) Director of Patron and Business Relations, 350 x $30 = $10, 500 Trainings – $10,000 ($5,500 exisiting contribution) Retention – Social outings including transportation and catering = $17,500 Volunteer fund for team selected charitable giving – $5,000 ($2,200 existing contribution)

Item	Description	Cost
Staff Time	Director of Education and Community x 200 hours ($27)	$ 5,400.00
Staff Time	Director of Patron and Business Relations x 350 hours ($30)	$ 10,500.00
Trainings	technology, safety, DEI, patron relations, accessibility	$ 10,000.00
Retention	transportation, social events	$ 17,500.00
Volunteer Giving Fund	usher corps charitable giving fund	$ 5,000.00
Total		$ 48,400.00

Fundraising		
ARAW Request	$	38,000.00
Individual Z Donors	$	8,200.00
Current Ushers	$	2,200.00

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	Dartmouth Council on Aging
Project Title:	Engagement Coordinator
Annual Budget:	$348,000.00
Project Budget:	$70,119.00
Requested Amount:	$42,315.00
Targeted Funding Areas:	Trusted sources of knowledgeable advocates in community who will identify and connect us to women in need.

Statement of Need

The Dartmouth Council on Aging feels strongly there is a value to having a partner in the community such as ARAW. As the senior population continues to show rapid growth we are seeing increasing need with financial assistance, access to housing and healthcare, and the need to provide a social outlet where seniors can thrive. The Engagement Coordinator, and Outreach program here at the Council on Aging can provide direct care to the most vulnerable population.

Project Description

The Engagement Coordinator will function as a Social Service advocate responsible for disseminating information, referrals, home assessments, advocacy, case management and identifying the immediate need of the elder. The coordinator will serve as the primary liason to local and community elder service providers for seniors and their families. Special attention will be given to woman living alone (or with minimal assistance), over the age of 65, living in the greater Dartmouth community.

In addition to the above duties, the coordinator will design and implement new strategies to assist the ARAW beneficiaries combat isolation through monthly meet-ups with peers and individualized care plans to enhance their quality of life and independence.

Methodology

The Engagement Coordinator will have a level of experience, skill and maturity to serve as a valuable asset to assist the ARAW beneficiaries in reducing everyday living expenses by analyzing current healthcare, housing and medical expenses. This support will allow the beneficiary to live an albeit frugal, intelligent financial life. This program will promote financial stability and life strategies through provided access needed to existing programs and resources.

Outcomes

Through this program, the Dartmouth Council on Aging will be able to increase the availability of trusted resources in the community for identifying potential beneficiaries, meet with existing beneficiaries to determine ongoing needs/impact of support, submission of requests on behalf of beneficiaries and connecting beneficiaries to resources. The program will also promote financial stability and life strategies through providing direct access needed to existing programs and resources.

Evaluation

Through the use of MySenior Center, the Engagement Coordinator and Council on Aging director will be able to track each new addition to the program. A system has been implemented to follow up each each ARAW beneficiary on a monthly basis.

Who will benefit?

All ARAW eligible woman living in the surrounding Dartmouth community will benefit from having an Engagement Coordinator. Current ARAW guidelines state the age guideline for recurring support is 70 years or older. Income guidelines are $1400 for woman living in subsidized housing and $1900 for woman living in non-subsidized housing. Liquid assets should not exceed $10,000. Preference will be given to woman living on their own but may take into account the finances and/or ability to contribute from family members who may be residing in the home. In addition, past beneficiaries who have been financially eligible for ARAW but not receiving on-going gifts at this time.

Implementation Timeline

The Engagement Coordinator will actively seek out eligible beneficiaries throughout the community. Each senior will be evaluated for ARAW benefits as well as have access to a coordinator who can put their best interests at the forefront. At the initial intake the coordinator will discuss the potential need with elder. Once a need has been a established, the Coordinator will conduct a home/office visit to complete a beneficiary request application with each individual. An individualized care plan will be developed between the coordinator and beneficiary. Monthly follow-up with each beneficiary will be conducted by phone, in-house visits or monthly meet-ups with coordinator and their peers.

Qualifications

The Dartmouth Council on Aging strives to be a trusted source of information for the community and has been a well respected partner of ARAW for many years. The Engagement Coordinator will be required to participate in trainings and certifications. At this time, the current Engagement Coordinator is a Certified Dementia Practitoner (CDP), Certified Master Trainer through the UCLA Memory Training program and Alzheimer's support group volunteer. The Dartmouth Council on Aging's commitment to furthering the education of all staff members remains a high priority.

The Ask

The Dartmouth Council on Aging is requesting $42,315 to continue to grow the Engagement Coordinator position. This position will enable the Dartmouth COA to provide a continuity of care that has been made possible this past year through the use of the partnership between the DCOA and the ARAW. This continuity will allow us to have improved relationships with community members and enable us to work more effectively as we continue to meet the needs of the senior population.

Future Funding/Sustainability

The Dartmouth Council on Aging has requested funding from the Town for a part time Outreach Worker to enhance the role of the Engagement Coordinator and enable the team to meet and assess each individual needing assistance. Without ARAW funding, this full time position will not be able to meet the needs of the existing and potential beneficiaries.

Dartmouth Council on Aging
Engagement Coordinator

Project Budget
$70,119.00

Budget Narrative
In-Kind
COA Director Over Sight of Program and Direct Interaction with potential beneficiaries: 3hrs/wk @ $41.76/hr for 52 wks.
= $6514.

Part Time Outreach worker will assess each potential beneficiary for eligibility before referring to the Engagement Coordinator. (The Dartmouth COA receives over 100 telephone calls per week with questions regarding services and referrals).
5 hrs/wk @ $16.50/hr for 52 wks.
= $4290.

Benefit Package Approx.
= $17,000.

ARAW Program Budget

(A)	(B)		(C)	(D)	(E)
Allocation Categories	**ARAW**	**Cash Match***	**In-Kind Match***	**Generated Income**	**Total**
Personnel 35 hrs per week Engagement Coordinator	**$42,315**				
Benefits			**$17,000**		
COA Director			**$6514**		
Part Time Outreach Worker			**$4290**		
Net Cost	**$42,315**		**$27,804**		**$70,119**

BUDGET JUSTIFICATION

COA Director Oversight of Program and Direct Interaction with potential beneficiaries
3hr/wk @ $41.76 for 52/wks.

The Part Time Outreach Worker will assess each potential beneficiary for eligibility before referring to the Engagement Coordinator. The Dartmouth COA receives over 100 calls per week with questions regarding services and referrals.
5hr/wk @ $16.50 for 52 wks.

Benefit Package including health insurance, PTO time and potential retirement benefits
Approx. $17,000

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	New Bedford Symphony Orchestra
Project Title:	Music for Life
Annual Budget:	$1,504,184.00
Project Budget:	$29,000.00
Requested Amount:	$29,000.00
Targeted Funding Areas:	Access to social engagement opportunities to combat loneliness and isolation.

Statement of Need

Elderly women often do not have access to high quality, engaging, and fun musical experiences. Cultural events and especially music is a wonderful way to bring people together for a shared, enriching experience and to provide beauty, comfort, and enjoyment in their lives. Music for Life will address this need though multiple avenues that will ensure the highest possible participation and impact.

Project Description

Music for Life has three main components: (1) performances/background music at ARAW's monthly lunches, (2) monthly performances at Council on Aging and other community partner sites on a rotating basis, and (3) providing free tickets to NBSO symphony concerts, chamber concerts, and youth orchestra concerts.

NBSO musicians will present wonderful small ensemble performances that delight and engage audiences, whether large or small. The programs will be designed to fit the occasion and will include a wide variety of classical music plus music from other genres. When appropriate, the music can be played as "background" during a meal or as a group gathers and socializes. On other occasions, informal concerts can be presented where the musicians will introduce each piece, take questions from the audience, and talk about their experiences making music.

These performances will feature a range of anywhere from one to five musicians. This will allow us to create a lot of variety over the course of the year. Audiences will experience solo works, duos, trios, quartets, and quintets. Instrumentation will also vary, involving strings, woodwinds, brass, and percussion.

As part of this program, the NBSO will actively solicit input from audience members and Council on Aging personnel to be responsive and creative in presenting these performances. Requests will be most welcomed! We will also be happy to give short presentations on the music and instruments if desired.

One of the purposes of taking the approach outlined above is that we do not want to only make music, but to develop relationships and interactions with the people we are making music for. Over the course of the year, we envision (hope!) for repeat audience members who will get to know our musicians as we get to know them.

Built into this program is also the capacity to adjust and evolve as the year progresses. If an opportunity arises to offer something new that will increase the impact of the program, we want to be able to do it.
The final piece of Music for Life is providing tickets to our symphony, chamber, and youth orchestra concerts. This will provide access to our formal performances and will be the perfect complement to the other parts of the program.

