

Jose* has been greatly affected by our case management program. He began participating in the Latino Cultural Diversity Program several years ago as a very independent and active individual. Many participants of this group were older than Jose and had a lot of health problems, but he enjoyed attending as it provided him opportunities to escape cultural isolation. In 2004, his health drastically deteriorated due to problems caused by diabetes; he has end-stage renal disease, is completely blind in one eye and loosing his sight in the other, and suffers from a variety of other health concerns as well. He was unable to fulfill the responsibilities of his job, could not afford to pay his monthly rent, and found it difficult to cope with daily activities. A bilingual/Spanish case manager from one of the 16 senior Focal Points in Dane County became aware of his struggles and began to search for ways to help. With the help of this case manager, Jose's quality of life has been enhanced:

- He is now residing at a senior apartment complex which he can afford.
- He has benefited from volunteers by getting assistance in his home with housekeeping and general companionship.
- Through the Wisconsin Council for the Blind and Visually Impaired, he learned ways to cope with his loss of vision and uses a closed-circuit TV that greatly magnifies writing to the point where he can read.
- He receives books on tape through the Wisconsin Library for the Blind.
- He utilizes Metro Plus to attend weekly study sessions at Centro Hispano helping him prepare for his citizenship exam.
- He receives his medicine in convenient and easy-to-use medicine boxes through the mail.

As is evident, this senior adult's quality of life has greatly increased as a result of being a part of the Case Management Program. He is more able to deal with the difficulties that have affected his life by counting on the help of a case manager.

**Name changed for confidentiality*

Sylvia* was surprised to find one day that her prescription drug cost was being directly deducted from her Social Security check without her consent. This was affecting her ability to have enough money in her checking account for her to pay her other bills. A NESCO case manager was sent to assist her in straightening the situation out. The case manager assisted Sylvia with the process of calling her prescription drug plan and filing a formal complaint with Medicare and advocating for her through the process. Sylvia was thankful that a case manager could help her as often times there are many different government and private agencies that need to be contacted to fix this type of situation. It was also through the process of the case manager being involved that Sylvia was found eligible for assistance with her home chores. Now Sylvia has her full Social Security amount restored and is receiving a volunteer's assistance in cleaning her home.

**Name changed for confidentiality*

Mario* was born in México but has recently earned his United States citizenship. Mario is facing diabetes, renal failure, low vision, and a number of other health issues. With the ongoing support and advocacy of his NESCO bilingual case manager, Mario has been able to remain independently in his own apartment. The case manager has also introduced Mario to the Latino Cultural Diversity Program (hosted by NESCO). Through his involvement with this program, Mario has had the opportunity to socialize with other Latino senior adults, reducing his isolation, and helping him to become more involved in the community. One of Mario's goals as his needs increase is to pursue bringing his wife, who resides in México, to be with him in the United States. Mario's case manager has connected him with a nonprofit organization which assists people with immigration concerns, and she continues to support Mario as he navigates the process of applying to have his wife come to the United States. Mario has expressed gratitude for his case manager's assistance, encouragement, and interpreting skills, and he knows that he can count on his case manager as he faces life's challenges.

** Name changed for confidentiality*

Mark* was recently discharged from a nursing home. He was referred to me and I immediately offered Mark case management services as he did not have family and friends that could assist with setting up programs to reduce his isolation while maintaining healthy eating habits and his independence. The other goal was to ensure he would not continue returning to the nursing home. I set up a home delivered daily meal service for Mark and contacted a local pharmacy to get his many medications delivered to him in a prepared medication box. I also accompanied him to one of our senior dining sites so he could meet other people his same age. Through the Home Chore Program (funded by the City of Madison & United Way of Dane County), Mark was matched with a volunteer who visited weekly to assist him with laundry and light housekeeping. Due to my help, Mark is now able to utilize the community resources and programs that are offered to assist him and remain living safely in his home as long as possible. Mark does not have family or friends that can continue to check on him—Mark is grateful I am able to take on this role.

** Name changed for confidentiality*

Barb* is an elderly woman who lives in her own home, but whose income is extremely low. I originally saw her to assist her with a change in her Medicare Part D plan, but upon further discussion discovered that she was taking out loans from her bank to pay her property taxes, which added so much stress to her in trying to pay it off in a year before she had to take out the next loan. I informed her of different programs, and she decided to apply for the property tax deferral loan program. This would eliminate her need for loans and she would not need to pay the loan back until she sold her home. This will allow Barb to have more money to work with every month and will greatly improve her quality of life. Had it not been for the involvement with a case manager, Barb would have continued to take out loans and in this economy one unplanned expense in a month could have had difficult consequences.

