

CHOICES. CONNECTIONS. COMMUNITIES.



FY19 Annual Report

A private, nonprofit organization with more than 36 years of experience. We provide case management and available resources to the individuals we serve.

ServiceCoord.org



A MESSAGE FROM OUR CEO

For more than 36 years, Service Coordination, Inc. (SCI) has supported the choices of people requiring our case management services and worked to identify available resources. We began as one of the nation's first independent case management provider agencies serving people with intellectual and developmental disabilities and have since expanded our services and offerings to children, families, older adults and veterans.

Choice has always been the foundation of our case management and other related services, and we believe that services should be tailored to meet the desires of people and their choices. As a non-profit case management agency, SCI does not operate to earn a profit, but rather to support community members in need of our services and to fulfill our mission of providing the highest quality Case Management services.

SCI is governed by a Board of Directors consisting of a volunteer group of community members. Each Board member brings the integral skills and passion required to oversee our organization and ensure that we adhere to our Mission and commitment to our community. Our team members work directly alongside the people we serve. On average, our team members have seven years' experience and are highly educated. They are part of a mobile workforce that can perform their work from anywhere in their communities, thus providing greater convenience, accessibility, and flexibility in our services.

In order to continuously evolve and continue to provide the highest quality services, we recently had the opportunity to review and update our Strategic Plan. We examined the internal and external environment of the organization and updated the mission, vision, and values that guide the organization. SCI's FY20-25 Outcomes are Quality Customer Services, Team Member Development, and Organizational Development. These include seven driving strategies with accompanying goals and objectives, each with action steps that will steer our organization over the next several years. This plan serves as a management tool for SCI's Board of Directors and team members as we work together to advance the organization's mission. Successful implementation of this strategic plan requires a commitment to shared leadership between the Board of Directors, the CEO, and all Team Members of SCI.

With our new Strategic Plan and Standards for Excellence Accreditation, with commendations, SCI is in a pivotal position to continue to offer the highest quality services, consistently evolving to meet the needs of those we serve.



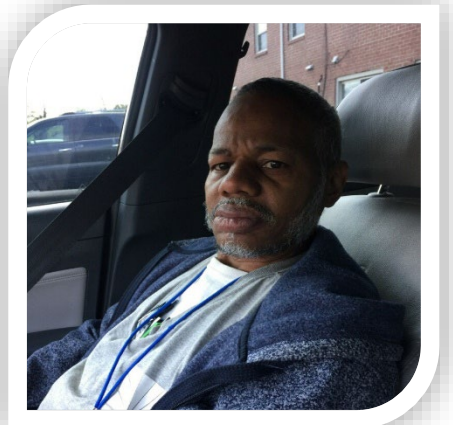
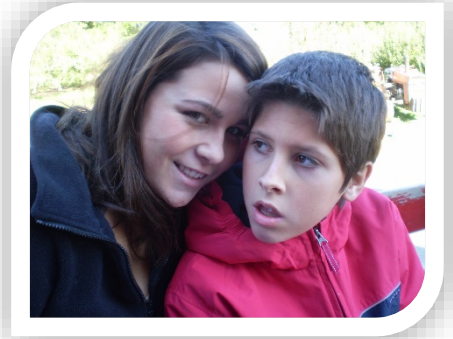
A handwritten signature in blue ink, appearing to read 'John Dumas'. The signature is fluid and stylized, with a large initial 'J' and 'D'.

- John Dumas, CEO



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ABOUT US

OUR BACKGROUND

In 1982, The Arc of Frederick County established one of the nation's first independent service coordination initiatives serving people. The service coordination division was founded on the belief that people with disabilities could benefit from having service coordinators act as brokers within the service delivery system to help ensure that services were tailored to meet people's needs.

The initiative began with seven service coordinators who served 173 people. In the 36 plus years since the initiative was created, the service coordination division expanded into 14 counties across Maryland and Baltimore City.

In 2005, Service Coordination, Inc. (SCI) was established as an independent, nonprofit organization and spun off from the Arc of Frederick County. The spinoff was necessary due to the tremendous growth the agency experienced and the need to have one organization focused on providing service coordination for so many people. SCI formed a new board of directors, adopted new bylaws, and began operations as an independent organization on January 1, 2006.

SCI preserved the skilled staff leadership, the staff of service coordinators, an effective approach to coordinating services, the relationship with the DDA, and the founding belief about the role and value of service coordination for people with intellectual and developmental disabilities.

OUR ROLE IN THE COMMUNITY

SCI is a nonprofit organization in Maryland that supports people of all ages to make choices affecting their lives and to access resources and services in their community.

SCI has been providing quality case management services since 1982. We began as one of the nation's first independent case management initiatives serving older adults, those with disabilities, those with mental health diagnoses, those with medically complex needs, and others. We believed then, and maintain our belief now, that services should be tailored to meet the preferences of the individual.

SCI is currently the largest case management agency in Maryland, serving more than 13,350 people. We also employ over 410 Case Managers in three regions in Maryland. Team Members are highly qualified with 95% having a bachelor's degree or higher and on average seven years' experience, and 27% have master's degrees. SCI is also unique due to our community based and technological capabilities which allow us to work from anywhere in the community.

SCI continues to reduce the "ratio" of case managers to individuals by increasing its staffing levels. In FY2017, each Case Manager served an average of 43.46 people. SCI reduced that number to 35 and plans to further reduce the number in FY2020.



SCI is a nonprofit organization governed by our Board of Directors:

BOARD MEMBERS:

Carl Hildebrand, Past President
 Teresa Berman, President
 Michelle Wright, Vice President
 William Stack, Treasurer
 Paula Blue, Secretary
 John Halley, Director
 Marlene Hendler, Director
 Alan Kampf, Director
 Eric Zimmerman, Director
 Vladimir Gorny, Director
 Jody Luttrell
 Shonyel Lyons

AREAS OF EXPERTISE:

Financial
 Legal, Healthcare
 Advocacy *
 Financial
 Veteran, Advocacy *
 Financial
 Self-Advocacy
 Financial
 Self-Advocacy
 Risk Management
 Case Management
 Financial

* Family member of individual supported by SCI.

OUR MISSION

Service Coordination, Inc. provides quality case management and other related services by helping people understand what their choices are and connecting them to resources in their communities in ways that respect their dignity and rights.

MEANING BEHIND THE MISSION

Choices, Connections and Communities: We welcome all people who can benefit from our services. We help people understand options in a dignified and respectful way. We provide quality information and helpful options that can guide people to resources of their choice, ultimately supporting their decisions to connect to available services.

2026 VISION

People experience the quality of life they choose. They are connected to an array of quality supports and services that are tailored to each of their unique wants and needs. People are valued in and by their communities.

CORE OPERATING VALUES

Our core operating values guide the way in which our board members, team members, and volunteers want the community to experience our organization. We want to be known as resourceful, educated, and respectful. We want to demonstrate daily excellence by embracing and living out these core operating values in the way we work.

- **People come first** – Show respect and honor for ALL people in words and actions.
- **We drive solutions** – Persistently seek opportunities and overcome obstacles. Navigate systems masterfully to make possibilities a reality.
- **We build connections** – Because relationships are the foundation of our work, we share strong working relationships with each other and with those outside our organization.
- **We educate** – Raise awareness in communities to appreciate the similarities and unique gifts of each person. Explore choices with people we support.



CORE COMPETENCIES

RELATIONSHIPS - At SCI we operate with an understanding that it is primarily through effective relationships that we are able to achieve positive change on the individual and systems levels.

NAVIGATIONAL EXPERTISE - At SCI we listen closely to people telling us their dreams and goals. With that knowledge and our expertise, we provide resources, connections and linkages to make dreams a reality.

THEORY OF ACTION

The following principles and beliefs guide the development of our programs and operations:

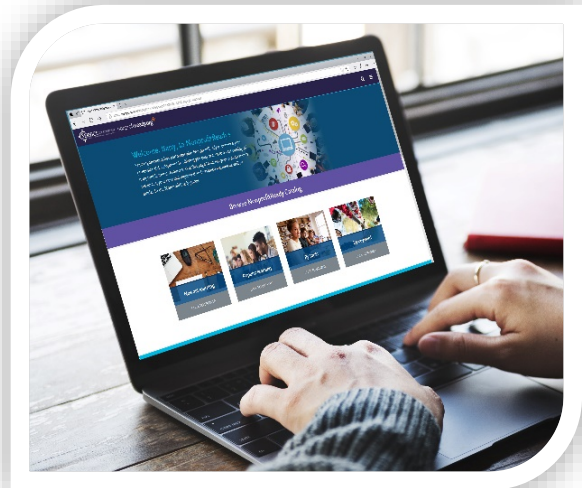
- It takes great expertise to find resources and to connect people to them. Success results from the quality of abundant creativity and resourcefulness.
- Positive working relationships reflect the commitment that we have to each other, the organization, and the people we support. Solid relationships are built upon trust and mutual respect.
- As a mobile workforce based in the communities of the people we serve, we focus our abilities to affect positive change in systems and within communities.
- All people should be able to make choices that affect their life. Our role is to help people discover and explore possibilities, weighing the value of all available options.
- With an increased understanding of people with differences comes appreciation of the value all people bring to their communities.
- As a strength-based, person-centered organization, we engage the people we support, their families, our staff, and others in making decisions, developing processes, and creating the structures that support the highest quality case management services.

TEAM TRAINING & RESOURCES

SCI understands the impact and importance of supporting the learning and growth of all team members. Continuing our effort to support and retain qualified, engaged, and productive team members, SCI has added a Training Manager to the HR team.

Our training team delivers New Team Member Training and on-going professional development through our in-house Training Specialists and our partnerships with online providers NonprofitReady.org and Open Future Learning. NonprofitReady.org is an online learning platform that offers customized curriculum and free training to support career and professional development for nonprofit staff. With Open Future Learning, we prepare our team members in the DDA Program to better support the people they serve covering a broad range of subject areas while remaining dedicated to the field of intellectual disabilities.

The SCI Training Team is working with the University of Baltimore to lay the groundwork for the Service Coordination University (SCU), a state-of-the-art quality training and development program to maximize workforce service quality and to provide career development opportunities for all team members. The SCU will provide instructor led and self-directed learning opportunities and career management for all team members.



NonprofitReady.org leverages Cornerstone OnDemand's state-of-the-art learning technology to create an online career development tool that provides free training to nonprofit staff and volunteers with access to a collection of e-learning and other training resources. The Cornerstone OnDemand Foundation established NonprofitReady.org to address the critical need for professional development in the nonprofit world.

STANDARDS FOR EXCELLENCE ACCREDITATION

The Standards for Excellence Institute® promotes “the highest standards of ethics, effectiveness, and accountability in nonprofit governance, management, and operations.” The foundation of this program is the published Standards for Excellence®: An Ethics and Accountability Code for the Nonprofit Sector. Six (6) major areas of nonprofit governance and management are identified which contain twenty-seven (27) different topic areas. Each topic area includes specific benchmarks and measures that provide a structured approach to building capacity, accountability, and sustainability in organizations. The 6 major areas are:



1. Mission, Strategy, and Evaluation
2. Leadership, Board, Staff, and Volunteers
3. Legal Compliance and Ethics
4. Finance and Operations
5. Resource Development
6. Public Awareness, Engagement, and Advocacy

SCI was evaluated on fundamental values such as honesty, integrity, fairness, respect, trust, responsibility, and accountability. Our programs and services, management, fundraising, and financial practices were subject to in-depth examinations by the Standards for Excellence Institute® culminating in our Final Accreditation with commendations for our Program Evaluation and Quality Monitoring system, including the Comprehensive Quality Review (CQR) process, resulting in our Accreditation in 2017.

As stated by our Executive Director/CEO, John Dumas, “This Seal of Excellence confirms the organization’s well-defined mission and adherence to the highest level of quality.”

2019: THE YEAR IN REVIEW

DEVELOPMENT & NEW VENTURES

SCI continues to grow in several key areas. The number of people we support now totals more than 13,350. To meet this demand, we have scaled our workforce accordingly and now have over 450 team members. The result allowed SCI to lower ratios of case managers to individuals, which equates to more time to spend with people and higher quality service.

In September 2017, SCI expanded DDA Case Management services into the Southern Region of Maryland to the counties of Montgomery, Prince George's County, Calvert, Charles and St. Mary's. SCI is now serving approximately 200 people in this region with 5 designated Service Coordinator positions and 1 Supervising Service Coordinator position.

The Supports Planning Services (SPS) program, which started at the end of FY2017, continued to grow and served over 1,240 individuals in FY2019. Program development focused on adequate staffing to meet the needs of those served and ensuring quality compliance and business sustainability.

SCI, in collaboration with a variety of crucial stakeholders and veterans' community organizations, continues development of a pilot program that will provide veterans in need of resources case management services in the Frederick County area. Our current Veterans Case Manager continues to provide comprehensive case management to approximately 15-20 veterans in the Frederick area. New referrals are received from connections made in working with community providers of services to veterans. Current services provided include development and monitoring of a comprehensive, person-centered plan, referrals and resources for crisis services, assistance with affordable housing, peer support and mentoring services, collaboration with discharge teams from local VA hospitals, and assistance with navigating benefits and other entitlements. Members of the internal committee continue to work toward making connections with crucial stakeholders, such as the Veterans Administration (VA), with the intention of developing an advisory group to assist the organization with further development of the program.