Methodology
Musical performance is the activity being provided by Music for Life. Required resources are musicians, musical instruments, music, marketing materials, and outreach and engagement efforts.

Outcomes
(1) Attendance at youth orchestra performances will provide intergenerational experiences for participants. (2) All performances will provide cultural experiences that participants can enjoy. (3) Music for Life programs will address loneliness and isolation issues. (4) Music for Life programs are designed to bring beauty, comfort, and fun into the lives of participants. (5) They are also designed to provide opportunities for participants to interact and develop relationships with our musicians.

Evaluation
Request for input from attendees at each performance on an ongoing basis; quarterly request for input from partners to assess program impact and consideration of adjustments and new opportunities; in October 2023, meeting with partners and collect input from all other stakeholders to assess overall program; in March 2023, final assessment of program and lessons learned evaluation.

Who will benefit?
We will work with you, Councils on Aging, and other organizations in the area to promote and facilitate participation in Music for Life. Elderly women in financial need living in New Bedford, Acushnet, Dartmouth, Fairhaven, and Westport will benefit.

Implementation Timeline
February-March 2022: planning and scheduling with ARAW, Councils on Aging, and other community partners; establish schedule of monthly performances. Develop and distribute information on performances and access to symphony, chamber, and youth orchestra concert tickets.

April 2022 – March 2023: monthly performances; ongoing distribution of information on performances and access to symphony, chamber, and youth orchestra concert tickets.

Qualifications
The NBSO has a strong reputation for excellence in music, education, and community engagement. Our music director, Yaniv Dinur, won the 2019 Sir Georg Solti Conductor Award as the outstanding young conductor in the United States. The NBSO was selected to perform a virtual concert at the 2021 League of American Orchestra's national conference. Our education programs have won several national, state, and local awards. We have a strong track record of success in community partnerships, including Music in the City with the New Bedford Parks and Recreation Department, Celebrating Black Culture with the New Bedford Historical Society, Junta Mon – Together in Music with the Cape Verdean Association, Garden Music with Haskell Public Gardens/Trustees of Reservations, and Music in the Woods with the Lloyd Center for Environmental Studies.

The Ask
The amount covering monthly performances are paid directly to musicians for their services. The ticket amount covers the cost of concert tickets. Coordination and engagement work covers the cost of staff time. Marketing materials and campaign covers the cost of marketing supplies, design, printing, and advertising.

Future Funding/Sustainability
With partial or no funding from ARAW, we would seek out foundation, corporate, and individual support to continue the program.

New Bedford Symphony Orchestra
Music for Life

Project Budget $29,000.00
Budget Narrative At present we do not have other funding for this project. If the requested amount is not funded in full we will seek other funding sources and/or reduce the scope of the project as required.

New Bedford Symphony Orchestra - Music for Life Project Budget

Monthly Performances at Wamsutta lunch	$8400
-covers musician fees	
Monthly Performances at Councils on Aging/Community Partner Sites	$8400
-covers musician fees	
Tickets for Symphony, Chamber and Youth Concerts	$4300
-covers cost of concert tickets	
Coordination and Engagement Work	$4800
-covers staff time	
Marketing Materials and Campaign	$3100
-covers supplies, design, printing, advertising	
Total	$29,000

Organization:	South Coastal Counties Legal Services
Project Title:	The Rachel Howland Advocate for Older Adults (Requesting renewal)
Annual Budget:	$7,000,000.00
Project Budget:	$106,725.00
Requested Amount:	$50,000.00
Targeted Funding Areas:	Trusted sources of knowledgeable advocates in community who will identify and connect us to women in need.

Statement of Need

This project, which will address the legal needs of low-income older women in order to promote their financial stability, health, and well-being, was proposed and funded by ARAW last year. The need continues. Twenty-five percent of the New Bedford population lives in poverty, and the older population is growing. According to a 2019 UMass Boston study, "single older people in Massachusetts are more likely to face economic insecurity than are single older people in any other state." (https://scholarworks.umb.edu/cgi/viewcontent.cgi?article=1039&context=demographyofaging) Combining economic insecurity with the complex healthcare needs faced by older people means they may be forced to choose to forgo paying rent, buying healthy food, or affording prescriptions. Therefore, this project will continue to provide additional assistance, through our paralegal, to older adults who are facing legal issues with their housing, benefits, and income.

Project Description

With renewed funding from ARAW, South Coastal Counties Legal Services (SCCLS), the principal provider of free civil legal assistance to low-income elders in Southeastern Massachusetts, will continue to address the most critical legal problems facing older residents of New Bedford, including housing preservation, financial security, and access to appropriate health care. With the initial award from ARAW in 2021, SCCLS was able to add a paralegal, fluent in Portuguese, to support our Seniors Law Project in the Greater New Bedford area. Financial support in the coming year would allow SCCLS to continue to utilize our paralegal (Rachel Howland Advocate (RHA)) to enhance available services to older residents.

The RHA will continue to follow the social justice tradition of the ARAW's founder, Rachel Howland, whose former home currently serves as SCCLS' New Bedford Law Office. The RHA will be supervised by SCCLS' Managing Attorney and will work under the guidance of SCCLS' Senior Law Project Attorney. The RHA will advocate for the legal needs of older adults most in need of assistance due to financial limitations or social isolation. The RHA will also perform outreach in the community and disseminate educational materials. In this fashion, the RHA will increase the capacity of the SLP to assist more older adults. The activities of the RHA will address the stated need in the following ways and remain consistent with those proposed for the first funded year of the project, which is not yet complete.

The RHA will assist at least seventy-five adults over the age of sixty with housing, income, and benefits-related legal issues through a combination of direct representation, advice and information. Housing issues would include terminations of rental subsidies, such as Section 8 vouchers, denials of applications for public housing, and evictions from public and subsidized housing. The RHA would address the stated need by advocating on behalf of older adults at grievance hearings to stop subsidy terminations, contesting application denials, and requesting reasonable accommodations and/or modifications to preserve the tenancy.

Income issues would include reduction in Social Security or Supplemental Security Income (SSI) benefits due to an overpayment, termination from SSI, and changes in State Supplement Program (SSP) benefits. The RHA would prevent loss of income by assisting older adults with requests for waivers of overpayments and advocating at hearings to prevent terminations.

Benefits issues would include eligibility, calculation and coverage determinations with programs such as the Supplemental Nutrition Assistance Program (SNAP), MassHealth, and Medicare. The RHA would help older adults afford quality nutrition by protecting their SNAP benefits. This involves advocating for older adults at hearings and helping them maximize benefit levels. For MassHealth and Medicare, this would involve attending fair hearings to ensure older adults do not have a gap in health insurance coverage and receive the appropriate amount of services for their unique care needs.

In addition, the RHA will conduct outreach and educational presentations in the local community. This will include the Councils on Aging for New Bedford, Acushnet, Dartmouth, Fairhaven, and Westport. Given the impact of COVID-19, this will likely be in the form of videoconference presentations. In addition, the RHA will create written educational materials on emerging issues and then disseminate the materials to key constituencies including the local Councils on Aging and Coastline Elderly Services. These outreach and educational efforts would address the stated need by informing older adults and the people who work with them of common legal issues thereby encouraging them to reach out to trusted sources for assistance.
Of course, the RHA also would continue to provide assistance to her current clients.

Methodology

The RHA will provide direct representation in administrative proceedings under the supervision of SCCLS' Managing Attorney and with the guidance of SCCLS' Senior Law Project Attorney. These proceedings will include Social Security, SNAP and MassHealth hearings challenging improper denials and terminations of assistance. The RHA will provide legal advice, information and referrals on a variety of legal matters within SCCLS' priority areas and on related issues. The RHA will conduct a minimum of six (6) community presentations on legal issues to the Greater New Bedford older population. In addition, the ARAW will prepare Community Legal Education materials on a variety of relevant legal topics. The RHA will be based in the SCCLS New Bedford Law Office, the former home of ARAW founder Rachel Howland.

The RHA will continue to provide direct representation in administrative proceedings under the supervision of SCCLS' Managing Attorney and with the guidance of SCCLS' Senior Law Project Attorney. These proceedings will include Social Security, SNAP and MassHealth hearings challenging improper denials and terminations of assistance. The RHA will provide legal advice, information and referrals on a variety of legal matters within SCCLS' priority areas and on related issues. The RHA will conduct a minimum of four (4) community presentations on legal issues to the Greater New Bedford older population. In addition, the ARAW will prepare Community Legal Education materials on relevant legal topics. The RHA will be based in the SCCLS New Bedford Law Office, the former home of ARAW founder Rachel Howland.