** Name changed for confidentiality*

Frank* is living with schizophrenia and anxiety. He lives alone in a one bedroom apartment and prefers to live a somewhat secluded life. He was referred to our coalition to assess Frank's inability to manage his finances and his challenge in keeping his apartment clean. It was extremely challenging for me to build a relationship with Frank as he preferred not to answer his telephone anymore because bill collectors were harassing him. Frank often would not answer his apartment buzzer and if he did, would not allow me to enter into his home stating that he was not feeling well that day. I built a relationship with Frank slowly by communicating through letters and writing him to give him advance notice of my visits. As Frank's trust in me increased, I was able to get him financial services with Independent Living (another community resource that helps senior adults). They visit him monthly and assist with check writing, budgeting, and managing his overdue bills. Frank also receives weekly cleaning through Dane County's Supportive Home Care program.

Unfortunately I have begun to notice some memory changes in Frank and overall confusion. It amazed me to find out he recently allowed a health insurance agent to enter his apartment and "convinced" him to switch his Medicare Advantage Plans. Frank already had difficulty understanding all of the details of his current coverage and now he switched to a plan that provided extremely limited coverage in the Madison area. Frank could no longer see his regular doctor unless he wanted to pay for the appointment out of pocket himself. For Frank (who is a lower income senior), the thought of having to pay even more in medical bills than he already had been or switch doctors, was extremely stressful. Fortunately Frank qualifies to change Medicare Advantage plans monthly (most others can only do so yearly) so I knew we could "fix" the issue. Unfortunately, Frank went back to being quite reclusive for awhile and I again had to attempt several times and in different ways to connect with Frank to get him enrolled into his original plan again. As a result, Frank was with the more expensive program for about two months longer than necessary.

Frank is not my only client who has been contacted by this same Medicare Advantage Plan. Linda*, an extremely active, independent, and organized 80-year old, was also contacted by a salesman from the same plan as Frank. She too was "convinced" to join the plan. Linda was happy with her current plan and was told she could keep her plan and also have the new plan. Unfortunately this information is incorrect and Linda was disenrolled from her original plan automatically. In the mean time, Linda discovered she would have costly co-pays (which the salesman failed to inform her) and decided to cancel the new plan. When she went to the pharmacy next, she was forced to pay the full amount of her medications as she now had no active coverage. I just learned about Linda's situation and I am now researching viable options to recoup Linda's money and help Linda file a formal complaint.

Both Frank and Linda are examples of the importance of having a long term relationship with a case manager. One meeting with this salesman caused changes and stress for each of them. Without the support of a case manager, both could have faced long term stress and financial consequences.

** Name changed for confidentiality*

Ana* was first introduced to the North/Eastside Senior Coalition through the staff at her dialysis clinic, where she dialyzes three days per week. In addition to her health and economic challenges, Ana speaks only Spanish; this can limit her ability to access the assistance she needs. As her case manager, I am assisting Ana in obtaining the resources she needs to remain independent and maintain a good quality of life despite being in a challenging situation. One issue was Ana's transportation to her dialysis treatments. I helped Ana to complete an application for the Madison Metro Paratransit Program, a program which provides specialized transportation service for individuals with disabilities to get where they need to go. I also connected her with the Retired Senior Volunteer Program (RSVP), through which senior volunteers provide free rides to other seniors to and from medical appointments. Ana and her husband had experienced feelings of isolation due to the language barrier and having limited transportation options, so I served as a link to our agency's Latino Support Groups, which Ana and her husband now attend on a monthly basis to connect and share with other Latino senior adults. When Ana needed glasses with a new prescription, one barrier was that her eye clinic did not always have an interpreter available. I was able to accompany her to the clinic and advocate for her ophthalmologist's assistance in getting new glasses for Ana. Most recently, Ana, our volunteer coordinator, and I have been working to connect Ana with a volunteer conversation partner to provide Ana with companionship and an opportunity to socialize in Spanish. Ana knows as her needs and situation change, I will continue to be available to support and advocate for her.

** Name changed for confidentiality*

Jack* was initially referred to us to coordinate for meals to be delivered to his home (via the Meals on Wheels program); yet upon further assessment, it was found Jack needed assistance in obtaining a more "senior friendly" apartment and a mental health referral. Jack had been suffering from situational depression due to the passing of his significant other. I referred his case to Mobile Outreach to Seniors and Jack worked closely with their psychiatrist and social worker to get stabilized on medications and counseling. Jack found a new apartment and became quite involved in the activities offered at his building. His depression stabilized as his isolation was reduced along with finding appropriate medications. I continued to be involved with Jack, continually monitoring his depression symptoms. When Jack had a relapse, I was able to make appropriate and timely changes. I also encouraged Jack to find other avenues to reduce his isolation and he applied to be a volunteer at our agency. He began by helping to distribute the monthly newsletter, assisted with various program activities, and served lunch meals in the senior dining site. Jack got out of his apartment building, met new peers, and felt "involved" again. Together, we were able to work through his recent depression symptoms and gain new coping skills.