Planning continues to develop a program that offers private pay care management and homecare services to older adults, which enables them to live at home safely and securely while enhancing their quality of life and overall well-being. Care Managers assist older adults to navigate and obtain needed resources, including financial, medical, assistive technology, advocacy, housing, and legal services. Homecare supplements care management by providing non-medical in-home and community-based direct supports, ranging from companionship to assistance with activities of daily living. Care management for the Older Adults Program is anticipated to launch in Montgomery County by the end of FY2020, followed by homecare in FY2021.

COLLABORATION WITH KEY STAKEHOLDERS

SCI, as a provider for both Coordination of Community Services (CCS) and Supports Planning Services (SPS), was invited to collaborate with the Maryland Department of Health and other agencies that provide both services. The purpose of the collaboration was to determine what information would be beneficial for the Developmental Disabilities Administration (DDA) to know about SPS to ensure that people served by both agencies get the most appropriate services.

National Leadership Consortium: Allan Sheahen presented on Positive Leadership at the National Leadership Consortium on Developmental Disabilities. Participants included members of DDA and representatives of CCS organizations from around the state.

Maryland Association of Community Services (MACS) Direct Support & Supervision Conference: Allan Sheahen and Tenneille Aleshire had the opportunity to present at this conference on the topic of Person-Centered Planning. The participants were engaged and the feedback from the session was very positive. This was a wonderful opportunity to collaborate with provider organizations and more specifically the Direct Support Professionals (DSP's) who are the foundation of DDA services and supports.



DDA Training Workgroup: The DDA announced the award of the Targeted Case Management Training request for proposal (RFP) contract to the Columbus Organization. The goal of this contract was to create, establish, and implement state-wide, competency-based training standards for the CCS's. The DDA established a workgroup to collaborate with the Columbus Organization to develop 13 training modules that will eventually be included in a packaged, approved certification for CCS agencies. Kristina Logan represented SCI on this workgroup.

January Howard County Legislative Breakfast: Tracey Mack and Marc Weinstein presented at this year's Howard County Legislative breakfast highlighting housing and transportation needs. Christine Towne discussed Supported Employment Services she receives from The Arc of Howard. This was a great partnership with The Arc of Howard County and the Howard County Autism Society.

DDA Transformational Committee: The DDA has initiated a committee with the purpose of identifying systems-wide concerns in order to better understand the drivers and explore solutions. Allan Sheahen is the representative for SCI as well as the Coalition of Community Coordinators (CCC). Other members include DDA leadership and members of the Developmental Disabilities (DD) Coalition. The committee meets monthly and is facilitated by Mary Sowers with the National Association of State Directors of Developmental Disabilities Services (NASDDDS).

The National Leadership Consortium on Developmental Disabilities: Several Program Managers with the DDA program participated in a week-long training with the National Leadership Consortium on Developmental Disabilities through the Maryland Leadership Institute. The Maryland Leadership Institute was designed to incorporate person-centered strategies from the broader systems approach to services and supports to develop individualized plans that address specific challenges facing each organization as the DDA transformation unfolds.

Employment First State Leadership Team: The DDA established workgroups to address specific components needed to make Employment First a reality for all Marylanders with Intellectual and Developmental Disabilities (I/DD). The workgroups have worked through the past year to create outcomes and goals. Allan Sheahen represents SCI and the Coalition of Community Coordinators (CCC) on this group.

Developmental Disabilities Day at the Legislature: SCI team members attended Developmental Disabilities Day (DD Day) at the Legislature in Annapolis on Feb 13th. DD Day is an annual event where citizens have a chance to rally and meet with their elected officials to encourage passage of bills that affect the disability community.

Maryland Association of Community Services (MACS) Providers Legislative Breakfast: Several leaders from SCI attended this event on January 17, 2019 in Annapolis. During this event, MACS members had the opportunity to connect with new and returning legislators over breakfast and coffee. The morning also included legislative and budget updates on issues impacting the I/DD community.

MACS Annual Achievement Awards: Team Members of SCI attended the MACS Annual Achievement Awards along with SCI nominee Melvin "Mel" Riebe, Jr. for his achievement of bringing awareness of epilepsy to the public. He enjoys helping others and is particularly passionate about sharing his knowledge of epilepsy.

MACS Volunteer Recognition: SCI recognized Marlene Hendler for her tremendous volunteer work. Marlene has served on the SCI Board of Directors for the past 5 years and is part of the Steering Committee which reviews policies to ensure they meet guidelines and are compliant.

Marlene is very involved in the Citizens Advisory Committee for Accessible Transportation, serving as the Co-Chair of the committee. This committee works with the Mass Transit Administration (MTA) and presents ideas for future planning. The committee also monitors the quality of MTA services, promotes policies in support of accessible transportation, and provides training for MTA drivers. As part of the Transit and Pedestrian Advisory Group of the Regional Transportation Agency (RTA), Marlene has been working to improve the services that RTA is offering with the routes in Howard County and was recently featured in the RTA booklet. In addition, Marlene is a member of the Consumers for Accessible Ride Services (CARS) Committee for Disability Rights Maryland and makes recommendations to the Maryland Transportation Authority (MTA) to solve issues with mobility. CARS meet with the MTA on a quarterly basis.



QUALITY

SCI employs a Comprehensive Quality Review (CQR) process which includes verification of documented activities for at least one individual per Case Manager per month; a thorough review of the notes content and quality, and a thorough review of that individual's record, person-centered plan, monitoring, and services received for the last full quarter. Individuals are selected for review as part of a random sample stratified by a Case Manager. This sampling methodology ensures the results of the year's CQR can be generalized to the total population of individuals served with a confidence level >98% and a <2.5% margin of error. Throughout the year, our CQR supported the review of over 3,100 records, and the survey of more than 400 people we support. Through the CQR, supervisors are required to review all aspects of a Service Coordinator's (SC's) work on a regular basis to ensure that team members are well trained in all job responsibilities and are delivering services that are of very high quality. People we support, their families, and providers are contacted to verify the SC's work and to learn what we are doing well and what areas we could improve on. Through this two-pronged approach, supervisors provide support, guidance, and instruction to staff reinforcing strengths and identifying areas in need of improvement in both the technical and personal aspects of their work. The CQR assesses the overall quality of the CCS service provision and the nature of the SC's work with people, including but not limited to self-direction, person centeredness, and implementation of SCI procedures. This broad assessment of quality is accomplished through the following review components:

- Customer Satisfaction Survey
- Visit Verification
- Person-Centered Plan Review
- Monitoring Review
- Data Integrity and Progress Notes Review
- Service Coordinator Competencies Review
- Regulatory Compliance

In a previous fiscal year, people we support told us the top three areas that are most important to them are responsiveness, being connected to resources, and knowing me. To better measure how we are doing in these most important areas, the CQR satisfaction survey was revised during FY2018. Since the revision, people we support have indicated:

RESPONSIVENESS

- 92% of people we support receive a response to their phone call or email within three business days; more than 76% are within one business day.
- Case Managers do what they said they would do on time or well ahead of time for more than 90% of people we support.

BEING CONNECTED TO RESOURCES

- Over 90% of people we support say they are connected to all the services and supports they need.
- Almost 90% of people we support say their case manager tells them about or connects them to resources as often or somewhat as often as they'd like.

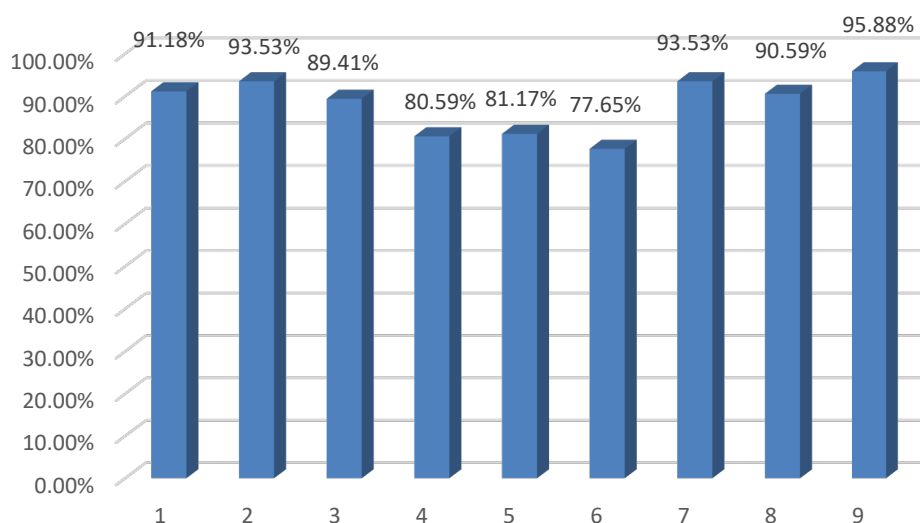
KNOWING ME

- Nearly 90% of people we support say their case manager knows what makes them happy and unhappy.
- Nearly 95% of people we support agree or strongly agree their case manager treats them the way they want to be treated.



Driving solutions and developing strong relationships leads to high measures of customer loyalty. One widely accepted measure of customer loyalty across many industries is the Net Promoter Score[®] (NPS). On a scale from -100 to +100, SCI's NPS for FY2019 among people we support, their families, and guardians is +61 compared to an industry benchmark of +37, and a "high engagement" standard of +50. This is consistent with FY2018 performance and indicates continued and extremely high engagement and loyalty among those we directly support. In addition, nearly 96% of people surveyed in FY2019 said they want to continue working with their case manager.

Our focus on continual quality enhancement yielded improvements to an already strong program, demonstrated by high levels of satisfaction among the people we support:



1. Agreed or strongly agreed their SC supports their choices about who provides their services.
2. Agreed or strongly agreed their SC listens to their ideas and makes changes based on what they say.
3. Agreed or strongly agreed their SC helps them get what they need/what is important to them.
4. Agreed or strongly agreed their SC helps them and their team think about job options.
5. Agreed or strongly agreed their SC supports them with developing relationships with people in their community (family, friends, neighbors, vendors, community leaders, church).
6. Agreed or strongly agreed their SC helps them if there are things about their living situation that they would change (like roommates, privacy, locks, food, clothing, furnishings, decorations, freedom to come/go, access to phone, computers, visitors, where I live, etc.).
7. Agreed or strongly agreed they are comfortable telling their SC if they have a problem or concern.
8. Agreed or strongly agreed their SC makes a difference in their life.
9. Agreed or strongly agreed they want to keep working with their current SC.

The DDA transitioned all SC documentation to their own database system called Long Term Supports and Services (LTSS). The transition to the LTSS system has impacted SCI's ability to plan and accurately measure compliance. Review of data and reports available in LTSS have revealed areas of under-reported information. During FY2019, visit compliance for people receiving community coordination was at least 80.7%, at least 76.2% for people on the waiting list- crisis resolution priority, at least 71.95% for people on the waiting list- crisis prevention priority, and at least 72.1% for people on the waiting list- current request priority. Since the implementation of LTSS, nearly 60% of required Person-Centered Plans (PCP) have been completed in the LTSS system. There is a known technical issue with LTSS that prevents some PCP's from being entered in LTSS. In those cases, the SC completes a paper version of the PCP for distribution to planning teams.

MOBILITY & TECHNOLOGY

SCI continues the endeavor to better serve the people who count on us for case management with our mobile program. Our team members are equipped with technology and training to perform their duties at places that may better meet the needs of those receiving our services. Our services have since become more flexible and more accessible to people we support. Although we retained two regional offices located in Frederick and Owings Mills, Maryland, our team members are able to perform most of their work anywhere.

Our mobility allows our team members to work directly in the community without the need to travel back to an office. Because this work can now be done directly and immediately, our mobility allows us more time to spend in the community with people we serve and to be more accessible to them.

SERVICE COORDINATION'S STANDING COMMITTEE

The dedicated members of SCI's Standing Committee have provided an unbiased review of organizational practices this year to include review of, and feedback for, our submission and handling of incident reports, as well as our QA quarterly reports.

Over the years, much effort and careful consideration has been put into the safety and well-being of every person who has required the completion of an incident report due to the occurrence of a reportable incident. Committee members request prompt follow-up action when needed and provide SC's with recommendations that may prevent future occurrence. Through the receipt of the annual Standing Committee training, they have been able to better implement their role, which is an asset to our organization and the people we support.

Marlene Hendler
Willie Fields
Sapna Nagabhushan

Special thanks to each of our Standing Committee members, as well as the leadership and direction of SCI's facilitators, and our team members Nicholas Zais and Vanessa Blackner.

5 FAST FACTS ABOUT SCI

1. Provides case management services to more than **13,350** people residing across the state of Maryland.
2. Has more than **36 YEARS** of experience providing case management services.
3. Is a 501(c)3 **nonprofit organization**, governed by a volunteer Board of Directors.
4. Operates with shared leadership and person-centered service delivery models and tailors all services according to an individual's specific wants and needs.
5. SCI is proudly accredited by the Standards for Excellence Institute® as having met all the requirements of the *Standards for Excellence®; An Ethics and Accountability Code for the Nonprofit Sector*.