Outcomes

The project activities will address the targeted areas and meet the success indicators in a variety of ways. First, the advocacy efforts of the RHA will keep older adults in stable living arrangements, prevent reductions in income, and reverse denials of health care benefits. These efforts will promote financial stability and improve life strategies by directly assisting ARAW eligible elders who access needed programs and who sign up for benefits to support income needed for secure housing and adequate nutrition, such as SNAP, PACE or SSI. The RHA will also advocate on behalf of elders in the workforce who have been wrongfully denied Unemployment

Insurance Benefits. In addition, the RHA would help ARAW eligible women establish safety and stability in the home by helping them with a variety of legal means to promote their safety, such as by seeking reasonable modifications to an apartment or a transfer due to a situation of elder abuse.

Second, by conducting outreach and providing educational materials, the RHA will further establish SCCLS as a trusted source in the community. SCCLS staff members regularly participate in various community groups and coalitions, including Age Friendly New Bedford, Southeastern Alliance for Elder Abuse (SAFE), and Fresh Start. SCCLS makes referrals and receives referrals from groups like those, and thereby connects clients with services to support their non-legal needs. Further, by meeting with potential clients and identifying their needs, the RHA will identify potential beneficiaries for ARAW to provide direct support. All of these outreach and educational efforts affect older adults by reinforcing SCCLS as a trusted source in the community.

Third, the RHA will promote financial stability by increasing access to public benefits including Social Security, SNAP and MassHealth and access to community resources including utility assistance or rental assistance through agencies such as PACE. Strategies will include a combination of representation in administrative proceedings, legal advice, information, referrals and community outreach. These actions result in strengthening the financial stability of older adults.

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Third, the RHA will promote financial stability by increasing access to public benefits including Social Security, SNAP and MassHealth and access to community resources including utility assistance or rental assistance through agencies such as PACE. Strategies will include a combination of representation in administrative proceedings, legal advice, information, referrals and community outreach. These actions result in strengthening the financial stability of older adults.

Evaluation

75 elders will benefit from the project through improved financial security and access to community resources as follows:

Twenty-five (25) financially or socially disadvantaged elders will benefit from free civil legal aid (counsel and advice, brief service, and full representation) from the RHA. The RHA will continue to assist current clients.

An additional 50 elders will receive information through Community Legal Education presentations.
Four (4) community presentations will be held throughout the grant year to community coalitions, agencies, and their staff and/or clients.

Individual case information, data and outcomes are maintained and monitored in SCCLS' confidential case management system. Evaluations are sent via mail to clients fully represented by SCCLS.

Who will benefit?

The beneficiaries served by SCCLS' New Bedford Senior Law Project are older adults over the age of sixty. Legal representation is prioritized to older adults with the greatest economic and social need. Approximately 66% of those served through the SLP are women with low incomes. This project will be in Bristol County, where 90,033 people live on incomes that are less than 125% of the federal poverty level. New Bedford, Dartmouth, and Fairhaven have some of the highest numbers of people living below 125% of the federal poverty level. Specifically in New Bedford, about 14,000 people are over the age of 65. In addition, 36.5% of the residents speak a language other than English with the two most common non-English languages being Portuguese and Spanish. About 18% of the population identifies as Hispanic/Latinx and 7% as African-American. Therefore, the RHA will serve a diverse group of older adults many of whom are living below 125% of the federal poverty level.

Implementation Timeline

February 11, 2022: ARAW notification of decisions
March 1, 2022: Lessons learned during the first year of the project assessed and implemented.
April 1, 2022: Project begins in earnest as the RHA already has been added to staff. All staff are in place and prepared to begin the project.

Ongoing throughout the grant period: The RHA will conduct a minimum of four (4) community presentations on legal issues to older residents of Greater New Bedford; The RHA will deliver legal assistance to eligible clients, as supervised by Managing Attorney Mary Ellen Natale; The RHA will participate in statewide trainings on relevant legal issues provided by the Massachusetts Continuing Legal Education, Inc. as well as national trainings as appropriate; and ongoing client intake activities will be conducted by professionally trained paralegals through SCCLS' multi-lingual, toll free, 800 number call center.

Throughout the year, the RHA will reach out to partner agencies to remind them of the civil legal aid offered through SCCLS. It is anticipated that the RHA will conduct quarterly community education events, and that materials will be prepared in advance of those events.

Qualifications

As the principal provider of free civil legal assistance to low-income elders in Southeastern Massachusetts, SCCLS has a proven track record of representing older adults in housing, benefits, and consumer matters. The direct supervisor will be Mary Ellen Natale, Managing Attorney for SCCLS' New Bedford region. She has over thirty years of legal experience, twenty-five of which is in legal services advocacy. Attorney Natale has been responsible for performance oversight for the Seniors Legal Services project funded through Coastline Elderly Services, and participates in local community coalitions including Fresh Start and the Homeless Service Providers Network (HSPN).

The RHA will also work closely with Andrew Bardetti, the Staff Attorney for the SLP in New Bedford. Attorney Bardetti began his career with SCCLS as a 2018 Fellow through the Borchard Center for Law and Aging where he launched an elder abuse prevention project to address the unmet needs of older persons suffering from

abuse in SCCLS' service area. In his nearly three years with SCCLS he has provided expert legal representation and advice to scores of older adults, presented relevant legal information to coalitions and agencies throughout the region and has developed significant expertise in elder law matters.

SCCLS and our predecessor agencies (including the New Center for Legal Advocacy) have provided civil legal aid services to vulnerable residents of New Bedford since the 1960s. SCCLS has a proven history of meeting the needs of its elder population with an experienced staff with appropriate language skills. Many staff are bi- or multi-lingual, speaking Spanish, Portuguese, Cape Verdean Creole, Haitian Creole, Arabic, Cantonese, , and French. We conduct active outreach and community education (including multi-lingual written materials), physical accessibility for persons with disabilities at all offices and 800 lines for callers. Portuguese and Spanish are the non-English languages most commonly spoken in the SCCLS service area although there are also significant populations speaking Cape Verdean Creole, Khmer, Haitian Creole, and Mayan languages. SCCLS' proven track record and experienced staff will allow for the successful implementation of this project.

As the principal provider of free civil legal assistance to low-income elders in Southeastern Massachusetts, SCCLS has a proven track record of representing older adults in housing, benefits, and consumer matters. The direct supervisor will be Mary Ellen Natale, Managing Attorney for SCCLS' New Bedford region. She has over thirty years of legal experience, twenty-five of which is in legal services advocacy. Attorney Natale has been responsible for performance oversight for the Seniors Law Project funded through Coastline Elderly Services, and participates in local community coalitions including Fresh Start and the Homeless Service Providers Network (HSPN).

The RHA will also work closely with Andrew Bardetti, the Staff Attorney for the SLP in New Bedford. Attorney Bardetti began his career with SCCLS as a 2018 Fellow through the Borchard Center for Law and Aging where he launched an elder abuse prevention project to address the unmet needs of older persons suffering from abuse in SCCLS' service area. In his nearly three years with SCCLS he has provided expert legal representation and advice to scores of older adults, presented relevant legal information to coalitions and agencies throughout the region and has developed significant expertise in elder law matters.

SCCLS and our predecessor agencies have provided civil legal aid services to vulnerable residents of New Bedford since the 1960s. SCCLS has a proven history of meeting the needs of its elder population with an experienced staff with appropriate language skills. Many staff are bi- or multi-lingual, speaking Spanish, Portuguese, Cape Verdean Creole, Haitian Creole, Arabic, Cantonese, Russian and French. We conduct active outreach and community education (including multi-lingual written materials), provide physical accessibility for persons with disabilities at all offices and 800 lines for callers. Portuguese and Spanish are the non-English languages most commonly spoken in the SCCLS service area although there are also significant populations speaking Cape Verdean Creole, Khmer, Haitian Creole, and Mayan languages. SCCLS' proven track record and experienced staff will allow for the successful implementation of this project.
SCCLS' Director of Finance and Executive Director also have significant experience with fiscal and grants management.

The Ask

Please see the attached budget. Funds will be used to continue the paralegal position, located in SCCLS' New Bedford office, to address the needs of low income elders in New Bedford and surrounding towns served by ARAW. Funds will support salary, payroll taxes and the direct costs identified.

Future Funding/Sustainability

SCCLS anticipates continuing the project in subsequent years. In light of the increase in the older population in

the SCCLS service area and the financial challenges faced by single older persons in particular, the need for the RHA will be ongoing. SCCLS is supported by a variety of federal, state and local funding sources, and continually investigates additional grant opportunities and other sources of support for its key priority areas. In light of the relevance of this project to the mission of ARAW, however, ongoing support from ARAW will ensure the longstanding success of the position.