** Name changed for confidentiality*

When I was hired by the North/Eastside Senior Coalition over 5 years ago, I remember Executive Director Cheryl Batterman telling me “As a case manager you might not know the answer to a question, but you will know how to research resources to find the answers.” That statement seems to still hold true for me today as it had then.

Just last week I was surprised to find one of my clients **Joe*** in the NESCO office right at 8:30 am. I was not expecting Joe, but was fortunate to have a few minutes free to see him. Joe was visibly upset and proceeded to show me his credit card bill that had charges totaling \$15,000. Joe informed me he was caught up in a real estate scam that he had found as an infomercial on TV. Joe ordered the real estate items on the infomercial and then received a telephone call from representatives of the product purchased. He felt pressured to provide his credit card number after an hour long conversation on the telephone. He tried calling his credit card company the next day to explain the situation, but the charges had already been incurred. And because he “provided his account number” the credit card company was not deeming this as financial abuse/theft. Joe was looking to me to help him with these charges.

Although I all too often work with seniors regarding scams, I did not have the best resource to offer Joe right away. Fortunately, however, it took me about 5 minutes and one email to a colleague who recommended that Joe speak to an attorney at the Coalition of Wisconsin Aging Group who works in their Elder Financial Empowerment Program. And because I was so quickly able to locate this service, Joe and his son were able to meet with this attorney on the very same day that Joe came to my office unannounced. It will still be an uphill battle for Joe regarding these charges, but he now has the needed guidance and expertise from this attorney.

This situation is just one example of the type of questions we as case managers are faced with, but it also demonstrates the circle of resources that we create and can offer to clients in such a timely manner.

** Name changed for confidentiality*

Bob's* contact with NESCO began when an outreach worker in the community referred him to our agency because he was homeless and in need of immediate help. Bob had worked for many years and was used to sustaining himself and living independently but had fallen on hard times and was also missing some important documents that would allow him to receive a social security benefit that he was entitled to. Through the help of NESCO, Bob was able to make the necessary contacts to retrieve his documents and started receiving social security. Once Bob had that income, he was able to look for housing so he could move off the streets and live independently once again.

** Name changed for confidentiality*

Bernie* resided in a two-bedroom apartment with his spouse. When his spouse's health concerns caused her to have to move into an area nursing home, Bernie struggled emotionally and financially, having lost half of the couple's shared income from Social Security and a small pension. As Bernie's case manager, I supported and advocated for him in working out a visiting schedule with staff at the nursing home; now Bernie schedules his life around when he can see his spouse. I also connected Bernie with Energy Services' financial assistance program for energy costs and got Bernie involved in the Home Instead Senior Care's Be A Santa to a Senior Program, through which Bernie was able to receive some much-needed care items during the holiday season. Recently Bernie contacted me, concerned that his Food Share benefit was not being deposited onto his Food Share card each month. Bernie had greatly depended on this benefit, using the funds deposited to purchase most of his food items for the month. I was able to follow up with the Dane County Department of Health and Human Services on Bernie's behalf, and found that his Food Share benefit had ended nine months ago due to Bernie's not having completed an annual review. Through my advocacy, Bernie was able to prove he had not received notification this review was required, and we argued Bernie's Food Share debit card should be reimbursed for the months in which he lost his benefit. I recently followed up with Bernie and found he is happily able to purchase the groceries he needs each month. Having the Food Share benefit allows Bernie to save money for the other expenses in his life, reducing his stress and freeing up more time that he can spend with his spouse. Bernie appreciates having a case manager who can look out for him and advocate for him when times get tough.

** Name changed for confidentiality*

As a case manager I often work with seniors that have long distance caregivers. Their immediate and extended family members live quite a distance away. For this reason, I am often called in to assist in facilitating as the primary caregivers have difficulty setting up resources from afar. I was given a referral exactly like this when I first started at NESCO over

one year ago. **Matt*** was referred to our agency as his family lived in another state. Matt suffered from a stroke and residually has difficulty with personal and home care activities. I was the "middle person" setting up a home health agency to continue on with Matt after the agency Medicare funded was through. I researched various county programs that could assist Matt in the long-term, yet due to his income of around \$2,100 per month and asset limit, he was not eligible. As a result, I have remained involved with Matt—conducting home visits as frequently as needed due to the worries the family has about his impairments. I have the flexibility and time to continue to check in with Matt and assess his needs on an ongoing basis at no cost to him. If it weren't for the case management program, it seems there would be little to offer Matt and his long distance caregivers.