STATEMENT OF FINANCIAL POSITION & ACTIVITIES

STATEMENT OF FINANCIAL POSITION		
ASSETS	FY19	FY18
Current Assets	\$5,098,619	\$3,701,151
Property and Equipment (net)	514,872	748,439
Other	365,426	376,121
Total Assets	5,978,917	4,825,711

LIABILITIES AND NET ASSETS	FY19	FY18
Total Liabilities	3,459,288	3,267,827
Net Assets		
Temporarily restricted	0	3,434
Unrestricted	2,519,628	1,554,450
Total Net Assets	2,519,628	1,557,884
TOTAL LIABILITIES & NET ASSETS	5,978,916	4,825,711

STATEMENT OF FINANCIAL ACTIVITIES		
REVENUE	FY19	FY18
Total Revenue	36,657,813	31,479,248
EXPENSES		
Program expenses	30,833,018	28,823,508
Administrative expenses	2,315,026	2,180,274
Total Expenses	33,148,044	31,003,782

Net assets at beginning of year	1,557,884	1,082,418
Net assets at end of year	2,519,628	1,557,884
Change in Net Assets	\$961,744	\$475,466

OUR SERVICES

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

CASE MANAGEMENT

We provide quality case management services to people residing in the Southern, Central, and Western Regions of Maryland. These services, referred to as coordination of community services or service coordination, are provided to people with intellectual and/or developmental disabilities across their lifespan, including but not limited to:

- People with a traumatic brain injury
- People with court or forensic involvement
- People with a co-occurring mental health diagnosis
- Youth transitioning from school
- Those with autism
- People transitioning from state hospitals, state residential centers, and nursing homes



SERVICE CATEGORIES

SCI provides case management services for people in a variety of situations or Service Delivery Categories:

Waiting List

SCI provides support to people on the DDA Waiting List. The DDA Waiting List is comprised of adults and children with intellectual and developmental disabilities who are waiting for funding from DDA to obtain community-based services. Waiting List includes services to youth and their families as they transition from school into adulthood. Waiting List categories include:

CRISIS RESOLUTION: The highest priority level is reserved for people in emergent circumstances who require immediate intervention or will require it shortly. Often, the situations that meet this category's criteria arise suddenly (e.g., the death of a caregiver). Crisis Resolution is for people who are:

- Homeless or will be homeless within 30 days
- Victims of abuse or neglect
- At a serious risk of causing physical harm to others
- Living with a caregiver who is unable to provide adequate care due to the caregiver's impaired health

CRISIS PREVENTION: This category is for people with an urgent need who are in deteriorating circumstances that put them in danger of meeting one or more Crisis Resolution criteria within 1 year. Crisis Prevention priority also includes people who have caregivers over age 65. Because age alone is not always a good predictor of the need for services, priority recommendations and determinations should address risk for the Crisis Resolution category within a year when that is the case, as well as the age of the caregiver. The Crisis Prevention category is also appropriate in situations where less intense intervention or support, provided sooner, might delay or eliminate the need for a more extensive service in the future.

CURRENT REQUEST: The Current Request priority is the lowest level of priorities. There are no crisis implications associated with Current Request, however, there is an expectation that the individual has an actual need for DDA funding. The test for this category is "Would the person take the service today, if it was offered today, or is there an anticipated event within the next three years, such as exiting school, retirement of caregiver, aging out of children's residential placements?" This category is not for people who simply want to be identified for planning purposes as potential service recipients.

Community Coordination

SCI provides person-centered case management to coordinate community services to match an individual's wants and needs. Some of these include employment, housing, recreation, community involvement, and more.

Comprehensive Assessment

Comprehensive assessments are completed for DDA to make a determination about an individual's eligibility for DDA services.

Transition Service

SCI provides services to people transitioning to the community from state hospitals, state residential centers, correctional facilities, and nursing homes.

SUPPORTS PLANNING SERVICES (SPS)

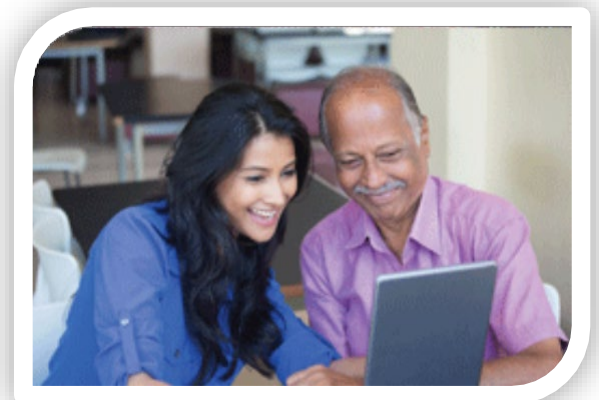
Supports Planning Services includes assisting those with activity of daily living needs with accessing and receiving Medicaid and non-Medicaid funded home and community-based services and supports, as part of Maryland Department of Health's Long-Term Services and Supports (LTSS).

REGIONS AND COUNTIES SERVED

Western Region - Allegany, Carroll, Frederick, Garrett, Howard, Montgomery and Washington Counties

Northern Region - Baltimore City, Baltimore, and Harford Counties

Southern Region - Anne Arundel, Calvert, Charles, Prince George's, and St. Mary's Counties.



SPS PROGRAMS SERVED

Community Personal Assistance Services (CPAS) program:

- Personal Assistance Services
- Nurse Monitoring
- Supports Planning

Community First Choice (CFC):

- Personal Assistance Services
- Nurse Monitoring
- Supports Planning
- Personal Emergency Back-up Systems
- Transition Services
- Consumer Training
- Home Delivered Meals
- Assistive Technology
- Accessibility Adaptations
- Environmental Assessments

Community Options (CO) Waiver and Increased Community Services (ICS):

- Personal Assistance Services
- Nurse Monitoring
- Supports Planning
- Personal Emergency Back-up Systems
- Transition Services
- Consumer Training
- Home Delivered Meals
- Assistive Technology
- Accessibility Adaptations
- Environmental Assessments
- Medical Day Care
- Nutritionist/Dietician
- Family Training
- Behavioral Consultation
- Assisted Living
- Senior Center Plus

This year SCI's Supports Planning Services program development focused on improvement of two main areas: Quality Compliance and Person-Centered Activity.

QUALITY COMPLIANCE

On June 5, 2018, Maryland Department of Health conducted an initial audit of our SPS Program. The purpose of the audit was to determine SCI's compliance with the 2017 Provider Solicitation for Comprehensive Case Management and Supports Planning Services for Medicaid Long-Term Services and Supports. The audit period was March 17, 2017 to December 31, 2017. The outcome of the audit showed that SCI was 72% compliant with the Solicitation Requirements. For the purposes of this audit, 86% and above is considered a compliant score, therefore SCI was found to be out of compliance.

Thirteen deficiencies were found:

1. Submit of Quarterly Conflict Report
2. Completion of Monthly Monitoring Forms
3. Completion of Initial Visit within 14 days
4. Contact LHD for Late InterRAI Assessment
5. Contact MDH for Late InterRAI Assessment
6. Completion of Community Setting Questionnaire
7. Obtain Plan of Service Signatures
8. Submit Plan of Service within 20 days of InterRAI Completion
9. Make Direct Contact with Participants Monthly
10. Meet In-person with Participants Every 90 Days
11. Completion of Monthly Monitoring Forms
12. Ensure Approval of Annual Plans of Service
13. Submit Weekly Billing Audits



As a result of the audit, the following actions were taken:

1. Review and revision of SPS Procedures.
2. Re-education of Supports Planners.
3. Development and implementation of SP Tracking Tool, which tracked Solicitation due dates.
4. Development and implementation of the Quality Improvement Plan which required monthly audits of the 13 deficiencies.
5. Routine monitoring and modification of processes.

An improvement in the average monthly Quality Compliance percentage was seen through the year as indicated below in the graph. It reflects the monthly results of the Quality Improvement Plan audit.



PERSON-CENTERED ACTIVITY

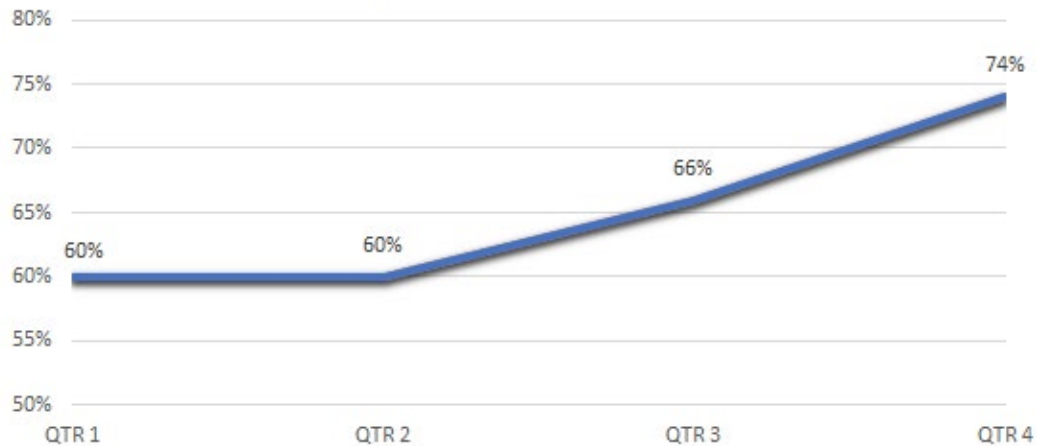
Supports Planners are responsible for providing quality person-centered case management services to the people they serve and should be spending the majority of their work time doing so. Performance Utilization measures the amount of a Supports Planner's work time that is spent providing person-centered activities.

To increase Performance Utilization, the following actions were taken:

1. Review and revision of associated SPS Procedures.
2. Re-education of Supports Planners and Supervisor led coaching.
3. Development and implementation of SP Activity Logs and Performance Utilization Reports.
4. Development and implementation of Incentive and Bonus Programs.
5. Routine monitoring and modification of processes.

This process includes steps for both Supervisors and Support Planners that supported consistency and progress across the program with a significant steady increase in average Performance Utilization percentage throughout the year as indicated below in the graph.

Average Performance Utilization



VETERANS SERVICES

Service Coordination, Inc. (SCI) provides case management, person-centered planning, and wrap-around services related to housing, employment, relationships, financial management, treatment and health monitoring, and recreation. With core competencies in relationship building and navigational expertise, the Case Manager develops meaningful connections with the Veterans Administration, community service providers, community-based businesses, veteran service organizations, and interested supporters of veterans to ensure each veteran has the support needed to be successful.

SCI provides connections to resources and services:

- Home Care
- Housing support/own or rent
- Health management connections and follow-up
- Peer support/social connections
- Crisis prevention and resolution
- Follow-up for discharge from hospital treatment
- Legal services connections
- Connection to veteran benefits services
- Connection to service animals
- Vocational/Educational services, training, community outreach and volunteer opportunities
- Transportation services
- Assessment of needs
- Ongoing Planning
- Monitoring of services



BACKGROUND

Our nation's military men and women are trained to be self-sustaining and interdependent individuals. They are indoctrinated into a system of values with an emphasis of honor and respect not only for each other, but also for the individuals they protect and defend. We have found that our military is probably the finest training system for leaders in our country. Engaging the men and women from the armed forces has been a unique experience. For some, the transition back to a civilian world can be difficult. Some of the difficulties have started while still on active duty, while others when soldiers become detached from their group, unit or "Tribe" that they have been working with and depending on for months to years.



The types of services needed by veterans are no different from ones that we offer to other groups served at SCI. The basic needs for all are stable housing, employment, medical needs, financial management, social and safety groups and networks, and relationships. Person-Centered plans are individualized and established around the outcomes and goals of these needs. Sometimes the outcomes and goals are short-term, for resolving crisis. In other instances, goals and outcomes are developed for medium to long-range planning.

Within the scope of need arises the demand for navigating through large and complicated systems for support, such as Department of Social Services, Department of Labor, Department of Aging, Department of Defense, DORS, Educational Institutions, and Veteran Affairs. It can be difficult to obtain and sustain a healthy relationship with each of these resources. While the majority of the veteran population can handle this navigation for services, a percentage of them cannot. The veterans most significantly affected by their military duties who are struggling with co-occurring health issues are the most vulnerable, and in need of case management and wrap-around services.

Since December of 2016, SCI Veteran Services has been offering case management, service coordination, and wrap-around services to veterans from all branches of the military. We are currently serving veterans from ages 26-86. The primary location of services has been in Frederick County, with a long-term goal to expand to the four-state region. We have served about 28 veterans with 20 veterans currently in active case management, needing a variety of wrap-around services identified for long-term and short-term needs. Contact and visits occur weekly to monthly depending on needs. We have averaged 2-3 referrals a month. Many of the veterans come to us from shattered family situations, abandoned by friends or acquaintances, thus becoming homeless and in need of employment. Some have entered our services through forensic involvement and in need of treatment from mental health complications. When a community referral is received, a needs assessment is completed through an intake process and an initial person-centered plan is prepared. Our person-centered approach ensures that supports are integrated, incorporating all available natural, community, and government-funded resources. This planning process has enabled us to provide assistance with resolving crises related to health, housing, and employment for a number of the veterans that we're serving.