South Coastal Counties Legal Services
The Rachel Howland Advocate for Older Adults (Requesting renewal)

Project Budget $106,725.00
Budget Narrative See the attached budget. We have requested $50,000 from ARAW to continue this position. The balance of the position will be funded either by the Legal Services Corporation or by Massachusetts Legal Assistance Corporation (MLAC). MLAC funding is secured for the grant year.

ARAW Grant Application

Rachel Howland Advocate for Older Adults

Organization Name:	South Coastal Counties Legal Services, Inc. for the Justice Center of Southeast Mass.
Program Name:	The Rachel Howland Advocate for Older Adults
Fiscal Year:	From: April 1, 2022 To: March 31, 2023

PERSONNEL (Salary + Benefits x Percentage of Time = Total Program Budget Amount)

Job Title	Total Salary (FTE)	Total Benefits	% of Time Allocated to Program	Total Program Budget	Original Amount Requested*	
Paralegal	70,350	24,623	100%	94,973	50,000	
					-	
Total Personnel:				**94,973**	**50,000**	**-**
NON-PERSONNEL						
Attorney Fees						
Other Consultants and Professional Fees (Incl. Audit)				2,954		
Insurance				513		
Equipment R&M				71		
Supplies/Printing				1,527		
Library				125		
Telephone/Internet				75		
Postage and Delivery				125		
Training and travel				342		
Other (Litigation, space, advertising, admin overhead)				6,021		-
Total Non-Personnel:				**11,753**	-	-
TOTAL EXPENSES:				**106,725**	**50,000**	**-**

**Please list your original request. **Please list your proposed revised budget in this column.*

ADDITIONAL FUNDING SOURCES: If the Total Program Budget is more than the amount awarded please detail additional revenue here. Indicate whether funding is **PENDING** or **SECURED**.

OTHER FUNDING SOURCES	Status	Amount
MLAC or LSC	Secured	56,725
	TOTAL:	106,725

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	YWCA Southeastern Massachusetts
Project Title:	Widowed Persons Program
Annual Budget:	$1,000,261.00
Project Budget:	$25,560.56
Requested Amount:	$5,000.00
Targeted Funding Areas:	Trusted sources of knowledgeable advocates in community who will identify and connect us to women in need.

Statement of Need

Losing a husband or wife is a devastating experience that many of us will have to face one day. The United States Census Bureau's 2019 American Community Survey estimated that in New Bedford, 44.2% of women over the age of 65 are widowed. This percentage has continued to grow during the COVID-19 pandemic. We have needed to expand our services, adding another support group to our program to accommodate the growing population of widows in our region. Research shows that peer support facilitates recovery and reduces health care costs. Peers also provide assistance which promotes a sense of belonging within the community. The ability to contribute to and enjoy one's community is key to one's well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.

Project Description

The YWCA's Widowed Persons Program (WPP) is a supportive services program that targets services to low-income, minority, disabled and non-English speaking elderly women, although outreach efforts are made to all newly widowed in the service delivery area. Widowed Persons Program is designed to identify the leadership and resources in the community that will publicly offer services to the newly widowed. The program serves the newly widowed age 60 and older who are still going through the grieving process. The program provides mixed group support and one-on-one emotional support; resource and referral information with a mutual self-help program. In addition, YWCA Community Health Workers provide translation, transportation, scheduling, and accompaniment services to ensure our participants receive information needed to maintain their health, as well as prevent and treat disease.

The YWCA's Widowed Persons Program started in 1992 and is the only program of its kind in this area. This is a real need in our community as the grief of widows is very different from other types of grief. Some participants attended other types of bereavement groups in the past and prefer the Widowed Persons Program because it focuses only on widows. They feel that Widowed Persons Program is the only place that truly understands what they are going through and is the only group that is helpful to them, as the Program Director and the volunteers are all widows themselves. People who have been widowed have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer this support, strength, and hope to their peers, which allows for personal growth, wellness promotion, and recovery.

Methodology

WPP will provide the following services to 120 individuals:(approximately 6-8 hours per month per individual). Outreach: providing volunteers who have been widowed for at least 18 months to the newly widowed to

discuss on a one-to-one basis their adjustments to the problems of widowhood.

Telephone service which the widowed can call for referral information and assistance. The Program Director and volunteers are available to accommodate this need. During COVID-19, staff are calling widows weekly for wellness checks, support and case management. Staff are also weekly delivering food, toilet paper, paper towels and cleaning supplies to those widows in need of these services. Staff have also delivered grocery gift cards to those in need.

Support group sessions meet monthly that will bring small groups of widows together in person or via Zoom to discuss problems, issues, and to provide mutual assistance. One group per month will be held only for those who are newly widowed. Separate groups will be held for those who are widowed more than one year. We have also established a private facebook group for the widows during the pandemic.
Public Education: Using resources of local public service agencies and educational media to call attention to the needs of the widowed and services available to them.

Referral Services: Providing widowed persons with a directory of local services available to them. A monthly newsletter is provided free of charge for the first four months to the newly widowed.
Health and Wellness education: Bilingual YWCA Community Health Workers (CHWs) educate seniors in their own communities and native languages (Spanish, Portuguese, or Cape Verdean Creole), and link them to medical service providers for screening services.

Financial Literacy Educational Workshops: WPP partners with the YWCA's Financial Literacy for Women Program. A majority of the widows we serve are learning how to manage their finances for the first time, and they require assistance with managing credit card debt, high mortgage/rent payments, missed loan/bill payments, bankruptcy, medical expenses, and/or have difficulty meeting their daily living expenses. To meet this need, our financial program assists them in transforming their lives through reaching and sustaining financial self-sufficiency. The program also helps widows build a network of community-based support, where they can go to receive necessary services and programs to help them continue on a path of financial empowerment.

Widowed Persons Program will provide the following services to at least 500 individuals:

- Outreach: providing volunteers who have been widowed for at least 18 months to the newly widowed to discuss on a one-to-one basis their adjustments to the problems of widowhood. Most widows are contacted through the obituaries, where an informational letter is sent along with a brochure and other printed information. The program is also listed in Senior Scope, Standard Times, O' Journal and on social media. Public service announcements are sent to the Portuguese and Spanish cable and radio stations. Outreach materials are also sent to Councils on Aging, senior centers and funeral homes. Non-English speaking volunteers are actively recruited. Outreach materials are available in English, Portuguese and Spanish. Referrals to the program are encouraged by agencies working with non-English speaking elders. Presentations are also made to staff at the Immigrants Assistance Center, Mayan Center, area councils on aging, senior centers, Coastline Elderly Services, senior and public housing developments, funeral homes, churches, etc.
- Telephone service which the widowed can call for referral information and assistance. Staff reach out to widows for wellness checks, support and case management. Staff are also weekly delivering food and other essentials to those in need of these services. Staff also deliver grocery gift cards, food, PPE and cleaning supplies to those in need.
- Support group sessions meet weekly, bringing small groups of widows together in person or via Zoom to discuss problems and develop mutual aide. One group per month is reserved for those who are newly widowed. Separate groups are held for those who have been widowed more than one year. Additionally, we will continue the facilitation of our newest session which meets on Thursday evenings. We also manage a

private Facebook group for the widows.

- Public Education: Using resources of local public service agencies and educational media to call attention to the needs of the widowed and services available to them.
- Referral Services: Providing widowed persons with a directory of local services available to them. A monthly newsletter is provided free of charge for the first four months to the newly widowed.
- Health and Wellness education: Bilingual YWCA Community Health Workers (CHWs) educate seniors in their own communities and native languages (Spanish, Portuguese, or Cape Verdean Creole), and link them to medical service providers for screening services.
- Financial Literacy Educational Workshops: Widowed Persons Program partners with the YWCA's Financial Literacy for Women Program. A majority of the widows we serve are learning how to manage their finances for the first time, and they require assistance with managing debt, housing payments, bills, bankruptcy, medical expenses, and daily living expenses. To meet this need, our financial program assists them in transforming their lives through reaching and sustaining financial self-sufficiency. The program helps widows build a network of community-based support, that provides necessary services to help widows continue on a path of financial empowerment.

Outcomes

FY'20

Goals: Support Services for Widowed Persons.

Outcomes: Provided a consistent and orderly outreach program offering support to all newly widowed persons age 60 and over.

How: 100% of participants in WPP received emotional and social support through monthly telephone calls from volunteers, one-one-one outreach, have opportunities to attend support groups in-person and remotely, and various other social activities, maintained a grief and loss library, and provided a monthly newsletter.

We plan to continue to achieve these outcomes and meet current and new goals by continually being fully accessible and knowledgeable to our participants while helping achieve their needs and providing the correct support in person and remotely.

FY'21

Goals: Support Services for Widowed Persons.