** Name changed for confidentiality*

Dane County's case management program serves individuals 60 years of age and older. This particular story is shared as it demonstrates many of the issues our younger seniors face.

Sally* moved to Wisconsin about 2 years ago. Her friends from Wisconsin discovered that Sally was in a domestic violence situation and that her husband had left her. She was barely managing in her apartment alone and was relying on credit cards to live as she had no income of her own. She suffers from agoraphobia, anxiety, depression, and attention deficit disorder. Her friends moved her to Wisconsin and began paying for her apartment, utilities, medications, food, etc. This situation became financially stressful for her friends who became unable to keep up with their own bills.

Sally's friends were able to get her connected with an attorney to assist with divorce proceedings. This lawyer in turn made a referral to NESCO in January of this year. Since starting case management, Sally has been connected with Dane County Mental Health for ongoing support and treatment, Food Share in which she receives about \$100/month for food, Meals on Wheels in which she receives meals 7 days per week, Energy Assistance in which she received \$400 for her utility expenses, and Supportive Home Care for weekly housekeeping assistance.

NESCO also assisted in applying for disability for Sally to receive SSI to allow herself some income. Although her ex-husband has been court ordered to pay her maintenance, he has yet to do so. Sally is desperately needing income as her friends are becoming more and more delinquent in paying her bills and she received a letter from her landlord that not only stated her lease would not be renewed in October, but she was also given 5 days to pay her rent or be evicted. The case manager was able to speak to the landlord and received an extension. Just this past week, Sally was notified that she was approved for SSI and should receive her first check in the next 10 days.

Even though Sally will now have income, the need for NESCO's case management services is still there. NESCO will still need to help Sally locate permanent subsidized housing. Her first application for housing has been declined due to poor credit, thus I will now need to advocate on her behalf at an appeals meeting. Even after housing has been secured, Sally will most likely need continued support and advocacy due to her mental health issues. Fortunately, NESCO's case management program can provide that long term support.

** Name changed for confidentiality*

Susan* has been a case management client with the North/Eastside Senior Coalition for some time now. Recently, however; her needs began to change and she found it harder and harder to keep up with household chores in her home. Susan expressed these concerns with her case manager who worked with her on finding a solution so that she could keep her home clean but not physically hurt herself or become too exhausted by the task. Since Susan lives on such a limited income, her case manager screened her for in-home chore assistance funded through the county that provides home chore and personal care services to those who qualify. Susan was interested in the home chore aspect of the program, which would match her with a cleaning agency to assist with the household cleaning at no charge to her. Susan's income was low enough to qualify her for the program without having to pay a cost share for services. She is now enjoying services from a local cleaning agency. Since starting on the program, Susan has found more time to do things she enjoys. She has even begun attending a weekly senior exercise class at the Warner Park Community Recreation Center and eats lunch at the senior dining site afterwards.

** Name changed for confidentiality*

Jill* was referred to NESCO about six months ago. She was referred as she has severe depression with psychotic features. I initially connected her to the Mobile Outreach to Seniors Team (MOST) program and provided information on socialization activities. Due to Joan's unique situation, having no monthly income yet a significant amount in assets, she didn't qualify for any state programs. She was living off of an inheritance and a divorce settlement. She did not have health insurance and had over \$60,000 in medical bills due to numerous psychiatric hospitalizations. As her case manager, I contacted places where her medical bills were outstanding and arranged payment plans and/or signed her up for their financial assistance programs. Because Joan was severely depressed, one symptom was neglecting to pay her monthly bills. I contacted various places to work out an arrangement to get her caught up on her bills or cancel a service she did not need. Until she could find a rep payee, I guided her in how to pay her bills on time and make sure her accounts were in order. I was her authorized representative in applying for SSDI and she did start receiving this payment eventually. Joan had another psychiatric break when she was suicidal and for this reason she was finally accepted into a supportive group home for women with mental health issues. So that she wouldn't lose all of her assets while living in the group home, I assisted in getting her set up with an attorney to enter into the WisPACT program. This way her assets would be in a trust and she wouldn't have to spend her savings while living in the group home. Now that Joan is no longer living in her own home, I am no longer her case manager. Yet if she does leave the home after her depression stabilizes and she can safely live on her own, I will then be her case manager again.