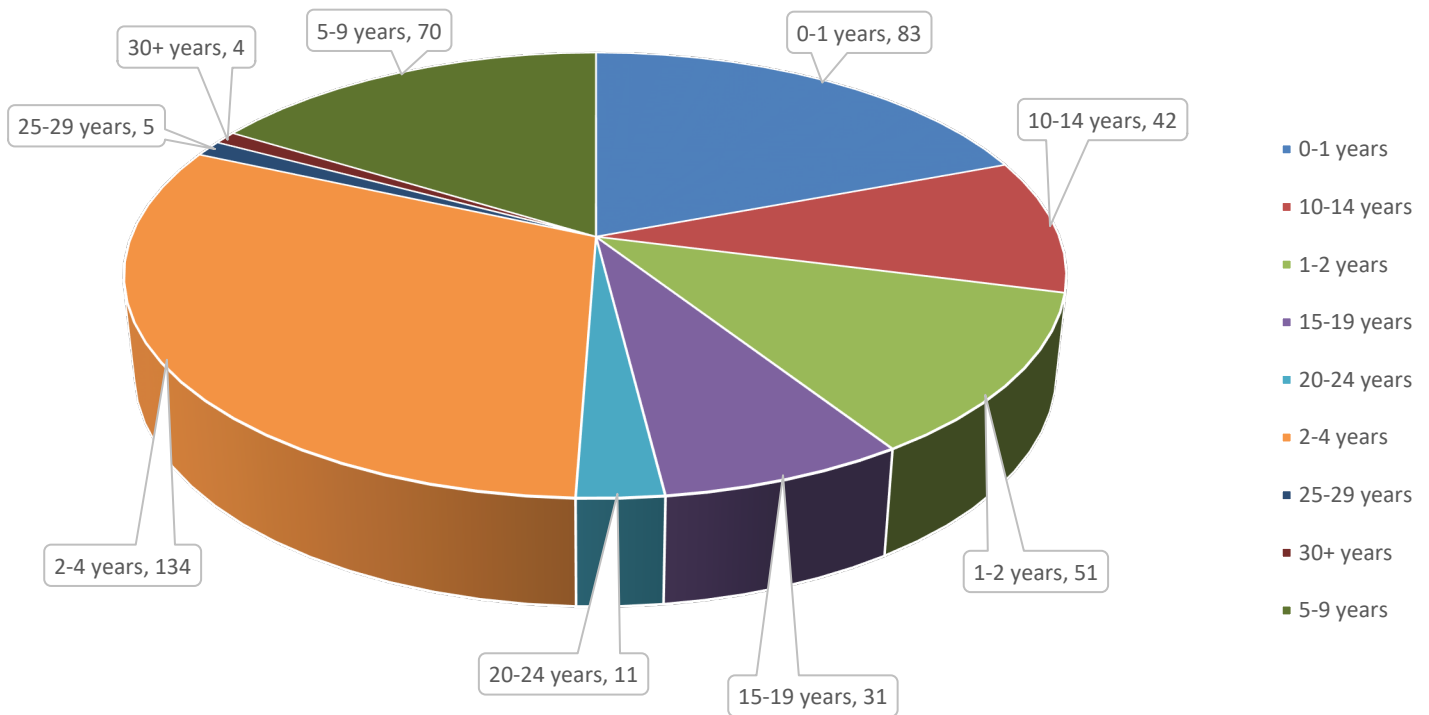
We have been able to establish a relationship with many veteran specific support organizations, such as Veterans of Foreign War (VFW), American Legion, Disabled American Veterans, and American Veterans (AMVETS). These groups have been donating thousands of dollars to our local vets to get them through crisis situations related to financial strain with housing, transportation, family assistance, burial, food, and clothing needs. The legal community has assisted with pro-bono services. Other agencies, support groups and private individuals have been able to offer transition support such as transportation, household moving, furniture, furniture storage, and home repairs. The list of available supports and services to connect and engage with are remarkable. The success rate for assisting the veteran population has been extremely high. The work involved, as like with other programs at SCI, has been gratifying.



TEAM MEMBER TENURE & RETENTION

SCI would like to thank our team members for their hard work and dedication, making a positive difference in the lives of so many across the state every day. Over the past fiscal year, SCI has added 95 new team members and had an annual retention rate of 84.55%. The pie chart below shows the breakdown of number of team members by years served.

Team Member Tenure



[illegible]

IMPACT STORIES

Sharing SCI's impact and success stories highlights and demonstrates how our work and commitment makes a difference in the lives of people and communities we serve.

DDA - IMPACT ON THE PEOPLE WE SUPPORT

GERALD'S STORY

Gerald has always been a hard worker. He has had several jobs over the years and continues to work on a janitorial crew with some of his peers and staff from Community Living, Inc. Gerald also works in Community Living's laundry department, where he helps to provide laundry services for businesses in Maryland. He held a job at Kids First Swim School up until 2017, but this ended because of safety concerns due to low vision. Gerald learned to use Transit, the Frederick County bus system, at age 68 to get to work. Gerald and his team discussed semi-retirement, but Gerald decided he still wanted to work. In addition to working, Gerald has volunteered his time at local agencies such as Habitat for Humanity, The Salvation Army, and the Frederick County Animal Shelter.

Gerald loves to keep busy. When he's not working, he loves to tinker around his yard, grill food on his own grill, and mow the lawn with a mower he purchased. He advocated for a deck for his home, a shed to store his lawn mower, and to finally be able to have a commitment ceremony to Linda, his longtime partner. Gerald worked on goals such as learning to use his Epi Pen, learning the side effects of his medications, learning to identify emergency situations and dial 911 if needed, and how to unlock his front door to gain the independence needed to have independent time with his girlfriend. Gerald advocated for being able to spend time alone at his girlfriend's home and to spend the night twice a week. He also advocated for her to spend time at his house once a week. As the two got closer, they decided that they wanted to be together forever. Gerald worked on a goal to have a commitment ceremony and honeymoon. With help from his team, Gerald and his partner planned a commitment ceremony, invited guests to the ceremony, ordered food for the reception, hired a DJ, and secured a pastor to officiate the ceremony.

He also planned and took a honeymoon to Tennessee, a place he and his partner have wanted to visit. Staff assisted minimally on this trip, but all decisions were made by Gerald and Linda. At age 69, Gerald had achieved his dream of commitment to his best friend. The united couple decided that they wanted to live together but need support to do so. As they both resided with supports from the same agency, each of their Service Coordinators supported them in submitting Modified Service Funding Plan Requests to move into a suitable Alternative Living Unit. They worked with Community Living to find a suitable home within their agency and since May have been living together.



JOSHUA'S STORY

Joshua is a 20-year-old young man who has autism and bipolar disorder. Josh had been living with his father in Hagerstown from the time Josh's mother passed away when he was three years old. When Josh was 15, his behaviors became more challenging, resulting in disruptions to his school attendance. He soon stopped attending school altogether and his father had to quit his job to care for him. Josh's behaviors also resulted in Josh and his father's eviction from their home, prompting a several-month period of homelessness. Josh's behaviors made it difficult for his dad to get him to doctors' appointments or out to explore the community. All in all, there was very little life outside Josh's home for him for nearly five years.

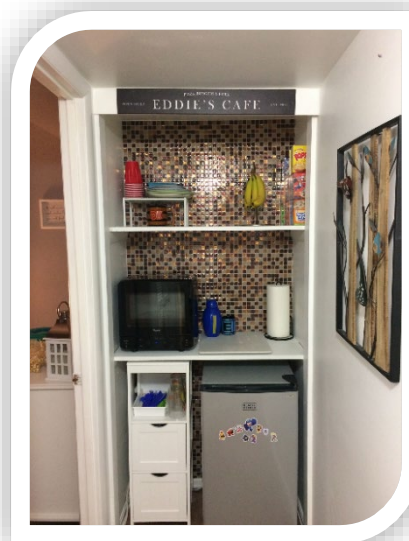
During one of Josh's outbursts in September 2018, a passerby called 911. The police took Josh to the ER for evaluation, prompting DSS notification. Although Josh's father had requested residential services (Josh had recently been approved for a DDA waiver), he loved his son very much and had a hard time when the opportunity to move forward arrived. DSS representatives and Josh's CCS, Lisa Kocis, worked closely for about six weeks to help Josh's father adjust to this next step and he eventually accepted that this was in the best interest for both of them. A court-ordered emergency petition was approved, and police took Josh back to the hospital where he received inpatient treatment to stabilize his behavior in preparation for DDA residential services. His treatment was so successful that several providers were interested in serving him and he was able to select the one he wanted. From the hospital he moved into a beautiful, newly renovated home in Hagerstown with his selected provider.

Josh is now getting the medical care, daily care, and supervision he needs. And, in a true sense, he has begun discovering his community for the first time in his life. It's a whole new world for Josh, not without some bumps along the way, but an exciting transition nonetheless for this wonderful young man.



EDDIE'S STORY

Eddie is a 34-year-old male living in Pasadena, MD. He has lived with Autism, Anxiety, Intellectual Disabilities, and Obsessive-Compulsive behaviors his entire life. Eddie has been receiving support services from Providence Center, Inc. for the past 13 years. The past three years that he has been in Community Learning Service have made quite an impact on his life. He has been working with his parents and provider for several years and he has lost over 100 pounds! Eddie began to take control of his health by simplifying his dietary choices through Nutrisystem. When Eddie would engage in community activities with his group, he would pack his own lunch to ensure he stayed on track. This past year he decided that he wanted to embrace his new lifestyle by learning to prepare his own healthy meals. Eddie began working with his Providence Center, Inc. team each week through an interactive cooking class. Eddie has been able to take the skills he learned in class and he has applied them to his meal preparation at home and his job too! He has been working at a local Hardee's for a few years, and recently he was able to prepare meals for customers without any assistance! This was a new experience for Eddie, and he hopes to gain increased exposure as the



newest kitchen staff. Eddie and his team are overjoyed with the progress he has made this past year. Eddie is hoping he can build upon his skills so he can move out on his own. The team is working towards Eddie moving out of his parent's home and his parents are trying their best to guide Eddie prior to his residential resource search. It seems this most recent update is another positive installment in Eddie's wonderful future.

The picture above is of a kitchenette that his family created in a hall closet by his room so he can practice his skills of independent living. His mom included the photo and said: "Take a peek at the attached photo! Eddie wanted his own apartment. So, we made him a "kitchenette" in the hall closet outside of his bedroom. He loves it!"

PETER'S STORY

Peter was a transitioning youth many years ago. He began DDA funded services upon his graduation from the Carroll County Public School System but did not have a good experience and withdrew from those services. He spent many years at home with just his family providing support. Peter was content with his life. He expressed no interest in meeting new people or venturing out. His parents were happy to support him in their family home, although they worried about the future. In February 2018, Tammy Dilley/CCS received a notification that Peter was chosen as a candidate for one of the new DDA waivers. She contacted Peter and his family to share this wonderful opportunity. To her dismay, Peter and his family decided they were not interested in pursuing funded services. Determined, Tammy did not take no for an answer! She continued to talk with Peter and his mom about what services could look like for him and how it would be different than what he experienced before. Reluctantly, after several months, Peter and his family agreed to meet with Randon Bittings from Bello Machre. Randon went out of her way to make Peter feel comfortable, even taking a golf cart ride with him when she went to meet the family. Due to Tammy's persistence and Randon's warmth and inviting personality, Peter and his family decided to move forward with requesting just a few hours of supports per week.



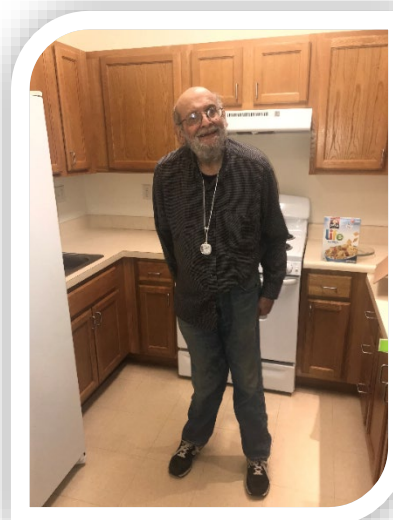
Bello Machre began providing support services to Peter in early November 2018. The plan was to have the support staff spend time with Peter in his home, working on some of the skills he mentioned he wanted to learn. The hope was that once they built a rapport, Peter may be willing to go out into the community with his support staff. In just a couple of weeks, even prior to his "30-day meeting", Peter's life had changed immensely. He had already ventured out with his support staff and was talking about needing more support hours in order to do all the things he wanted to do! Peter's parent's felt a sense of excitement for him and relief that he now has a connection other than to them. In Peter's words: "I haven't had opportunities to make friends due to my anxiety and fear of the outside world. For years, I preferred to stay with my family and would only go to very familiar places. I've only been with Bello Machre for a few short weeks and I already gained confidence in myself! For the first time, in a long time, I want to work on building relationships with peers. I would like to research some community groups such as Aktion Club so that I may join a club or group someday. I decided that the easiest way for me to ease into this is by working with staff on meeting other individuals within Bello Machre in hopes of building relationships. I think that is my comfort zone at this point. As I feel more comfortable, I see myself integrated within community, both with people who have disabilities and those who don't. When I am out in my community I like to go to the mall, video game stores, car shows, and the local airport. I've enjoyed doing that with support staff. We have also gone out to eat. Over the next year I see myself participating in community activities such as miniature golf, duck pin bowling, and visiting a coffeehouse venue. I even want to plan a day trip to Ocean City during cars week. I've never been that far away from my family, but I want to try it. I also want to learn how to be more independent in my meal preparation. I want to learn how to use the microwave and toaster oven independently. I may even want to attempt to use the stove! I love making dipping sauces and the spicy ones are my favorite! Perhaps I can join a cooking class. Every day during the week except Wednesday, I like going to the Westminster Town Mall to walk. I enjoy providing feedback and often fill out suggestion cards."

Congratulations to Peter for facing his fears and being willing to try something that truly scared him. Many thanks to Tammy/SCI and Randon/Bello Machre for sticking with Peter and supporting him to make this life-altering change!!