Outcomes: Provide a consistent and orderly outreach program offering support to all newly widowed persons age 60 and over. All participants will receive individual and group support, as well as a community of peers, throughout their grieving process. All participants receive educational resources and learn strategies and techniques for coping with grief and loss.

Goal: Provided a consistent and orderly outreach program offering support to all newly widowed persons.

Outcomes:

•100% of participants in Widowed Persons Program will receive emotional and social support through monthly telephone calls from volunteers, support groups, trips and social activities.

•100% of participants in Widowed Persons Program will receive outreach, education, and translation by bilingual Community Health Workers, and, for those that need it, a portion of participants will receive accompaniment to appointments, transportation, and support services in accessing healthcare.

•100% of participants in Widowed Persons Program will receive a monthly newsletter that will provide them with information on the grieving process, as well as program services, activities and program offerings.

Evaluation

Client satisfaction is tracked through continued participation in program activity, newsletter subscription renewals, and written program testimonials. Volunteers and program staff monitor progress of the programs

participants to see if they are moving along the accepted course with their grief. Surveys are completed annually by all program participants. Success is measured by the number of participants enrolled in the program and the number of services and activities provided to each person. The organization also measures and monitors success through qualitative feedback from program participants, including but not limited to improvements or changes needed for the newsletter, support groups and social activities. Participant testimonials are also encouraged and welcomed.

The Widowed Person's Program has improved its performance and impact through suggestions and recommendations from the participant surveys given. Participants have asked for more group speakers that our Program Director continually tries to incorporate into their monthly events. Workshops and seminars are also regularly attended by the Program Director both in person and remotely to stay as up to date as possible on new techniques related to coping with grief. Her more recent certification as a grief educator makes Jane an even greater asset to this program.

We are developing both digital and paper surveys that will go out to participants. The purpose of these surveys is to evaluate the success of the program and to ensure that we are meeting the needs of our participants. These surveys will be sent bi-annually to seek both qualitative and quantifiable data. They will consist of Likert scales, multiple choice and open-ended questions in order to obtain a range in data. Surveys will also be translated into Spanish and Portuguese.

In the upcoming year we would like to expand the topics that we cover with our participants. We will use the surveys to assess for interest in new topics. We are seeing a need for new topics because of the pandemic. Many of our participants have found that the pandemic has created new barriers. Technology is used more than ever for socializing and connecting with others. It is because of this that we would like to offer a digital literacy workshop. With the increase in technology use, comes an increase in digital scams. A session on recognizing and avoiding scams will also be valuable to our participants. We also plan to work with our Director of Mission Impact to create racial justice training and financial literacy training for our participants. With the development and implementation of new workshops, we will include pre-testing and post-testing to evaluate for retention and measure success. As with our overall program surveys, Likert scales, multiple choice and open-ended questions will be included. These evaluation methods will help us refine our offerings.

Who will benefit?

The Widowed Persons Program serves many widows over the age of 60. All participants are asked their age range on the attendance log that is used at all programs and activities. Everyone is encouraged to participate in the program and no one is turned away for services for any reason. The program is also LGBTQ+ friendly and works to reach a diverse population.

Our YWCA serves Bristol, Barnstable, Plymouth, Dukes and Nantucket counties, an area of 1.37 million people (American Community Survey, 2019). The main urban center we serve, New Bedford, has a documented population of approximately 101,079, according to the 2019 American Community Survey. We assume an increase in the population with the release of data from the 2020 census, as we know that our true population is well over 100,000 with many undocumented groups of people from Central and South America, Cape Verde Islands, and Portugal. According to 2021 statistics from the Department of Labor, this area suffers from a 6.3% unemployment rate, as compared with the state rate of 5.1% and a national rate of 4.6%. The 2019 American Community Survey also shows that 20.2% of our residents live in poverty, with a median household income of $47,305 compared to the statewide median household income of $85,843. Currently, 34.9% of the population has graduated from high school, with only 7.9% of the population graduating from college. In addition, 50.8% of the population are women, with 20.8% of the population being foreign born and 37.6% of the population having a first language other than English.

Implementation Timeline

The Widowed Persons program is an established program. Because of this, all of our program components are ongoing and will occur continuously throughout the year.

1. Telephone and mail contact to the newly widowed: January 1st 2022-December 31st 2022

2. Provide one-to-one outreach to the newly widowed: January 1st 2022-December 31st 2022

3. Provide telephone services for resource and referrals: January 1st 2022-December 31st 2022

4. Provide socials and trips for socialization and education: January 1st 2022-December 31st 2022

5. Maintain a grief and loss library: January 1st 2022-December 31st 2022

6. Provide monthly support groups on Zoom and in-person: January 1st 2022-December 31st 2022

7. Provide monthly newsletter: January 1st 2022-December 31st 2022

8. Host monthly financial literacy workshops for widows on Zoom and in-person: January 1st 2022-December 31st 2022

Qualifications

Since its inception in 1992, WPP has trained 30 volunteers, who themselves are widowed. The support group has grown from one group serving 15 to two support groups serving 120 participants. Many program participants feel isolated and alone before coming to WPP. Many were caregivers for years and have lost contact with the outside world. WPP provides a place for them to go and discuss their needs, make new friends and discuss their problems with people who care, listen and understand. The Program Director, Linda Rose, who started in the program as a participant and a widow, retired this past summer. We are thrilled to welcome our new Program Director Jane Rocha, a widow herself. Linda and Jane have been working together since the summer conducting virtual outreach and programming for the participants during COVID-19.

The YWCA's Widowed Persons Program has a proven track record of success. Since its inception in 1992, Widowed Persons Program has trained 30 volunteers, who themselves are widowed. The program has grown from one group serving 15 to three support groups and outreach serving over 500 participants though its support groups and monthly newsletters. The ongoing pandemic has unfortunately increased the number of widows in our region, making this program more needed than ever. Many program participants feel isolated and alone before coming to the Widowed Persons Program. Many were caregivers for years and have lost contact with the outside world. Our program provides a place for them to go and discuss their needs, make new friends and discuss their problems with people who care, listen and understand. The current Program Director is Jane Rocha, a widow herself. Jane took on this role in the summer of 2020, working alongside her predecessor to train for the position. Jane has an Associates Degree in Sociology and Education from Southeastern MA University and is a certified grief educator. Jane's Grief Educator Certification was completed under David Kessler, a leading expert in grief education.

Our program director is joined by a Community Health Worker, Valentina Martinez, CHW, who is fluent in Spanish. Valentina has a Bachelor's Degree in Spanish and has been with the YWCA since 2004. Valentina has completed Healthy Lifestyles and Fall Prevention Training, Patient Navigation Certification from the Massachusetts Department of Public Health, Diabetes Education Training from SouthCoast Health and is a certified applicant counselor for the Massachusetts Health Connector State. She is a certified trainer in the

ENCOREplus Curriculum, is a certified Community Health Worker from the MA Community Health Education Center, is a member of the Massachusetts Association of Community Health Workers and a certified medical interpreter.

The Ask

The YWCA seeks $5,000 in funding for day-to-day program support for our Widowed Persons Program. Widowed Persons Program is a supportive services program that targets all widows, especially those who are low-income, minority, disabled, LGBTQ+ and non-English speaking. The program serves newly widowed women age 60 and older who are still going through the grieving process. The program provides mixed group support and one-on-one emotional support, resource and referral information with a mutual self-help program. Volunteers widowed at least 18 months are trained as outreach volunteers helping the newly widowed to regain their sense of well-being. Funding will be used for day-to-day program expenses for support groups, newsletters and social events.

Future Funding/Sustainability

The program holds an annual memorial fundraising activity in the spring and fall to sustain the program. In addition, limited funding is secured by Coastline Elderly Services and the Sophia Romero Trust to support the program. Requests for grants from foundations, donations from businesses etc. are continually being researched and proposals and contribution requests are submitted as appropriate. The loss or significant reduction of funding for the program could potentially lead to cuts in the number of participants allowed in the program, reduction in staffing to implement the program including coordinating the support groups, telephone outreach and public education. All are crucial components of helping a widow find a sense of belonging within the community.

YWCA Southeastern Massachusetts
Widowed Persons Program

Project Budget
$25,560.56

Budget Narrative
The YWCA Southeastern Massachusetts' Widowed Persons Program has several sources of funding. Coastline Elderly Services has provided us with $5,000 for the time period of July 1, 2019 to June 20, 2022. We received this funding in August of 2021. Additionally, in January of 2021 Sophia Romero Trust provided us with $10,000 for the time period of January 1, 2021 to December 30, 2021. We are anticipating receiving this grant again in January of 2022. We anticipate that this program will receive approximately $1,000 in individual contributions during the 2022 fiscal year.