** Name changed to protect confidentiality*

Bertha* was born in another country. She was widowed several years ago and now lives alone in the home she and her late husband owned. Although Bertha speaks a good deal of English, she prefers German and sometimes feels frustrated at having to read and communicate in English. She misses Germany and the way things were many years ago. Bertha does not drive and has a number of mental health concerns, including depression. She hoards items and her home is cluttered. All of these factors lead to feelings of depression, loneliness, and isolation for Bertha.

Bertha benefits from the simple support, interest, and check-ins I provide as her case manager. She receives a great deal of junk mail and her limited English skills make the mail confusing and frustrating. I have been assisting Bertha to read and understand her mail, and to discard and shred unwanted junk mail in NESCO's shredder. In addition, I help Bertha to work through any pertinent mail, paying bills, scheduling appointments, and arranging transportation for her to accomplish her goals.

I have also connected Bertha with Dane County Mental Health's Mobile Outreach to Seniors Team (MOST). Being able to reach out to a therapist has been greatly beneficial to Bertha.

Bertha benefits from NESCO's Home Chore program also: In the fall and winter, a volunteer assists Bertha with raking and shoveling her yard. We were fortunate enough to find a volunteer who speaks some German, and this language ability is greatly comforting to Bertha.

NESCO lead case manager Cortney Doescher-Hino is coordinating *Mind-2-Mind*, a new program which matches senior adult volunteers with other seniors struggling with mental health problems. The volunteers will provide much-needed social interaction and a listening ear to seniors who are isolated by mental illness. We were recently able to match Bertha with a wonderful, vibrant senior volunteer who will visit every few weeks to assist Bertha in reading her mail and be a friendly presence in her life.

Bertha is someone who has poor follow-through and really benefits from the encouragement and reminders I provide as a case manager. Bertha's volunteers, her MOST therapist, and I are some of the only people she interacts with on a regular basis, and the knowledge that we are "there for her," keeps Bertha going when times are tough or situations prove overwhelming.

* *Name changed to protect confidentiality*

As a case manager, many of our senior adult clients have complex issues that can be drawn out and take awhile to solve. Sometimes though there is a simple solution that can easily be

fixed! **Sarah*** is a longtime client of mine; she lives alone and is essentially homebound due to health concerns. She has many services to help her live independently—Meals on Wheels, Supportive Home Care, and Foodshare to name a few. During this past cold spell, I went to visit her to drop off a “Be a Santa to a Senior” gift. This program (sponsored by Home Instead Senior Care) provides holiday gifts to seniors that otherwise don’t have family and friends to provide this luxury to them. When I walked into Sarah’s apartment, it was freezing! I thought her heat was broken and I went on the offensive, ready to get this problem solved! Come to find out, two of her windows were cracked open at the top. These windows open on both ends and at some point they didn’t get locked into place properly, most likely during the warm days of summer. Due to her limited mobility, Sarah couldn’t shut the windows herself and had a message into the building maintenance person to assist. It can take awhile for them to respond as they are very, very busy too. It was negative degrees out so I went over to her windows and shut them into place and locked them securely. A simple solution indeed! As a case manager, more often than not there are convoluted issues that need to be addressed, yet in Sarah’s case once and awhile solving a problem that is a little “easier” is rewarding.

** Name changed to protect confidentiality*

Jim* gave NESCO a call on December 31st looking for some help. He is a 55 years old; he has cancer and is disabled. He needed assistance with transportation and although he is not qualified as a case management client (age 60 is the minimal age), I was still provided him with resources that were helpful. The gentleman was very appreciative, which made me feel great. I’ve also started working with another senior adult client who needs assistance with snow removal. I met with her at her home and discussed her needs; I suggested a home safety assessment be done. She explained that she has fallen several times and does not feel safe while moving around in her home. I am feeling very confident assisting our seniors here at NESCO and it has been an inspiring experience for me. It has increased my awareness to the needs of our aging seniors.

Andy* lives in his own home. He has no children and no family in the area; Andy has lived by himself since he was widowed several years ago. A neighbor friend of Andy's contacted NESCO to refer him for case management services. At the time of the referral, Andy's most pressing concern was his financial situation. Between his mobile home lot rent and food and utilities costs, Andy's monthly expenses were totaling just under his monthly Social Security Disability income; he was barely making ends meet. Another significant need was for Andy to acquire or prepare healthy meals. Andy shared that his late wife did most of the cooking when she was alive, and since her death Andy has struggled to prepare food on his own. The problem was compounded by Andy's precarious financial situation: he chose to purchase cheap, easy-to-prepare foods with low nutritional value. As Andy's case manager, I introduced him to NESCO's senior dining sites and he is now a regular visitor to the Warner Park Community Recreation Center dining site. I also shared knowledge of lunchtime Meals On Wheels for those days when Andy doesn't come to the dining site. I assessed Andy for Food Share and Energy Services and assisted him in applying for those programs. Andy has been found eligible and is awaiting news of his benefit amounts. He and I expect that his participation in both of these programs will help him to balance his budget and allow for some extra spending and saving money to protect him against unexpected expenses. Andy has also been connected with a Home Chore volunteer to assist him with snow shoveling this winter. Before Andy learned of NESCO's Home Chore program, he had been shoveling his own snow despite significant back injuries and mobility challenges. Now he is able to relax in the knowledge that a volunteer will support him in this task. Likewise, Andy knows that as he faces questions and concerns about staying independent, connected, and involved, he has his case manager to guide him.