NEIL'S STORY

Since July 2018, the Coordination of Community Services (CCS) Misha Sanders has had the pleasure of working with Neil Speert. Neil is a kind gentleman who loves his Ravens, Orioles, spending time with his personal supports staff, and eating out at Burger King at least once a week. When they met, Neil lived in a very unhealthy environment. He is a "collector", and often collects items, but had struggled with maintaining the cleanliness of his home. Neil's apartment was extremely unsanitary and overall seemed to affect his mood as well as his health.

Neil lived in his apartment for 13 years and it needed a great deal of upgrades. Neil also needed assistance with keeping the apartment clean. The CCS could tell that he was very discouraged, and he would often share how badly he wanted to move. His personal supports staff assisted with helping him to maintain cleanliness 3 days a week. It seemed that Neil began to feel overwhelmed with the way in which his home looked and felt. It did not feel like a home. The CCS advocated on Neil's behalf for the property manager to do some renovations to the apartment, but they would not agree. The CCS remained committed and soon got a call from Neil, advising that he received a letter from Weinberg Village II in Owings Mills. He was placed on a waiting list for reduced housing (for seniors) in 2016. Two years later, his name had been chosen to join the Weinberg community! Neil was extremely excited and wanted to take advantage of the opportunity. With the help of Neil's Case Manager at the JCS, personal supports staff and his CCS, Neil signed his new lease with Weinberg on 10/30/18. He was over the moon happy! He told his CCS that he was so much happier in his new home, and according to Neil's personal supports staff, he has maintained a healthier living environment. Neil still collects but keeps it manageable. This transition was a little scary for Neil, but he admitted that change was a good thing. WAY TO GO NEIL!



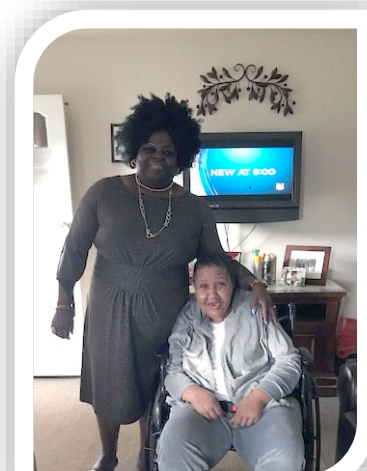
CELEBRATING THE 10TH ANNIVERSARY CLOSURE OF THE ROSEWOOD CENTER

On Friday, May 22, 2009, the last resident of Rosewood left the institution for the very last time. Today, former residents and others with developmental disabilities are our neighbors, our colleagues, and our friends. They are leading meaningful lives in the community. https://www.youtube.com/watch?v=hy8_BfvgGNU&feature=youtu.be

Roslyn Johnson's Own Home: Submitted by Muna Elia-Abass

Roslyn's family was filled with trepidation when they learned that Rosewood was closing. They attended many meetings to plan, share their fears, and wonder what the future would hold. Rosewood was all Roslyn had known since she was 8 years old, having lived there for 44 years beginning in 1964. Roselyn was known by all and loved by many, and the people who supported her and lived with her had become a part of her family.

On October 29, 2008, Roslyn moved into her new home and started day services with a Baltimore County provider. Ten years later, the fear has been replaced with joy. Moving changed Roslyn's quality of life and gave her choices she had never known. She loves her home, has the most amazing staff, and has conquered many hurdles. Roselyn lives a life with joy and happiness and enjoys the freedom of planning the grocery list, assisting with the laundry, and listening to her choice of music uninterrupted on her stereo, iPad, and CD player. Because she was not allowed to carry her stereo around at Rosewood, this is very important to her.



One thing that Roslyn enjoys is food, which is much better at her house. Some of her favorites are salad and fried chicken. Because celebrating her birthday is important to Roslyn, she and her sister go out to have fun and then Roslyn has a party at her home. Roslyn loves going out and can often be found shopping at her favorite dollar store and at Rite Aid. She clips coupons as she plans her shopping list and enjoys going to favorite restaurants including Hibachi Grill, San Antonio's, and Golden Coral. It is easy to see that relationships are a significant part of Roslyn's life. One of her most important relationships is with Linda, her DSP since she moved out of Rosewood who "takes good care of and loves her." Roslyn knows she would not want to go back to Rosewood, adding "I like that I have my own things". At her request, we helped Roslyn reconnect with her boyfriend from Rosewood. The two lost contact when he moved away. Since Roslyn continues to ask for him, her CCS is trying to help her find him again. Roslyn would not care for any other man except this man and so the story continues.

Life and Times of Richard Breitenbach:

**Written by his brother/guardian Glenn Breitenbach,
and submitted by Desiree Pennington**

Richard has had a long journey to finally live in peace. I am Glenn Breitenbach and I am writing about my brother's life. Richard is a 65-year-old man, with an intellectual disability. He is fully dependent on support to aid in his daily activities due to a hearing and speech loss. We were both raised in the 1950's, in a blue-collar world in which my Father worked full time and Mom was a homemaker. Richard stayed home until he was a grown man in his 20's and Mom could no longer take care of all his needs.

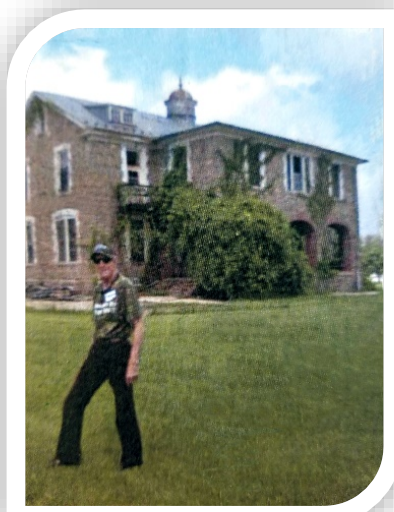
Around 1977, our family visited Rosewood to see if it would work for Richard. When Richard first moved into Rosewood, it was in full operation and staffed correctly for the number of people. I remember because my parents were 100% engaged in all activities and we went twice a week and every Sunday to visit. Rosewood was managed by Directors, Managers, and there was supervision at each facility with the correct amount of staff. Those were great days because he was around people like himself and the residents of Rosewood took care of each other. There were events, parades, games, movies, and proper medical care. I remember my Mom saying Richard seemed happier because he was with people more like him and could act accordingly in his own environment.

That changed as funding from the State decreased. In the 1990's, staffing was cut in half and new ideas took place to move the Rosewood residents into the community. People who could communicate verbally and/or work were lucky enough to go to group homes, while people like Richard, who needed more support, remained at Rosewood. Again, I remember my parents still supported Rosewood, was on the Board, and registered for some role to keep things from a complete breakdown. On Sunday visits Richard came from a locked down room that they kept everyone in during the day. Yes, one large room with everyone sitting around with nothing to do and one TV mounted from a cage hung up on the wall. Soon after, announcements were made that Rosewood was closing and everyone would be relocated. Now the fear set in for my parents, would Richard adjust? Where would he go?

My Mom and Dad had some interviews with Gallagher Services, and I remember us praying they would consider Richard. Thank God they did, and he was accepted. Gallagher Services knew he would be a challenge because of the many years of being institutionalized. In order to survive Richard learned how to steal food and drinks, fight, and do whatever it took to get by. Remember, he was raised in a normal house with rules and his foundation was good. It just got lost along the way. Once in the Gallagher program, Richard started to change, adjust, and go back to living a normal life in his element. This was only accomplished because of the wonderful staff, supervision, and programs in place. My family and I are so happy with Richard now. In fact, he has even been on a plane to Florida for a vacation, yes, a vacation. With the aid of his case workers, State requirements, and the new programs in place like O.B.I., he now has a great life. In closing, I would like to outline what I see now: Great medical records on Richard, one on one support when needed, scheduled events, vacations, trips, and a staff within Gallagher Services that run a fully proficient operation. Also, the State of Maryland supports meetings twice per year to review his needs and check-off sheets on yearly progress. Excellent support from everyone!! Our family is blessed! Thank God for progress down the long road of learning.



Wilbur's Story: Submitted by Alecia Fields



Wilbur was born in 1950. In 1957, at the age of 7, Wilbur's parents dropped him off at Rosewood. His parents stated that they were leaving him at the center because he had red bumps all over his head. His parents and other family never came to visit him while he was at Rosewood. In 1976, at the age of 21, Wilbur exited the Rosewood Center and entered the outside world. As Wilbur told his story, he shared how he faced harsh disciplinary actions during his 14-year stay at Rosewood. As Wilbur's eyes began to tear, he stated that he wished not to elaborate on what occurred as this makes him sad and uncomfortable. Wilbur did share that he had his arm broke and has many scars on his back due to the physical abuse that he endured. Wilbur explained the environmental conditions as well. He stated they were not allowed to have personal belongings. He shared that when they were able to get a shower, they were made to do so with many of the other individuals that resided at Rosewood. The dorms consisted of hard steel beds with nothing on the walls. He explained that the residents were not allowed to go outside. He went on to say that when he tried to look outside the windows, he only saw the steel bars and was reminded how awful and stuck he felt.

Wilbur exited Rosewood at the age of 21. He was asked to speak regarding his experience at the facility and to talk about what went on behind the closed doors at Rosewood. He was instrumental in helping to close Rosewood. Wilbur and two others testified in Annapolis regarding the horrible conditions and inhumane treatment they had gone through. During the press conference and testimonial in Annapolis, Wilbur shared the moment when a man told him he had a handicap and that was the reason for him being admitted into Rosewood. Wilbur proudly continues to say that his response was "I'm not handicap or have a handicap. I'm like everyone else here."

After Wilbur left Rosewood, he quickly began receiving residential services in Baltimore, Maryland. He also accesses meaningful day services from the Arc of Baltimore County. Wilbur eventually moved back to Frederick where he was born and raised as a young boy. He began to utilize services and supports from the Arc of Frederick County and lives in his own apartment with supports. Wilbur shares that he has many reasons to be happy since leaving Rosewood, however the biggest reason is that he is no longer pushed around and treated differently because of his disability. Wilbur stated that when he was released from Rosewood he felt "free as a bird."



Michael's Story: Submitted by Adam Cunningham

I was assigned to work with Michael when Rosewood was closing. During his PCP meeting at Rosewood, the social worker said he believed that Michael had a brother named John, who had also lived at Rosewood, but had moved out several years ago. I went to work trying to track down his brother because I thought it would be great if I could help reunite them. The institutional files mentioned a brother with a different name but did not include information about John. I kept looking and eventually was able to find a man named John who had the same last name, who was receiving DDA services, and was able to identify him as the correct person by matching the "common brother" listed in both of their files. Working with Michael's residential provider, we arranged for John to come to Rosewood to meet with Michael. This is when one of the coolest things I have ever seen in my 11+ years of being an SC happened. Mike, who

paced the perimeter of the cottage that he lived in non-stop, came to an abrupt stop in front of his brother when one of his revolutions of the cottage brought them face to face. They made immediate eye contact. John reached out and held his hand. Mike, who didn't like physical contact, reached out to him. They touched and held hands for a few moments before Mike continued on. On each revolution of the cottage Mike would stop in front of his brother. Sometimes they would touch (not always), but they would make eye contact confirming they recognized each other. With the help of the provider, Mike was able to leave Rosewood and move in with his brother where they spent as much time together as possible until sadly John passed away. Mike passed away a few years later. It is still one of my proudest moments as an SC I've had by helping these two long lost brothers reconnect and spend their twilight years together in a happier setting in a home in the community!

2019 MARYLAND ASSOCIATION OF COMMUNITY SERVICES (MACS) AWARDS

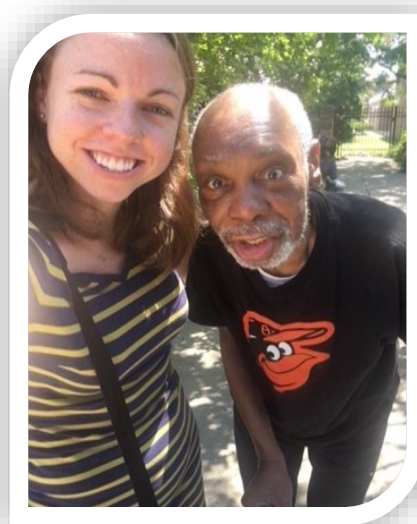
Team Members of SCI attended the MACS Annual Awards along with SCI nominee Melvin "Mel" Riebe, Jr. for his achievement of bringing awareness of epilepsy to the public. Mel enjoys helping others and is particularly passionate about sharing his knowledge of epilepsy. Believing in the need for epilepsy awareness, he decided to tell his personal story by becoming an author. His book titled "Living with Epilepsy", was published and released in January 2019 and is available on Amazon and in Barnes and Noble. Mel leads a very active life. For the past 15 years he has worked at Home Depot. On his day off he and his wife enjoy spending time together and like to travel to the eastern shore to visit with their children and grandchildren. Mel is also an Abilities Network Board Member. While working full time and attending monthly board meetings, Mel is writing his second book, which he hopes to have published by the end of the year. Learning about Sam's Law, which was passed in Texas to make sure that seizure education and training is mandatory for all school staff, Mel began contacting Maryland schools and local government and is advocating for Sam's Law to be required in Maryland schools to protect the health and well-being of all students with epilepsy. He is also a Purple Day Ambassador through The Anita Kauffmann Foundation, which promotes awareness of epilepsy through awareness initiatives and events in their community. His dream is to help find a cure for Epilepsy!