Widowed Persons Program Budget | FY22

Revenue

Source	Amount
Grants	$20,000
Individual Contributions	$1000
Total Revenue	$21,000

Expenses

Expense	Amount
Widowed Persons Program Director 1 @ $15.45 hr @ 15 hrs wk @ 52 weeks	$12,051
Administrative Assistant 1 @ $14.71 hr @ 3 hrs a mth @ 12 mths	$529.56
Executive Director $35 hr @ 2hrs a mth @ 12 mths	$840
Travel 400 miles @ .53.5 a mile	$214
Building Space $125 mth @ 12 mths	$1,500
Communications 1 Telephone @ $ 69 a month @ 12 mths	$828
Utilities $100 mth @ 12 mths	$1200
Printing (Monthly Newsletter/Brochures/Stationary)	$1600
Office supplies	$800
Postage	$800
Insurance	$500
Administration (21.65%)	$4698
Total Expenses	**$25,560.56**
Revenue Over Expenses	**-4,560.56**

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	Town of Westport
Project Title:	Community Outreach Project
Annual Budget:	
Project Budget:	$83,438.00
Requested Amount:	$38,750.00
Targeted Funding Areas:	Trusted sources of knowledgeable advocates in community who will identify and connect us to women in need.

Statement of Need

Westport's growing elder population (44% age 55 plus), includes older women who need support to maintain the greatest level of independence. we are prepared to assist these ladies with recreational, social, nutritional, personal care, and financial assistance at the Westport Council on Aging. Our professional staff works closely and collaborates with seniors, their families, caregivers, and community resources to achieve the best outcome while respecting individuals' needs.

Project Description

Our Outreach Department partners with Westport Police, Fire, and Emergency Departments to identify seniors in need. They coordinate services with Bristol Elder Services, Coastline Elder Services, South Coast and St. Ann's Hospitals, as well as local physicians' offices, nursing homes, or assisted living facilities. The Outreach staff attend local health fairs and community events in an effort to identify and educate the public on the center's resources. Once an individual is identified, the Outreach staff completes an initial assessment to determine immediate and long-range needs. All interested parties work collaboratively to develop a plan. Staff aid seniors with applications for fuel assistance, food stamps, medical insurance, loan durable medical equipment, provide support at social security and housing meetings, and assist with local, state, and federal programs. Referral programs may include home-delivered meals, home and personal care, Friendly Visitor, File of Life, money management, tax assistance, SHINE (Serving the Health Insurance Needs of Everyone), Senior Safe Cares program, as well as other identified needs.

Due to COVID, health fairs and community events have been shut down for twenty months. We are just beginning to awaken from the COVID restrictions, and are energized to be able to again meet in person with seniors interested in receiving information about the senior center and its programs and activities.

We plan to target all the local senior housing facilities in Westport when they re-open their community rooms. We will offer informational sessions on each of the five senior center departments; Transportation, Supportive Day Program, Activities, Volunteerism, and Outreach Services. We will also start a “getting to know us” campaign for our local businesses.

In the spring of 2022, we will complete a three to five-year strategic plan, focusing on our need for more physical building space, the needs and wishes of our community, and the opportunity to expand virtually. As we continue to grow and change, we will need the support of the town, local businesses, and its residents to continue to provide exemplary services to our most valued senior population.

Methodology

The Outreach staff will continue to receive referrals from our local police, EMT and fire departments, neighbors and family members, hospitals, and doctors' offices. Last Fiscal year we received 2,549 referrals from 23 different organizations and referred 444 individuals to 39 organizations for assistance. We will continue to reach out to the community to educate residents on the services we provide. We will schedule

"Get to know us" seminars and attend local health events in surrounding communities, housing developments, local businesses, and churches. We will offer a "meet and greet' opportunity for residents to enjoy a meal, ask questions, visit the center, and meet the staff and volunteers from the center. We will increase our visibility by using local cable access by participating in Creative Connections interviews. We will utilize local newspapers and Facebook to advertise activities, events, and services.

The Outreach staff will continue to receive referrals from our local police, EMT and fire departments, neighbors and family members, hospitals, and doctors' offices. Last Fiscal year (4/1/2020-3/31/2021) we received 3,256 referrals from 25 different organizations and referred 510 individuals to 43 organizations for assistance. As we awaken from COVID, we will continue to reach out to the community to educate residents on the services we provide. We will schedule "meet and greet" seminars and attend local health events in surrounding communities, housing developments, local businesses, and churches. We will offer a meet and greet opportunity for residents to enjoy a meal, ask questions, visit the center, and meet the staff and volunteers from the center. We will continue to increase our visibility by using local cable access by participating in Creative Connections interviews. We will utilize local newspapers and Facebook to advertise activities, events, and services.

Outcomes

The Outreach support from ARAW will allow us to continue to identify older women in need of financial assistance to remain in their homes, introduce ladies to social and recreational activities to limit isolation and loneliness, and offer transportation and assistance to help each individual maintain good health.

The Outreach support from ARAW will allow us to continue to identify older women in need of financial assistance to remain in their homes, introduce women to social and recreational activities to limit isolation and loneliness, and offer transportation and assistance to help each individual maintain good health.

With the awakening of the community, we will work to increase our visibility in hopes of becoming a trusted source of senior services information and referral.

Evaluation

Our progress will be measured by the increase in the number of ARAW ladies served and the number of ladies able to maintain independence and remain in their home of choice. We will also measure the number of ladies attending our events for recreation, socialization, the Supportive Day Program, and utilizing our transportation services.

One of the successes of our technology survey in fall 2020, was the realization that many seniors need assistance on their technology devices. We have provided phone and email hotlines for tech support and held the orientation and intermediate tech classes. One-third of the 180 attendees had never been to the center, and many of the attendees did not know of all the services offered. Word of mouth is spreading as seniors feel comfortable coming to the center for help with their technology. and other services offered. This program will continue in spring 2022, and we hope to reach more seniors.

Who will benefit?

All disabled individuals and seniors aged 55 and above who reside in the town of Westport and local surrounding areas are eligible to participate in the Westport Council on Aging activities, programs, and services. Activities include numerous and varied levels of exercise programs, educational programming, activity instruction, cultural events and trips, congregate meals, Supportive Day Program, Transportation Services, Outreach Services, as well as volunteer opportunities.

Implementation Timeline

Spring and Summer – February – August 2022

- Cultural Council Event Museum Trip – March or April 2022
- Strategic Planning Committee meetings – March – April 2022
- Meet and greet Open House hosted by Outreach Department and Supportive Day Program April 2022
- Creative Connections Interview continue on local cable - ongoing
- Host informational meeting in local housing community rooms – TBD
- (Edgewater I, Edgewater II, Noquochoke Village, Greenwood Terrance, Westport Villages)
- Provide AARP Tax Preparation by individual appointment – February through April 2022
- Attend District Attorney's and MA South Coast Senior Health Fair at White's – (TBD May)
- Summer outdoor picnic/music events – TBD
- Hold Farmers Market Coupon Distribution day – July 2022

Fall and Winter – September 2022 - March 2023

- Meet and greet Open House hosted by Outreach Department and Supportive Day Program October 2022
- Host informational meeting in local housing community rooms – TBD
- (Edgewater I, Edgewater II, Noquochoke Village, Greenwood Terrance, Westport Villages)
- Medicare Open Enrollment – October 17 – December 7, 2022 (TBD)
- Call on Banks, local businesses, and local medical centers for quick meetings to introduce the community to the senior center services.

Qualifications

Our Outreach Department is comprised of a full-time Outreach Coordinator, Andrea Lemos, who has over 13 years at the Westport COA in the Outreach Department, was a group Home Supervisor for 8 years, and a Personal Care Attendant. Andrea holds an Associates Degree from Bristol Community College in Human Services with a minor in Psychology and is a certified SHINE Coordinator.

Susan Routhier has been employed at the WCOA since November 2012, accepting the Volunteer Coordinator position initially, and transitioning to the Outreach Department in February 2016 as a part-time Outreach Specialist. Susan completed both the Phlebotomy Program and the Nurse Assistant Program at Bristol Community College. Susan is a certified SHINE Coordinator and has experience as an Activity Aide at an Adult Day Health Program and Personal Care Attendant.

Cynthia Kinnane came to the WCOA in June 2015 as a part-time Outreach Specialist. Cindy holds a BS in Accounting from Binghamton University, and has significant experience as a Personal Care Attendant and held an Administrative Assistant position at a Psychotherapy office. The WCOA is a SNAP Outreach Partner, and Cindy is our SNAP Benefit Coordinator.

Beverly Bisch is the Director of Senior Services for the town of Westport. Beverly holds a BA degree from Rhode Island College in Psychology with a minor in Biology. Beverly has extensive experience working in the Human Service field, from Nursing Home Aide, Residential Supervisor, Family Support Coordinator, and Adult Day Health Program Director. Beverly was a member of the committee that designed and developed the Medication Administration Program for the state of Massachusetts.