** Name changed to protect confidentiality*

Mark* has Schizophrenia. He is high functioning yet still refuses to take medication to ease his symptoms. He was initially referred to NESCO to apply to a Medicare Savings Program. This worker also felt Mark would benefit from someone ongoing to check in with him due to his mental illness. When I first met with Mark, he was understandably very distrustful of a new person. She can only assist with housing issues and due to her high caseload could not provide more intense case management. Mark has been a case management client of mine since March 2009 and in that time usually stops into the NESCO office weekly. He will bring me mail that he receives and I am able to help decipher what is or isn't important. It has taken awhile for Mark to become more trusting of me, yet this is slowly happening over time. Due to NESCO having a Community Car membership (<http://www.communitycar.com>), I was able to take Mark to Social Security to replace a lost card. He seemed very thankful and having access to the Community Car is so helpful as a case manager. Since Mark is higher functioning, he chooses not to receive more mental health services, which is his right, yet having a NESCO case manager monitor him in a way is beneficial if this ever changes.

** Name changed to protect confidentiality*

A popular phrase right now within the senior community is “aging in place.” I truly feel NESCO’s case management program is an ideal resource for many seniors who have this goal.

Joe* started attending the Warner Park Community Recreation Center’s Senior Dining Site about 5 years ago as an AgeAdvantage employee. He was a very independent and private person and other than a tendency to shuffle his feet and a constant tremor in his hands, he was relatively healthy. Within 6 months, I was asked to work with Joe because it was discovered that he was sneaking food in NESCO’s employee break room daily and Joe admitted to not having much food in his home. I quickly assisted Joe in applying for Food Share and helped him become familiar and comfortable with using the local food pantries. And although Joe had an adequate monthly income, I determined that because of his hand tremors, Joe was not able to balance his checkbook or pay his bills on time. This often resulted in expensive late fees and overdraft charges. I was able to match Joe with a volunteer with Catholic Charities who visited monthly to help him not only pay bills on time, but actually helped him create a budget to allow him a savings account.

As the months progressed into years, Joe would faithfully attend the senior dining site Monday-Friday rain or shine. Even when he was no longer an AgeAdvantage employee, he continued to volunteer with NESCO daily and never faltered in his dedication to this position. It allowed me the opportunity to have daily contact with him and for me to learn of new needs quickly. When Joe was no longer able to drive, I was able to connect him with transportation resources. When he needed assistance with cleaning his home, I helped him enroll into the Volunteer Timebank where he was able to “buy” help with his own volunteer hours from the dining site. When he needed help reordering medications, he was matched with a volunteer who helped him on a monthly basis. Joe also became familiar with NESCO’s foot care clinics, Be a Santa to a Senior Program, Energy Assistance, and Farmers Market Vouchers. And although Joe’s personality was a little “rough around the edges,” in his final year of life he even began to enjoy NESCO’s social programming. He surprised us all when he attended our senior prom and summer concerts and participated in the dancing with a huge smile on his face.

To most people’s standards, Joe’s life was not one that people would think of as ideal. He was alone often and his home not kept up to the standards of most. But Joe was a “bachelor type” and liked things his way. I found myself defending his choices many times to others who called me concerned about him. Sadly, Joe’s health declined rapidly in the last 6 months. I began advocating to his medical team for assistance in trying to find out what was wrong. Eventually he became hospitalized and passed away during the 3-week stay at the hospital. I was so saddened to hear that it was being recommended for Joe not to return home, something Joe would not have been content with. But it gave me great joy to know that I was able to help him remain in his home for so many years, when all others were so quick to give up on him. As always, Joe was able to do things his own way and I was simply there to advocate for him.

** Name changed to protect confidentiality*

Rita* suffers from paranoia and anxiety. Her mental illness has caused isolation from her family and friends. She has a hard time trusting people and believes everyone thinks she is “crazy.” With her mental illness, she feels she is being stalked and watched. She desperately wants to move out of her home to get away from the stress her mental illness has caused her. As her case manager, I have helped her to set goals and attain them. She has already begun to reach her goals by packing and getting her home ready to sell. She has also agreed to meet with a mental health counselor to address and overcome her mental health concerns.