JAMES' STORY

James McCray is a resident of Baltimore City who recently celebrated his 78th birthday. James is an avid Orioles fan and loves spending time with his family. Throughout most of 2017, James struggled with different health concerns that affected his well-being and his day to day routines. James' great-niece and guardian were also the only person caring for James with very little support. When Service Coordinator Mary Rosekrans first met James and his niece, he was attending a day habilitation program Monday thru Friday. After taking some time to get to know James, his niece and SC team felt that James was not connected to the services that would best fit his current needs, goals, daily health care, and support.

A referral was made for the Community First Choice Program. After assessments were completed, James was approved for daily in-home supports. James has now been with his in-home nursing supports since May 2017 and both he and his family are very happy with the extra supports.

Next, a request was made for personal supports and respite care services to help James spend more meaningful time in the community doing things he enjoys, both in the evenings and on the weekends. James was approved for 20 hours a week of personal support services and the maximum days of annual respite. The family was not happy with the first provider that was selected for providing supports and respite, so SC helped them change to a different provider. Weekly personal supports hours and respite care equips James and his niece with additional supports beyond his day program and meaningful time in the community doing activities James loves to do, all of which ensures James is safe and well-cared for. James' niece reported to SC that James is "noticeably more engaged in his day to day routines and more energized" since the different support services were added.



Lastly, after James' day to day healthcare needs and support started to increase due to his age and new medical concerns, he was often being sent home by staff at his day program due to the fact they did not have the appropriate resources to best care for James. SC knew that James would be best supported in a medical day program setting versus a day habilitation setting. SC helped the family explore medical day programs in the area and after the referral process, James is happily attending the League for People with Disabilities. SC visited with James at the League recently during a gorgeous summer day. James and SC walked around the beautiful courtyard area at the League. James was up walking around, engaging in his environment, and appeared the happiest he has been since SC started working with him in January 2017. A few months ago, James' niece told SC "before you started to work with James, he basically had nothing. Now it seems like he has everything." SC knew that James would benefit from applying for more services and changing existing services around to best support his wellness, health, and well-being.

HABITAT WELCOMES FRIENDS INTO NEW HOME FROM STAFF REPORTS @ THE GARRETT COUNTY REPUBLICAN



Garrett County Habitat for Humanity held the home dedication ceremony for Jacob and Kelly Friend on June 29, 2019 at their Hope Land Village development near Deer Park. The Friends were welcomed into their new home by a group of more than 30 friends, family, and Habitat supporters. Garrett County Habitat holds a dedication ceremony for each new family that purchases a Habitat Home. Executive Director Brent Stone officiated the ceremony, while Pastor Carl Fike gave the invocation. Affiliate President Fred Eggleston presented the Friends with a hammer. The hammer symbolizes all the work the family did on their home and other Habitat projects. Habitat volunteer Ida Maust presented the family with a Bible. The Bible symbolizes the Habitat's Christian ministry to help families in need receive decent, safe, and affordable housing. Stone presented the Friends with the keys to their home, symbolizing the transition of the house into a family's home. Fred Eggleston also presented the family with a fire extinguisher, compliments of Rockville United

Church. Pillar of Life Mennonite Church presented the family with a handmade comforter. Virginia Grove read the "Bless this House" poem, and Fike closed the ceremony with the Dedication Prayer. Food for the dedication ceremony was provided by the GCHFH Hospitality Committee.

The Friends purchased their home after completing the Garrett County Habitat for Humanity's application process. As part of the process, the family had to complete 500 hours of "sweat equity" on their home and other Habitat projects, as well as complete mandatory homeowner education courses. Upon completion of the application process, Garrett County Habitat sells the home to the Partner Family at cost, and supplies the family with a 30-year, fixed 0% mortgage. It is the mission of Garrett County Habitat for Humanity to provide lower income families in need with safe, decent, and affordable homes. This is possible with the support of the community and with the hard work of many volunteers.

This article appeared in the local Oakland Newspaper [The Garrett County Republican](#) on Thursday, August 2, 2018.

Note: Service Coordinator Debbie Baird works with Jacob and Kelly Friend

ABBY'S STORY

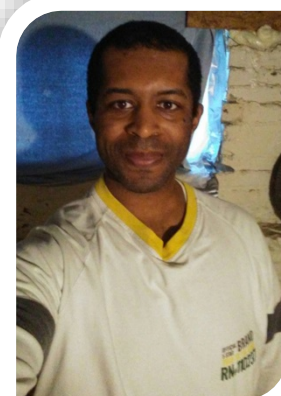
Abby is a 35-year-old female that has a diagnosis of Cerebral Palsy. Abby receives Supported Employment services from Abilities Network and works at Wegman's. In the future, Abby wants to be the manager of a coffee shop.

Abby was living in a Richcroft residential site for over ten years. During the preparation process for Abby's PCP meeting, she expressed she no longer wanted to live at the house. Abby and the team worked together to find Abby a home she liked that was also safe and affordable. Abby now lives independently in an apartment. Abby receives 35 hours per week of drop-in supports. When asked about her apartment, Abby could not contain her excitement about how much she has enjoyed living there. Abby plans to have an "open house" soon to show her family and friends how much she loves her new home.



KAREEM'S STORY

This year when a Black and Decker work site became NexDine, the contract with the DDA provider Kareem worked for ended. While Kareem was offered a position with the new company, he would not have any on site coaching from the provider. Kareem embarked on training and learned a totally new position with new duties in order to obtain and maintain the employment he desired. His team supported him to learn how to use public transportation in a new way. During the past year, he was named Employee of the Month. He loves his job and his supervisor, and his co-workers love working with him. They value what he brings to their team. This is a success story not only for Kareem, but for his CCS Jessica Jordan and the team that made sure he had the support to be successful.



SPS SUCESS STORIES

JAMES' STORY

James Taylor is a 62-year-old, lifelong Maryland resident who grew up in Reisterstown. James was born with a mild cognitive intellectual disability but was not formally diagnosed until 2012 at the age of 56. As a young child James had a close relationship with his parents. His mother was his primary caretaker, but he also spent frequent afternoons fishing and enjoying nature with his father. James experienced challenges growing up, but he took comfort in knowing he had the support of his parents. James still reminisces about the enjoyment he received being with his father as he drove to town. James no longer has any living family members but draws comfort from the memories created all those years ago.

As a young man, James was a hard worker with a positive attitude. For over 10 years he was able to make a living doing janitorial work. As James got older, he continued to live with his mother who assisted with his care until her own health began to decline significantly. She was forced to move into a senior living community in which James did not qualify to stay. For the first time in his life, James found himself on his own. Unfortunately, James no longer had the support he needed. This caused a great deal of stress to James and he began drinking to cope. He struggled on his own and his health began



to fail. As a result of his circumstances, James lost his job. Things spiraled quickly and he found himself homeless, living on the streets unsure of how to make things better. At times, James would receive assistance with a meal or a place to sleep at a homeless shelter for the evening, but help was always temporary, and James became more depressed. When the shelters were closed during the day, he would sleep on benches and spend time wandering along the road. This pattern of behavior continued for years and James felt hopeless and despair. He wondered if his life would ever change.

In 2012, James found himself at Streets of Hope, a church operated homeless shelter serving people in Baltimore County. This is where he met staff member Barbara, with whom he quickly became close friends. Barbara cared about James. She quickly became his advocate and helped him to access housing and other programs that he desperately needed. She linked him with Health Care for the Homeless in Baltimore County. They provided access to the physician who was able to diagnose his intellectual disability, as well as assisting him to apply for SSI. Things began improving for James and with assistance from Barbara, he was able to move into his own apartment in Towson in 2015. He kept up with his new responsibilities at first, but years of untreated anxiety and depression combined with alcohol abuse left James struggling to adjust. He found himself having trouble maintaining his new responsibilities as a renter. His health continued to fail which caused him to neglect his apartment further. He became at risk once again to return to the streets when his lease was terminated and moved to a month-to-month option with the understanding that he would be required by the apartment management to move out at the end of August 2017 if things did not improve.

In May of 2017, Barbara decided she had to do something to help her friend before things declined further. She made a referral to the Community First Choice (CFC) program and at that point, Supports Planner Keyawna Hoyte was assigned to his case. Keyawna worked hard to develop trust with James. He had been through many negative experiences in his life and building trust with new people was difficult for him. James valued his freedom and feared being sent to an institution. At first, James declined the help from Keyawna, but she was persistent. Through her patience and kindness, she was able to help James better understand the CFC program. She explained that he had the right to choose the services, as well as the right to choose the providers of those services. She helped James to understand how accepting CFC services could provide support that he so desperately needed to make a better life for himself while remaining independent. With help from Keyawna, James found himself motivated to improve the quality of his life. He was able to locate the apartment where he currently resides in Essex. Through the CFC program, Keyawna was able to help James access Personal Assistance Services. He has made connections with the caring staff of Serenity Home Care, LLC. and they assist him 19 hours per week. With these services in place, James has taken on a new sense of pride in his appearance and his apartment. James has always been a quiet and shy individual, but his newfound self-esteem has helped him to develop friendships in the community in which he currently resides. With CFC services in place, James has the support he needs to thrive. Keyawna has described James as “happier and healthier.” Keyawna stated, “he is living his own life, and this is the life that he has chosen.”

CINDY’S STORY

Cynthia (Cindy) Willingham is 57-year-old resident of Mt. Vernon in Baltimore City. Cindy takes pride in growing up as a resident of Baltimore City and has spent her entire life there. Cindy has a close-knit family and they are very important to her. Her family members reside within a few miles of each other in the Baltimore City area. Cindy is the proud grandmother to seven lovely grandchildren ranging in ages from 6 to 21 years old. She enjoys spending time with her grandkids as much as possible. Cindy loves her grandchildren and they are very helpful to her by running errands and keeping her company. She is encouraged and inspired by her family. Cindy’s love for her grandchildren is part of the reason why she pushes herself day-to-day.



In 2008, Cindy was diagnosed with a blood clot in her spine. As a result, she was paralyzed for about two and a half months. Cindy had surgery on her neck vertebrae in 2008 and again in 2009. This corrected some of her medical issues, but she has not regained full functionality on her left side. Following the initial surgery, Cindy found her apartment in Mt. Vernon to be too small as she came home to recover. The entry way of the apartment was less than 10 feet from the hospital bed where Cindy rested. Cindy is able to advocate well for herself and was able to do so even while attempting to overcome the challenge of becoming partially paralyzed. While recovering from surgery, Cindy worked diligently with her primary doctor and the apartment complex where she resided to obtain a larger apartment, as well as a power chair to increase her mobility. In addition to needing a larger apartment to accommodate her own needs, Cindy had the needs of her family in mind. She made it a priority to have enough space for her grandchildren to come to her home on occasion for sleepovers. Her goal was to recover enough to be able to cook pancakes for them for breakfast. This motivated Cindy to work hard to get better. Securing a larger apartment and learning to use her new power chair helped Cindy to meet these important life goals. Despite overcoming these challenges, she was still finding it difficult to meet her ADL needs on a regular basis. At that time, the Social Worker in her building stepped in to help and made a referral to the Community First Choice (CFC) program. Supports Planner Supervisor, Dan Mathwin, was assigned to assist Cindy and he got to work right away. After the referral was made, Dan moved quickly to develop a person-centered Plan of Service to assist Cindy in her home and the community. This Plan of Service was developed for 10 hours a week to provide assistance with her ADLs. Dan was also able to help Cindy acquire a Personal Emergency Response System that will keep Cindy safe, particularly when she is home alone. These services were the final pieces needed to improve Cindy's quality of life. Cindy shared with Dan that she was most comfortable with allowing her daughter Danielle, provide the assistance with her ADLs. Dan explained that the CFC program can allow for family members and friends to become professional caregivers to their loved ones and he was able to assist this family through the hiring process. This arrangement worked well for Cindy and her daughter who was able to be flexible with her schedule and help her mom as needed for 10 hours throughout the week. Since services began, Cindy feels "a stronger kinship" with her daughter, Danielle, and her entire family. Cindy is able to see Danielle more often while receiving the help she needs on a regular basis. As a result, she spends more time with her grandchildren. The CFC program, along with Cindy's advocate skills, helped to get her life in order and she feels her family relations have improved. Supports Planning Supervisor, Dan Mathwin said, "Cindy is doing quite well, and I am very happy for her."

JACQUELINE'S STORY

Jacqueline "Jackie" Shumac is a fun and dynamic 58-year-old Maryland resident currently being served by Service Coordination. Born in California, Jackie later settled in Virginia before moving to the Baltimore area. She tells people that she has "lived everywhere" and enjoys sharing stories about her travels throughout the world. When Jackie was born, her parents were given the news that their daughter would not make it past the first year of life due to a birth defect affecting her brain. For this reason, Jackie's mother treated Jackie as the "baby" of the family and held a special fondness for her growing up. Jackie overcame the odds and survived. Jackie was the only girl of three siblings. She remains close to her brothers and feels they provide constant support. She appreciates their encouragement and feels that with their help, she has learned to be more self-sufficient than many people originally believed she could be. This value has served Jackie well in her life and she has become a strong, outspoken individual. Jackie has a "lively spirit" and the ability to advocate for her own needs. Jackie is hard worker and spent many years in Virginia employed at the office of the County Executive. Jackie is now a divorced mother of one son. Her son has recently married and although he does not live nearby, he stays in regular contact with his mother.