Our Outreach Department is comprised of a full-time Outreach Coordinator, Andrea Lemos, who has over 14 years at the Westport COA in the Outreach Department, was a group Home Supervisor for 8 years, and a Personal Care Attendant. Andrea holds an Associate's Degree from Bristol Community College in Human Services with a minor in Psychology and is a certified SHINE Coordinator.

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I have supervised the Outreach department and its staff since 2015, and in my many manager's roles, I can honestly state this is one of the best departments and centers I have had the pleasure of working with. Their dedication to clients, resilience, and flexibility in meeting the needs, and trustworthiness is exemplary. The culture of the senior center is welcoming, positive, and always helpful. On a regular basis, I receive a phone call or letter thanking the Outreach staff for their assistance, patience, and professionalism in helping a senior with a need.

The Ask

The Community Outreach Project funds will be used for 50% of the Outreach staff salaries and the small percentage of the Director's salary.

Future Funding/Sustainability

The Executive Office of Elder Affairs funds the Formular Grant at $12 per elder based on the 2010 census. Our new 2020 census numbers are projected to increase for the town 20-25%, $12,000 - $15,000 per year. We will continue to research and apply for grant funding from other organizations to assist in keeping the Outreach Department a vital service for the Westport seniors.

Town of Westport
Community Outreach Project

Project Budget
$83,438.00

Budget Narrative
Our Community Outreach Project includes all WCOA Departments. Transportation Services provide rides to ARAW ladies for medical appointments, food and medicine deliveries, hospital and nursing home visits, social security appointments, and personal errands. Our drivers and our transportation clerk positions are involved in the scheduling and implementation of the service. Their salary is provided from Town funds, Transportation Revolving Funds, and Formula Grant Funds. Our Supportive Day Program provides day activities, Monday + Wednesday 8:30 - 2:30 pm. ARAW ladies are welcome to attend, and the salary of all SDP staff is provided from SDP Revolving Funds, Formula Grant, and South Coast Community Foundation Grant. Our Outreach staff and the Director recruits, interview, train, process mileage sheets, and refer volunteers to ARAW ladies in need of a Friendly Visitor or companion assistance on the van. Four (4) positions were affected by the ARAW Grant Fund cuts in 2019. While we were able to fully salvage 2 positions by re-allocating other grant funds, one Outreach Specialist hours were reduced to 18 per week and the Volunteer Coordinator position was furloughed on April 28, 2020. I have attached an ARAW budget spreadsheet with a funding comparison below.

ARAW COMPARISON	9/14/2021	TOWN	SNAP	TRANSP	FORMULA	ARAW	OUTREACH PROJECT EXPECTED COSTS	OUTREACH PROJECT %
	7/1-6/30/2021	FY 21	FY 21	FY 21	FY 21	FY 21	FY 22	FY 22
Council on Aging - 541	CURRENT BALANCE	202,326	3,373	45,296	50,376	34,500		
5101	Department Head	70,703		0	0	0	3,535	5%
5105	Clerk FT	39,965		0	0	0	1,998	5%
5108	Non-Clerical PT-Custodian	19,552		0	0	0		
5108	Non-Clerical PT Meal Site Mgr	0						
5120	Sick Leave/Vacation Buyout	0		0	0	0		
5109	Visitors	0						
5148	Sick Leave Buy Back	1,084		0	0	0		
5114	Professional - Meal Site Manager	4,690		0	0	0		
5111	Van Drivers	24,307		0	0	0	2,431	10%
N/A	Transportation Clerk	0		9,245	5,087	0	1,433	10%
5130	Overtime	2,200		0	0	0		
5140	Incentive	1,100		0	0	0		
5142	Longevity	0		0	0	0		
5190	Snow & Ice (Storm Account)	0		0	0	0		
	SDP Staff (total)	0		0	0	0		
	medicare			132	730	0	86	10%
	Volunteer Coordinator	0		0	0	0	0	
	Outreach staff (total incl medicare)	0	1,904	0	34,500	34,016	35,210	50%
	Instructors (Total)	0		0	0	0		
	Subtotal Wages & Salaries	**163,601**	**1,904**	**9,377**	**40,317**	**34,016**	**44,693**	
These amounts are only for staffing costs, and do not include expenses for utilities, supplies, repairs, etc.		TOWN	SNAP	TRANSP	FORMULA	ARAW	70,420	2021 cost outreach staff only
		38,725	1,469	35,919	10,059	484		

FY23 COMMUNITY PARTNER GRANT | APPLICATION SUMMARY | COMMITTEE REVIEW

Organization:	Coastal Neighbors Network, Inc.
Project Title:	Enhancing Quality of Life and Promoting Independence for Aging Women in Dartmouth and Westport
Annual Budget:	$101,000.00
Project Budget:	$35,120.00
Requested Amount:	$35,120.00
Targeted Funding Areas:	Trusted sources of knowledgeable advocates in community who will identify and connect us to women in need.

Statement of Need

Dartmouth's and Westport's older population is skyrocketing and many people do not have family nearby or are new to the community. According to 2010 census figures, for example, roughly 11,000 people between the ages of 50 and 85 were living in Dartmouth. By 2018 that number had jumped to 13,714, nearly a 25% increase. Over 40% of Dartmouth's population is over 50 years old; in Westport, they represent 47% of the population.

As the populations age in these two towns, the risk of social isolation grows but the desire to continue living at home remains strong. Coastal Neighbors Network (CNN) adds a layer of personal support, and our Volunteers will come to a Member's house to take her to an appointment, help with a small chore in the house or just visit for social interaction. We create a community of friendship and support for our Members.

Project Description

According to an AARP study, 90% of people 65 and over would prefer to stay in their own homes as they get older. Coastal Neighbors Network is a membership-based, non-profit focused on enabling people to "Age in Place" independently and actively. CNN can play an important role in providing social connection and opportunities for the elderly, creating community for many who may no longer have friends and family available to them.

According to the National Institute of Health (NIH) and the National Library of Medicine, meta-analyses have found that social isolation or loneliness in older adults is associated with a 50% increased risk of developing dementia, a 30% increased risk of incident coronary artery disease or stroke,and a 26% increased risk of all-cause mortality.

Originally established in 2017, the organization is one of a rapidly growing network of Villages across the country providing one-to-one services and group events – as well as a breadth of information and support from the Board of Directors, vetted Volunteers, and preferred providers so Dartmouth and Westport Members can stay connected to their community and live comfortably. Some of the more popular services and social events include rides to medical appointments, help with small household chores, potluck suppers, and outings. In addition to membership services, Coastal Neighbors Volunteers also participate in broader community support such as neighborly check-ins, food deliveries, and mask-making as needed during critical times of the year.

Specifically, Coastal Neighbors Network offers its membership a wide range of services including:

TRANSPORTATION: Providing transportation to our Members is a significant portion of the services provided by CNN. Volunteer drivers provide rides to medical appointments, stores, markets, fitness centers, deliveries, pet to vet. This is particularly important in both Dartmouth and Westport due to the lack of significant public transportation in both towns. For example, in Westport, of the 300 miles of roads in the town, only six miles are accessed through public transportation.

SOCIAL OPPORTUNITIES: Coastal Neighbors organizes group outings to movies, lectures, gallery exhibits, concerts and classes. Recent outings have included bird watching, a bonfire, and an olive oil tasting. Smaller gatherings will include book and discussion groups, listening to live music, dining out. In addition, Volunteers can visit Members on a regular basis, establishing a friendship and social connection with them. Social connection is thought to be an important component in preventing dementia.

HEALTH CONNECTIONS: Coastal Neighbors is not a health care provider, but can assist Members with referrals for doctors, therapists, in-home health care, medical equipment, home modifications (grab bars), and help with insurance forms.

HOME MAINTENANCE: Coastal Neighbors connects Members with vendors for interior and exterior repairs. Coastal Neighbors Volunteers provide help with simple chores where a professional is not needed, such as lightbulb or filter changes, storm door inserts, leaf raking, etc.

In addition, CNN works with the YMCA food insecurity program and delivers food once a month to qualifying Member recipients. We anticipate implementing a program in the future to provide Relief opportunities for caretakers of elderly relatives.

Methodology

Membership Application Process

An applicant interested in joining CNN may indicate their interest by filling out aprinted or Online Information Form. One can choose to become a a Single Member ($660/year) or a Household Member ($900/year) to be eligible to receive services from our Volunteers as well as participate in social activities. Sustaining Members ($350/year) are able to participate in all of our social activities.