**Name changed for confidentiality*

I met **Martha*** this past winter when she moved into our service area (north/eastside of Madison). Martha has diabetes and was paying out of pocket for costly medications. She also had several outstanding medical bills from her visits with her doctor. Martha had suffered isolating experiences at the last senior apartment building she lived at and was hesitant to trust that I would be able to help her with anything. Martha has family that lives in the area but her daughter, who suffers from a host of health problems, was often unable to assist Martha with her affairs. As Martha’s case manager, I arranged Meals on Wheels for her as she was finding it difficult to cook for herself in her home. Thereafter Martha and I worked for several months trying to straighten out her medical bills and apply for a Medicare Savings Program to save her about \$100 per month. Besides saving money, she now has prescription drug insurance and is enrolled in a program that eliminates her co-pays at her doctor’s office. Martha feels more secure now knowing that her fixed income can stretch further each month because some of her medical costs have been reduced. While it took some time and patience for Martha to learn to open up and trust me, she now feels comfortable sharing with me and even decided to visit the NESCO senior dining site for lunch and bingo.

**Name changed for confidentiality*

My client **Bill*** suffers from depression and has been diagnosed with a cognitive disability. He is a hard worker and has done maintenance work for a long time.. He was recently evicted from his apartment for not paying his rent and had nowhere to go. As his case manager, I have helped him set goals and attain them. He currently lives in a new apartment with his fiancé, has a new job, and has begun to manage his finances better. He has also decided to meet with a mental health counselor to address and overcome his mental health concerns. My client is happy and thankful for my assistance.

**Name changed for confidentiality*

Matt* initially referred himself to inquire about transportation options. Upon further review, his finances revealed he was struggling with getting his basic needs met. He had a combined income of \$700 per month in Social Security and SSI and paid \$475 in rent. This left little for his other bills and necessities. I was able to look at his finances and determine where he could start saving money. The major hindrance to living more affordably was his housing expenses. The hope was to get Matt into subsidized housing, yet unfortunately his criminal history was preventing him from securing that. He was denied access to HUD sponsored affordable housing due to the nature of his crimes. Without going into more identifiable details, Matt is ineligible for subsidized housing. The search for suitable housing is something that we continue to work on together. Although the housing angle hasn't yet resolved itself, I have been successful in minimizing his expenses in other ways. Since he has Medicaid, he is eligible for free transportation to medical appointments. He was previously using the bus, so he now has one less expense. I signed him up for MOWs (Meals on Wheels) to reduce his food cost, in conjunction with his Foodshare, his groceries are now minimal. I signed him up for energy assistance, and he was awarded a sizeable grant through Energy Services. He uses Safelink wireless and now doesn't need his landline phone. His SSI was going to charge him an overpayment, which meant his SSI would be reduced monthly until this overpayment was paid off. If this were to occur, it would majorly impact his cost of living. I was able to file an appeal with Social Security to request the overpayment charge be waived. This way he wouldn't have less of an income each month. These little things have been successful in Matt's living expenses be reduced, in turn creating a more affordable way of life. Although our collaboration in finding affordable housing continues, having an advocate navigate other possibilities is key in Matt's housing search.

**Name changed for confidentiality*

Marvin* was referred to me for housing. Marvin lived in a one-room apartment on the third floor of an old house. He had numerous medical conditions that made it extremely difficult to use his home's stairs. For this reason, Marvin isolated himself in his room to prevent breathing difficulties from climbing stairs. Marvin had lived in this apartment for a long time; he was very attached to his space and had no interest in moving. He had everything he needed in his tiny room, and felt comfortable, safe, and secure. I met with Marvin for a few months, establishing a relationship and slowly brought in the idea of moving to more accessible housing. He continued to disagree with this need for change, until one day he had a pretty frightening scare to his health. He agreed to make the change and I was there with him every step of the way to reduce his anxiety of moving. He is now living in senior housing; although he is in a different Senior Focal Point service area now, I still get updates with how he is doing. I referred him to another coalition about one month ago and spoke with the case manager yesterday. She reported that every time she visits this senior housing complex, Marvin is downstairs in the Community Room, socializing with the residents. He appears to have a zest for life now, participating in many social activities and enjoying his new life.

**Name changed for confidentiality*

It occurs quite often that our senior adults are hospitalized and then require a short term rehab stay at a nursing facility post hospital discharge. And as long as they had a Medicare approved admission of three days at the hospital, Medicare will pay for the care at the

nursing facility. Thus, when my client **Alice*** was hospitalized for five days almost five months ago, I did not have any concerns about how her care would be paid for.