A few years ago, Jackie suffered a stroke that left her with chronic pain and limited mobility. In 2012, swelling in her head lead to the placement of a titanium stent in her forehead. Jackie fought hard to regain the abilities she had lost, but the results of the stroke, combined with repeated falls, migraines, as well



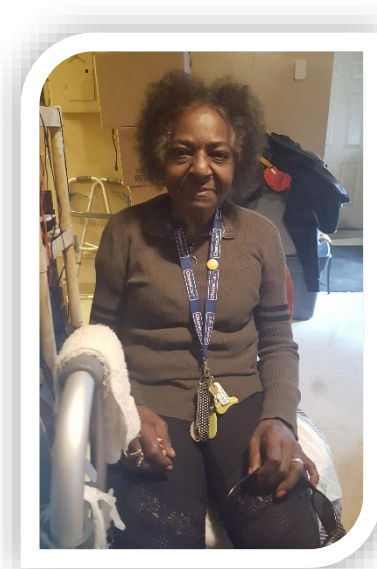
as a carpal tunnel surgery on her left wrist made recovery a slow and difficult process. For this reason, Jackie was advised that she could benefit from placement in a long-term care facility and she was admitted to Transitions Health Care Nursing Home. After almost two years in long-term care, she applied for the Community Options Waiver. Supports planner Sharnele Ranson met Jackie in April of 2017. Sharnele quickly learned that Jackie felt the timing was right to leave this institution and move into an environment where she could be more independent. Jackie shared with Sharnele that she desired to have her “own space” and that she would like to venture once again into the community on her own. Sharnele discussed with Jackie the choices available through the Community Options (CO) Waiver. Sharnele let Jackie know that Assisted Living is a service that can be offered to those who qualify with the CO Waiver. Jackie felt this option would best meet her current needs while providing more independence that she longed for. Sharnele was able to locate an Assisted Living community in Jackie’s preferred area with an available room. Sharnele assisted with all aspects of the transition into this new location to ensure things went well. Next, Sharnele assisted Jackie with obtaining a motorized wheelchair which allowed Jackie to go places on her own. Jackie was very pleased with the freedom that this chair returned to her. Unfortunately, Jackie’s assisted living could not accommodate this particular chair due to the size. Once again, Sharnele was able to help. A year after transitioning from the nursing home into the first Assisted Living community, Sharnele helped Jackie to relocate into a second Assisted Living called K and R’s. Sharnele spent many hours researching and made many phone calls to ensure that this location would provide all the accommodations Jackie needed. This new location met all of Jackie’s needs and had enough space for the motorized chair that had become so important to her.

Jackie is grateful to Sharnele for all the assistance she has provided. Sharnele went above and beyond by assisting Jackie to move on two occasions. Sharnele said she enjoys working with Jackie because “she is one in a million with her character and her personality.” Jackie and Sharnele have formed a strong bond. Sharnele shared that Jackie taught her “to never give up, to stand firm, and to speak up for yourself.” Sharnele said, “I look forward to continuing to work with Jackie so that I can help her to live the best life possible!”

ELOUISE’S STORY

Elouise Miller is a 63-year-old, lifelong resident of Baltimore City. She is kind and personable. Elouise has a close relationship with her family, which includes three sons and one daughter who all live in Baltimore City. She is married and lives with her husband. Some of her hobbies include, cooking, making jewelry, and creating gift baskets. Elouise is an accomplished hostess and has enjoyed creating welcoming events for her friends and family to share. Before Elouise became ill in 2005, she loved to work outside of her home. Elouise was a homecare provider and provided care to others for many years. About thirteen years ago, Elouise began to show signs of memory loss and was later diagnosed with schizophrenia. In 2005, she experienced high blood pressure and had dizzy spells. She struggled in the following year and in 2006, her health had declined to a point where she had to apply for disability. Elouise’s family became concerned and worked together to intervene, offering help to ensure she remained as healthy and safe as possible. Unfortunately, Elouise’s conditions worsened, and the family was overwhelmed with the high level of involvement of her care. Some of the aspects of care that she needed assistance with included help with getting dressed, as well as safely preparing meals. There was a serious concern that Elouise was not able to cook meals safely as she would forget to turn the gas stove off when she was done cooking a meal for herself.

In May 2018, Supports Planner Dwedeh Hne started working with Elouise. By that time, Elouise was unable to be left alone for any period of time due to wandering and leaving the home during episodes of hallucinations or delusions. Dwedeh was able to work with providers in the area to obtain items that would allow for a safer home for Elouise including a shower chair, shower wand, and a cane. Elouise’s family remained very supportive throughout this time. Dwedeh was able to assist Elouise with the approval of nineteen hours per week of attendant services in the home to



help with her care. Elouise also receives five meals per week through the Home Delivery Service from Moveable Feast. Her sister-in-law Gwen was even willing to go through the process of becoming her professional caregiver. Gwen has been able help Elouise with dressing, preparing meals, bathing, housekeeping, medication management, and is able to be present to ensure she will not wander from the home alone. Elouise is much more comfortable and safer in her home when her husband leaves for work during the day.

Dwedeh is currently working with Elouise and the family on her annual Plan of Service. The family requested that Elouise change her primary care doctor. Dwedeh was able to collaborate with the University of Maryland PACT team to help change her primary doctor. This involved talking with Andrew at the PACT team who was then able to identify a primary care physician who was closer to the Elouise's home. This has been a positive change for Elouise, and it takes significantly less time to travel to necessary appointments. Her husband is very thankful for the assistance that is being provided to his wife. He feels confident when he leaves home to work in the community that his wife is receiving the care that she needs and will remain safe. Elouise has shared with her family, as well as to her Supports Planner Dwedeh, that she is happier and feels supported in her home.

CYNTHIA HADDAWAY'S TRANSITION

Ms. Haddaway is 64 years young! She was born and raised in Baltimore, MD and was a nursing assistant for over 10 years. She stated that she loved helping older people. Cynthia has one daughter and four grandchildren who she is very close with. She first went into the nursing home in 2012 when she broke her ankle and was there for 1 year recovering until she was able to move into an assisted living facility. Once she regained her mobility, Cynthia was able to move back in with her daughter. Unfortunately, another break caused Cynthia to go back into the nursing home in 2016. This time it was her leg that broke, leaving her in the nursing home for over 2 years.

Cynthia's social worker Monica suggested applying to the Community Options Waiver. Cynthia, with the help of Monica, applied to the program. She then chose to work with Service Coordination, Inc. where she was assigned to her Supports Planner Brooke Dasch. Brooke worked very closely with Cynthia and her family to create a plan of service (POS) addressing her needs. Cynthia reported difficulty walking and standing for long periods of time. She stated that she would need assistance with cooking, walking, transporting, and bathing. Cynthia also stated that she would need assistance finding a place to live, specifically somewhere close to her daughter. With Cynthia's needs in mind, Brooke suggested personal assistance hours and home delivered meals, both of which she gladly agreed. Brooke worked diligently calling apartment complex after apartment complex until she came across the perfect place - an affordable, 1-bedroom/1-bathroom senior apartment complex less than 2 miles from her daughter with a senior center attached to the building. After seeing the apartment complex, Cynthia exclaimed, "This is too good to be true!"

However, the good news did not stop there. Brooke mentioned to Cynthia that she is eligible for both Transition Funds (TF) and Money Follows the Person (MFP) Funds. Brooke explained that TF are to be used for obtaining housing, furniture, essential personal/household items, and small appliances. While MFP funds would be available for groceries, over the counter medication, and nutritional supplements. Together, Brooke and Cynthia created a wish list of all desired items. Brooke was able to submit the plan for approval, and within a few weeks, Ms. Haddaway's POS was approved and she was ready to transition. As the transition date neared, Brooke made sure that Cynthia's requested items were delivered. Brooke met Cynthia at the nursing home and her new apartment the day of the transition to ensure everything went off without a hitch. She moved out on December 12, 2018. Cynthia stated, "The process has been both very stressful and exciting. I thought the program was too good to be true, so I was apprehensive about getting out. Brooke calmed my nerves and helped me get all these nice things so I'm glad I was able to apply."



CHRISTINE'S STORY

Christine Whittle is a 35-year-old woman living with her parents and sister in the Timonium area of Baltimore County. Christine is bright and kind to everyone she encounters. She has a bachelor's degree in English and enjoys listening to audiobooks and music using her Alexa. As a child, Christine was diagnosed with Friedreich's Ataxia; a neuromuscular disease characterized by muscle weakness, loss of balance and coordination, and progressive loss of cerebellum function. In Christine's case, it has also caused progressive loss of vision, dysarthria (muscle weakness in facial muscles and the tongue that leads to impaired speech), and bilateral hand contractures. Previously, Christine lived in Florida with her grandmother. She speaks fondly of her time there. They spent time together and had personal supports to assist them in their home as they are both disabled. However, in late 2017, Christine's grandmother moved into a nursing home and Christine moved home to be with her parents in Maryland.



In February 2018, Sara Jacobs began working with Christine as her Supports Planner. Christine was one of Sara's first participants and they recently celebrated a year of working together. When Sara met Christine, her family was struggling to keep up with her care.

With the progression of her disease, Christine is totally dependent for most activities of daily living. Together, they worked to create her Plan of Service, which was approved for thirty-five hours per week of personal assistance, as well as other services such as a personal response alert system and an environmental assessment. Sara also assisted Christine in setting up delivery of her disposable medical supplies and becoming a part of Maryland Transit Administration (MTA) mobility. Despite the need for help, Christine is involved in her own care and remains as independent as possible. Her sister Gwen functions as her representative for the Community First Choice (CFC) program. While Christine makes all her own decisions, Gwen can sign documents on her sister's behalf at her sister's request. Christine and her family have all benefited from the CFC program. Christine's mother Liza provides care as one of Christine's three personal attendants. With the extra help in place from CFC, Liza has been able to return to work outside the home.

Recently, Sara and Christine worked through her annual redetermination process. With the help of the nurse from the local health department, Christine was able to identify that she was experiencing more muscle weakness and vision loss. This was causing her to require longer amounts of time to complete activities of daily living, even with assistance. By working together, Sara was able to help Christine receive approval of an increase of personal assistance to 56 hours per week. During this process, Christine also expressed the desire to move out of her parents' home and live on her own with support. Sara has assisted Christine in applying for public housing and applying for Developmental Disabilities Administration (DDA) program assistance. Currently, her applications are pending, but they remain excited to see what comes next. With encouragement, Christine also took initiative in her future planning and put her name on the Community Options (CO) Waiver Registry waiting list. When her name is drawn from the list, she will be eligible to apply for the CO Waiver, which could potentially allow for additional services that will allow Christine to live safely in the community.

Christine's family is very thankful for Service Coordination and the Community First Choice program. She now feels that she has the support to live safely at home and has resumed the quality of life that she had in Florida. Christine's confidence and satisfaction continues to grow as she continues her journey and advocates for her own care and happiness.



IFEOMA'S STORY

Ifeoma Ezeofor is a 19-year-old young woman residing in Prince George's County, Maryland and was diagnosed with autism and intellectual disability disorder at the age of 5. Ifeoma was not meeting the necessary milestones as a child and struggled to communicate her wants and needs effectively. By the age of 14, Ifeoma had grown frustrated with her inability to communicate her desires verbally and often being misunderstood by others. As a result, Ifeoma became extremely violent. Prior to the assistance of the Community First Choice (CFC) program, she would break windows, televisions, and mirrors, and once ripped the door off her sister's car out of frustration. Ifeoma also had difficulties in school. Due to feeling misunderstood, she would become violent with students in the classroom, the teachers, and even bus drivers. Ifeoma currently lives with her eldest sister Chinenye Ezeofor, who is very supportive. Despite Ifeoma's behavioral challenges, she has a loving, kind, and sweet personality. She always has a smile on her face. She really loves to paint as a form of expression and loves animals. Her favorite animal is a dog.



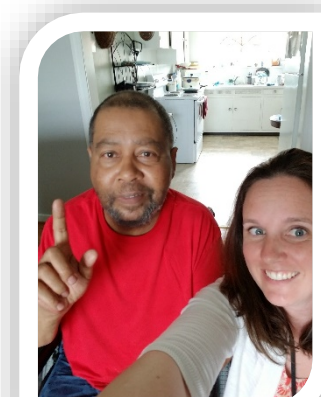
After being assisted by her Supports Planner Caleb Jackson to enroll in the CFC program in December 2018, Ifeoma has made dramatic behavioral improvements. Caleb was able to assist Ifeoma to obtain 31.5 hours of personal care assistance per week being provided through Blessed Angels Home Healthcare. The personal assistant from this agency can help Ifeoma with her Activities of Daily Living (ADL) by providing hands on or stand by assistance and reminders as needed. The caregiver was able to understand Ifeoma's needs and worked with her family to develop a reward system that has contributed to positive changes in her behavior. The personal assistant has developed a chart that allows Ifeoma to track her behavior each calendar day. Every day that she behaves well, she will receive a smiley face sticker on the calendar for the day and at the end of that day, she will receive a reward in the form of candy. On the contrary, the days when she exhibits inappropriate behavior, she will receive a frowning face and she does not receive a reward at the end of the day. Additionally, Ifeoma has the opportunity to win an outing to one of her favorite restaurants if she goes two weeks without a frowning face. Chinenye Ezeofor stated "Ifeoma's behavior has improved and she has made a 180 degree change behaviorally since starting the program and working with the personal assistance agency." Because of Ifeoma's behavioral difficulties, she was not allowed to go to speech therapy. Prior to the CFC program, Ifeoma had not received speech therapy in over 5 years, but now she is attending speech therapy three times a week with no behavioral incidences. Chinenye expressed "If it was not for this program, I am not sure I would have been able to keep her with me because I was not able to handle it mentally." Ifeoma is doing well and no longer has behavioral outbursts as a result of the implementation of the CFC program with the help of her Supports Planner.