After submitting an application, our Executive Director will contact the applicant to set up a time to meet to discuss their needs and our policies. They will discuss services, determine whether a Member prefers to communicate requests for services by phone or computer, and help set up activities or follow up other interests.

Service Members must be over the age of 50 and live in the Town of Dartmouth or Westport, Massachusetts. All Service Members are required to fill out an application. A Service Member must also be physically and mentally able to live in his or her home. While a Service Member might need help with certain tasks that have become more challenging with age, Coastal Neighbors Network cannot provide the level of services that would be available in an assisted living facility. A person applying for a Service Membership must provide health insurance information, emergency contact(s) and proof of homeowners insurance.

There is a one-month waiting period prior to acceptance. Either the prospective Service Member or the Executive Director can decide to cancel the Membership during this period. After the one-month waiting period, a Service Member may begin requesting Volunteer Services, participate in Member social activities, and have access to the other benefits of Service Membership.

Volunteer Application Process
Trained Volunteers perform almost all of the services that are offered to Service Members. Initially, Volunteers have to pass a criminal record information check (a CORI, which CNN pays for) and provide two personal references. Training includes: General Expectations of Volunteers, Guidelines for a Successful Visit, Maintaining Boundaries, Signs of Potential Problems, Tasks That Cannot be Performed, Identifying Elder Abuse, and Emergency Guidelines. All Volunteers are responsible for maintaining the privacy of all Members and Volunteers.

A Volunteer driver will initially and annually provide the Executive Director the face sheet of their insurance policy that shows the driver's driving record and the limits of the driver's automobile insurance policy, in order to determine that the limits of the insurance coverage are adequate. A Volunteer will also report any accident that he/she has had during the year that involves injury or damage in excess of $1,000.

ARAW Members
We anticipate adding eight ARAW members each quarter, working with two or three members per month. The grant structure will enable Andy to provide highly individualized service to each member with a personalized meeting where he can meet the applicant, completely explain the process to them, learn their needs, and strategize with them the best way that CNN can provide services for them. This is a deliberate and lengthy process as Andy works to best accomodate each applicant.

Outcomes
CNN will carefully track the number of ARAW members enrolled in our Coastal Neighbors Network program they receive. We currently survey each CNN Member and Volunteer after each service to ensure that all parties were satisfied with the interaction, and will continue this practice with our ARAW members. In addition, to further measure the ARAW members' satisfaction with their CNN membership, we will ask each member to complete a survey at the beginning of their CNN membership and one at the end of the first year of membership. This pre and post assessment, designed specifically for the ARAW grant, will provide additional qualitative information regarding the ARAW's satisfaction with the services and opportunities.

Specific Outcome metrics include:

75% of enrolled ARAW Members report feeling an increased access to transportation services due to their CNN membership

80% of enrolled ARAW Members report feeling increased social opportunities due to their CNN membership

80% of enrolled ARAW Members report feeling increased social connection due to their CNN membership

75% of enrolled ARAW Members report feeling decreased social isolation and loneliness due to their CNN membership

75% of enrolled ARAW Members report feeling an improved quality of life due to their CNN membership

30% of enrolled ARAW Members will use our home maintenance services

Evaluation

Quantitatively, CNN will be able to track several different participation metrics for ARAW Members:

- Total Number of ARAW Members participating

- Number of Services/Events per ARAW Member

- Total Number of Services/Events for ARAW Members

Qualitatively, we monitor all service reports (completed by the Member and by the Volunteer) on an ongoing basis to ensure all is going well. In addition, as the ARAW members will be completing a pre and post survey assessment, we will have an additional evaluation tool to measure the program's success. CNN has the ability to provide aggregate monthly or quarterly ARAW Member service information to the foundation as requested.

Who will benefit?

Coastal Neighbors Network can help elderly women to "Age in Place" independently and actively in Dartmouth and Westport so that they can stay connected to their community and live comfortably. By providing the financial resources to give CNN scholarships to aging women in need, the ARAW can further meet the social, transportation, health, and home maintenance needs of its beneficiaries.

To watch a short video overview on the CNN program, go to https://www.youtube.com/watch?v=9OCi-h5_CsY

There are approximately 66 ARAW members who live in Dartmouth and Westport. Conservatively, we anticipate working with approximately 50% of them the first year as a pilot program. We hope that we will be able to further grow our collaboration with ARAW in the future.

Implementation Timeline

Feb. 2022 - Notification of Grant Decision

March 2022 - Submission of Signed Grant Agreement

March/April 2022 - Initial Notification of ARAW Members by mail of CNN Membership
- Application mailed to all ARAW Members in Dartmouth and Westport

April/May 2022 - Phone calls to ARAW Members in Dartmouth and Westport
-- For those who sent in applications, purpose of call is to Set-up time to meet to discuss their need and our policies; OR
-- For those who haven't sent in an application,purpose of call is to explain the opportunity and to Set-up time to meet to discuss their need and our policies
- Begin individualized meetings of ARAW applicants with Andy with a goal of two or three per month

June 2022 - March 2023 - Individualized meetings of ARAW applicants with Andy with a goal of ten quarterly
- ARAW members actively participate in CNN program

Qualifications

Coastal Neighbors Network is part of the national organization, Village to Village Network, which works to connect individual villages to help them collaborate to raise their impact and sustainability. The Village

concept started on Beacon Hill in 2002 and has blossomed into a robust movement that's sweeping the country. There are roughly 200 Villages currently serving seniors across the United States and 150 more Villages being formed.

The "Village movement" has been sweeping the nation due to the growing senior population. It addresses the fundamental desire of older adults to remain in their homes and neighborhoods. CNN is a virtual village centered in Dartmouth and Westport assisting seniors to maintain connections to friends and community through the use of volunteer services. However, a ride is more than a ride and changing a light bulb does more than increase the light in the room. Of all the benefits CNN offers, the best may be the sense of well-being that comes with expanding connections, building new friendships, and knowing one is part of a community who cares.

Coastal Neighbors Network was formed in 2015, incorporated in 2016 and received 501 (c) 3 status in November 2016. We officially launched in September 2017 and are governed by a volunteer Board of Directors. Andy Pollock, our Executive Director, is the only paid employee, working part-time. We anticipate that additional growth in the number of Members will result in bringing Andy on in a full-time position.

Born in Dartmouth, Andy has an MBA from University of Maine and has operated a medical billing business. In addition to being at CNN, he is currently working for Home Instead, a Home Health Care Agency, and pursuing certification in this field. Andy's experience in health as well as running a small business bring a wealth of valuable skills to Coastal Neighbors Network.

The Ask

The CNN board and leadership are excited about the possibility of partnering with ARAW to provide services to ARAW members who reside in Westport and Dartmouth. CNN has been providing services to the elderly in the area for four years and we are well poised to further grow our membership. Working with ARAW will enable CNN to expand our services to a new group in a deliberate and structured manner. We believe that CNN will be able to bring much quality of life to the elderly low-income women that make up ARAW's clientele.

We anticipate that this new venture will require a significant time investment by Andy Pollock, our Executive Director, as he works to contact the ARAW members, set up the initial meetings, meet with them individually to introduce the CNN concept, help them enroll in the CNN program, and then work with them to successfully understand and implement the program. An Individual CNN Membership is $660; we anticipate 32 ARAW memberships the first year totalling $21,120. As this is a new pilot program requiring substantial time investment by Andy and CNN resources (for the meeting process, survey design, volunteer recruitment, ARAW member communications, etc), we are requesting $10,000 to cover Andy's salary. We also are requesting $4,000 in additional funding for administrative support, volunteer training, and supplies and materials.

Future Funding/Sustainability

CNN plans to grow the number of Sustaining Members who support the organization with their annual gifts of $350 or more. All donations and membership fees are tax deductible and Sustaining Members are entitled to attend all the CNN social events. In addition, we will continue to actively cultivate and steward major donors. We will continue to hold our friendraising and fundraising Garden Tour event and may hold other fundraising events in the future.

Coastal Neighbors Network, Inc.
Enhancing Quality of Life and Promoting Independence for Aging Women in Dartmouth and Westport

Project Budget $35,120.00
Budget Narrative All philanthropic support of CNN comes from the generosity of individual donors and through membership fees. We currently receive no foundation or corporate support.

Coastal Neighbors Network

Enhancing Quality of Life and Promoting Independence for Aging Women in Dartmouth and Westport
Project Budget

Expenses

32 Service Scholarships @$660	$21,120
Executive Director Salary (allocation to project)	$10,000
Administrative Support	$2,000
Supplies and Materials	$2,000
Total	$35,120

Notes:

- Executive Director Salary – additional duties for this project will include numerous initial ARAW outreach visits, on-boarding meetings and communication with new ARAW Members, and recruiting and training additional Volunteers
- Supplies and Materials – include Membership application and reference materials, and Volunteer Training Booklets