After a routine home visit with Alice in July, I discovered that she was receiving a costly invoice from the care facility. After much investigation, I was told that Alice's five day stay in the hospital was coded as "observation" and not a formal "admission," thus Medicare was not paying any portion of her care at the facility. Never have I had a client deemed "observation" for so many days and felt that this must be a coding error. Again, after much research, I was told that this is a new trend with hospitals and not a mistake. My client (who makes approximately \$800/month from social security) was still responsible for the \$6,000 nursing facility bill.

Fortunately because this particular client is so low income, we may have some assistance through the Medicaid program and/or community care assistance directly from the nursing home to waive a portion or all of her fees. But this situation has allowed me to share this information with other case managers to help advocate for their clients while they are still in the hospital to confirm their admission status.

Ironically, Alice was again recently hospitalized and is again being recommended to receive short term rehab. She was now educated to question the hospital as to what her status was and she was changed from observation to a formal admission.

**Name changed for confidentiality*

Pauline* lives on her own. She originally came to the North/Eastside Senior Coalition to learn about Food Share and food pantries. Grocery bills take up a large amount of her Social Security payment each month. However, after meeting her new case manager, it became apparent she also needed medical insurance. She has Medicare A but no Medicare B or D. She has medical bills and medications that she is paying for out of pocket. Hopefully, Pauline will get assistance with these costs through Capitol Care and Senior Care. If Pauline had not had a case manager, she would not have known these two programs exist. Also, Pauline's case manager assisted with completing a Food Share application and obtaining the names and locations of food pantries in the Madison area.

**Name changed for confidentiality*

A little over a year ago I began working with two new senior adult clients, a couple who had recently moved to the United States a year ago to with their daughter. (They are legal permanent residents of the United States.) Four years prior, the wife **Diana*** suffered a stroke in her home country and was left without the ability to speak and limited mobility on her right side. Diana received no therapy or recuperative care in that country after her stroke. I found it was extremely difficult to assess Diana's needs without being able to directly communicate with her. She desperately needed assistance with personal cares such as bathing and dressing as well as speech therapy. I was able to assess Diana for the home chore program and enroll her in the program after determining her eligible. She now receives weekly visits from a home health professional that assists her with her personal cares. Diana's most disheartening issue was her inability to speak. I spent many hours searching for any clinic or professional who might be willing to provide Diana with free or low cost speech therapy. Diana has no income and is ineligible for Medical Assistance until she completes five years of residency in the United States. I finally came across a program through that was able to take Diana on as a patient at a low cost. Diana now attends speech therapy twice a week and can feel good knowing she is working to improve her independence and ability to communicate with others. Diana can now communicate better with her family and even participates in NESCO's Latino Cultural Diversity Program. Working with a case manager to become connected to the programs mentioned above has improved Diana's quality of life and given her a reason to feel hopeful for her future.

**Name changed for confidentiality*

My client **Nancy*** has financially supported the North/Eastside Senior Coalition for years but had never utilized our case management services. Recently, Nancy found herself facing a health insurance dilemma and she called NESCO for some advice. Nancy's husband was laid off and after 20 years with the same health insurance, Nancy and her husband were stuck paying three times their normal premium for COBRA coverage. Knowing that the COBRA coverage would eventually end, or become economically impossible for them to maintain, Nancy wanted to explore what options she had for a supplemental insurance policy to Medicare. Being that her drug coverage was going to end as well, we needed to find Nancy a suitable Medicare Part D plan. Nancy does not drive and was concerned that she would have to start going to a clinic further away instead of the clinic just a few miles from her home. After numerous meetings, Nancy enrolled in a supplemental Medicare plan that would allow her to continue seeing her regular doctor at her regular clinic. Also, Nancy was able to find an affordable Prescription drug plan that would send the medications to her home so she wouldn't have to depend on family members who drive to get her medications on time. Nancy told me she, "could not have done it alone!" and is very appreciative of the help I was able to offer as a case manager.

**Name changed for confidentiality*

***Bob** had difficulty reading and understanding his mail. His vision was impaired due to health challenges. This mail included important information concerning Medicare and Part D plans. Bob would soon turn 65 and qualify for Medicare, Medicare Part D prescription plans, and SSI. At our initial meeting, we began discussing the steps required to start the application process. I helped him go through his mail and discovered scam mail requesting personal Medicare information; I was able to inform Bob about this before he responded to the scam. I ultimately assisted him with applying for Medicare, Senior Care, and insurance through Medigap. We also discussed groups and programs he could attend at NESCO.

**Name changed for confidentiality*