CHARLES' STORY

In 1968, Charles was a senior in high school. Like many young men at that time, he was drafted into the Army at the age of 18. He went to boot camp in Ft. Knox, Kentucky and in 1969, he was stationed to service in Vietnam. He flew to Vietnam with six fellow Army soldiers that he had come to know as his friends. Shortly after their arrival, the soldiers decided to go into town. Normally Charles would have gone with them, but he was not feeling well on this day, so he decided to stay back at the camp. This trip ended in tragedy when his friends were electrocuted and killed attempting to get into a building in one of the villages off base. Losing his friends in this traumatic way has stayed with Charles throughout his life. Unfortunately, this was not the last traumatic event Charles would endure while serving in the Vietnam War. On another occasion, Charles was going back to his base camp one evening on a transport truck that was hauling water and supplies from the main compound, when he and another soldier drove over a land mine with their vehicle. The resulting explosion sent barbed wire into Charles's back and through his stomach. He was hospitalized for almost a year as a result of these injuries. After he recovered, he continued his service in the Army and was stationed in Germany with the Communications Unit until 1972.



Following his Army service, Charles returned home to the United States and began working as a cook in a restaurant owned by a family member. Charles became a father and had 5 children. Charles attempted to return to a normal civilian life following his Army service, but his experiences in Vietnam left him suffering with intense flashbacks and nightmares, as well as anxiety. The negative memories caused him to make some poor decisions which affected his physical and mental health. Charles reached a low point until the birth of his youngest daughter Shayla. He credits her birth as an event that helped him realize he wanted to turn his life around. He remembers fondly cutting her umbilical cord when she was born. It was a powerful moment when he realized he was the first person that Shayla saw when she opened her eyes. This experience caused Charles to devote himself to Christ and changed the course of his life for the better. Even now, Shayla has been her father's main source of support and encouragement. She encourages him to get stronger and advocates for him when needed. The two have a strong bond.



In 1995, Charles started going to the VA Medical Center for treatment. It was then that he learned he had been suffering for decades from Post-Traumatic Stress Disorder (PTSD). This was another turning point in his life. He felt that connecting with the VA Medical Center was another step into making positive changes to create a better life for himself. Charles's physical health issues forced him to leave his job at the restaurant after 17 years. He could no longer maintain long hours of standing on his feet. Charles continued to work by assisting at a horse farm. He also did side work for the church across the street from his apartment. Unfortunately, in April 2018, Charles had a stroke which resulted in a month-long hospitalization. Charles was then admitted to Fahrney Keedy Nursing Home to continue his recovery. During his time at this facility, Charles felt his connection to Christ deepen and he was baptized while residing there. The team of professionals at Fahrney Keedy were very supportive of Charles and he felt very motivated to get back home to his apartment. In July 2018, Charles met his Service Coordination Supports Planner Marjorie Schlosser. Marjorie was able to assist him with his enrollment in the Community Options (CO) Waiver. With Marjorie's help, Charles was able to return to his apartment in October 2018. Marjorie assisted Charles to access Transition Funds for groceries and toiletries, a new sofa, and a new bed before returning home. He was also approved for home delivered meals and 35 hours per week of Personal assistance.

"I feel very lucky to serve Charles," said Marjorie. "He has been a bright spot for me at SCI." Marjorie describes Charles as very kind and generous. She said, "Charles is the type of person that no matter what is going on in his life, he is going to give you the shirt off his back." Despite many challenges, Charles never lost sight of his goals and continues to work to get stronger since his return to the community. He said, "I have faith in God that I am going to walk again."



When asked about his Supports Planning Services with Service Coordination, Charles said, “I’m tremendously happy because I am at peace at home. I know I’d be more depressed if I didn’t have Marjorie’s help. I appreciate all that she has done.”

LAKIESHA’S STORY

My name is Tyra Jefferson and I am a Supports Planner at Service Coordination. I would like to take a moment and reflect on an amazing person that I have the pleasure to serve through the Community First Choice (CFC) program. Her name is Lakiesha Deloatch and she lives in Baltimore City. Lakiesha has allowed me to tell her story to Service Coordination, but she did not want to share her picture out of respect for her privacy. This beautiful, young woman was in a terrible place when I first met her in October 2018. Her pride kept her in such a dark place that she could not see the light that was shining upon her. When I first met Lakiesha in her home, she was very reserved and uncaring about her current situation. As a patient and somewhat private person myself, I understood that I would need to be quiet and listen to her carefully as she talked about her life.

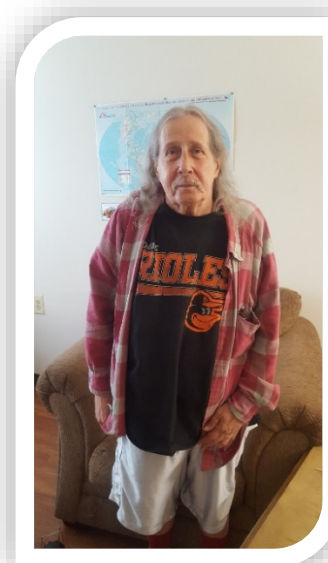
Lakiesha has since opened up to me to discuss her suicide attempts, the loss of all three of her unborn children, and the recent loss of her mother. Lakiesha would not leave her home due to insecurity reasons, which had a great impact on her health as she didn’t see a doctor for many years. I encouraged her to take one-step at a time to cope and process what was necessary in her life to survive safely and remain in the community. First, she had to openly address her health issues and make some medical appointments. However, when she finally went to see the doctor, she would not tell the doctor her concerns for fear of being judged and embarrassed. Lakiesha would call me and tell me her concerns and issues she was having medically because she said I made her feel comfortable. I suggested that if she could not talk about her concerns with the doctor, then she should write them down and give the written list to the doctor to reply with recommendations. I am happy to say that this approach worked, and a long overdue biopsy was completed. Lakiesha is still in her forties. Initially, she expressed that she believed she is “too young” to need caregiver services and an Environmental Assessment for her home.

We have developed a trusting relationship and with time, she allowed me to add the home modifications to her Plan of Service. After gaining her trust, I was able to encourage her to use the services available through the CFC program to possibly prevent falls, which she was having in her home. It is my hope that by having a railing installed outside, grab bars installed inside, and a new accessible tub, that this will help Lakiesha stay safe in her home for many years to come. In addition to this, I expressed great concern when she fell down the steps in her home and reminded her that a stair glide could be installed as a CFC service. She allowed a stair glide to be placed in her home to prevent further falls and possible serious injury. Lakiesha has allowed these suggestions to work for her, which has opened a new view on life thanks to the CFC program.

FREDERICK’S STORY

Frederick Sirody is a resident of Harford County, Maryland who recently celebrated his 70th birthday. Frederick, known to his friends as Fred, attended the University of Maryland in 1978 and graduated with a bachelor’s degree in criminal justice. Fred held many employment positions throughout his working years and developed an extensive resume. For example, he worked at the National Center of Institutions and Alternatives, preparing cases and assisting with alternative options to incarcerations for individuals accused of crimes. Among other job titles, he also spent time as a live-in residential supervisor for the Arc. Fred is a caring person and held volunteer positions with organizations such as Health Care for the Homeless and Jewish Big Brother Big Sister League to name a few. Fred has always been a sports fan and particularly enjoys baseball and lacrosse. He continues to be an avid reader and his favorite hobby is to spend time at the public library.

Throughout 2017, while residing in a townhome with several roommates, Fred found himself struggling with his health. His physical well-being declined rapidly,



and he began to experience daily pain related to his illnesses. Lacking proper support, Fred's ability to care for himself deteriorated. He was diagnosed with a gastrointestinal infection that required surgery in November 2017. Following the surgery, Fred was admitted to a rehabilitation facility. After three months, he was discharged, and the transition was difficult as he attempted to continue his recovery process at home. The hospital outreach coordinator from Harford County, Susan Germeroth, stepped in to help. She made a referral for the Community First Choice program, also known as CFC.

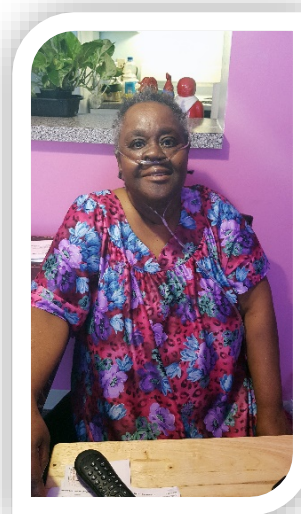
Fred wanted to remain as independent as possible but agreed additional support could help with his recovery process. Supports Planner Alysia McVey was assigned in March 2018. Alysia helped Fred to obtain six hours per week of personal care through an agency called Caring Nurses Services. Fred shared with Alysia that he felt his living arrangement no longer suited his changing physical needs. A long staircase led to Fred's bedroom and this made moving about his home difficult. In addition, Fred had limited access to public transportation. Alysia was able to identify options for Fred to move forward with a new living arrangement. She located a senior living apartment complex called Burton Manor that provided everything Fred needed. As his Supports Planner, Alysia was able to assist and guide Fred to obtain necessary legal documents required to apply. Alysia informed Fred there was a waiting list for this location, and it could take up to 2 years before there would be an opening. Fred understood and was prepared to wait as this location was a perfect fit. Surprisingly, two weeks later, Fred received the call that a unit was available for him and he could move in the following week. Alysia began working immediately to locate resources to assist Fred with his move but was unsuccessful. The short notice and limited funds created a barrier. Alysia was determined to help Fred with a successful transition. She stated, "I decided to take matters into my own hands." Alysia coordinated with Caring Nurses Services and together they developed a plan. One evening Alysia, a staff member from Caring Nurses, and two community volunteers arrived at Fred's old townhome. Working together, the small team took six hours to move Fred's belongings into his new apartment using their personal vehicles. Alysia continued to provide support to Fred until the move was finalized by assisting him to set up utilities and cable. She was able to locate donations of furniture, and once again, delivered the items personally to him.

Since his move, Fred has been more independent and has better access to the community in his new location. A public bus arrives daily to the apartment complex allowing Fred to easily access the community for doctor's appointments and shopping. His health has improved with services in place. He has developed friendships with his peers in the apartment complex and enjoys time socializing. Fred is grateful to have such a supportive team. Alysia McVey said, "Working with Fred has been such a rewarding experience. We moved quickly through the process. We went from meeting initially, to providing options for housing, then implementing approved services, and finally moving Fred into a new home in less than a week! We had to accomplish a lot together in a short period of time." In reply, Fred stated, "My apartment is starting to feel like home, and I want to thank you for all your time and effort making sure this transition in my life was successful."

LOIS'S STORY

Lois Williams was born in 1949 at Johns Hopkins Hospital in Baltimore, Maryland. She had a twin brother named Louis and the two shared a special bond as they grew up together in Cherry Hill. Lois is a lifelong resident of Maryland and raised four children in Randallstown in Baltimore County. In 1996, Lois moved from her home to be closer to her twin brother who was suffering from cancer. Lois cared for Louis as his illness progressed and he passed away a few months later. Lois was grateful to spend this time with her brother prior to his passing. Family has always been important to Lois. Distance and busy schedules prevent frequent visits, but Lois's children and grandchildren hold a special place in her heart. She surrounds herself with pictures of her loved ones and these memories bring Lois comfort.

Lois worked as a Personal Assistance Aide for a family-operated agency and developed a career of caring for others. She was a hard worker and assisted people who needed help with their daily needs for many years. Lois enjoyed her work but was forced to retire in 2012 when back pain began to limit her mobility. Throughout



that same year, her pain became “intolerable” and she developed shortness of breath that worsened as time went on. Unfortunately, Lois’s health continued to decline despite seeking medical treatment and in the summer of 2017, a referral was made by the Centers for Independent Living to the Community First Choice (CFC) program. They recognized that Lois was struggling on her own and could benefit from additional assistance. Supports Planner Megan Fansler was assigned. Megan worked closely with Lois to determine what services would be most beneficial to her. Lois was able to obtain a Personal Emergency Response System. This device is worn as a pendant on a necklace and allows Lois to call for assistance should something occur when she is alone in her home. Megan was also able to help Lois obtain a shower chair to make bathing safer and easier. During the Plan of Service process, Megan learned that Lois was hesitant to accept Personal Assistance Services. Lois was intimately familiar with the hard work involved in the care of others. She was concerned for the aide who may be assigned to help her. Lois was worried that time spent with her would be time that the aide would be away from their own family and these feelings made the process difficult for her. Even though Lois struggled to accept this service, Megan believed it could benefit Lois. Lois lived alone and had little support. Megan took a person-centered approach with Lois and expressed her understanding of Lois’s feelings. Megan provided encouragement that Lois needed throughout the planning process. Megan was able to help Lois understand that she had taken care of others for many years and she was now worthy of assistance during this time of her life. Megan’s thoughtful approach was successful, and Lois accepted 10 hours of Personal Assistance per week through CFC. A Personal Assistance Aide was scheduled. Over time, Lois developed a very strong relationship with this aide. Lois said she looks forward to seeing her aide every week and accepts help with her personal care needs, preparing meals, grocery shopping, and help with medical appointments.

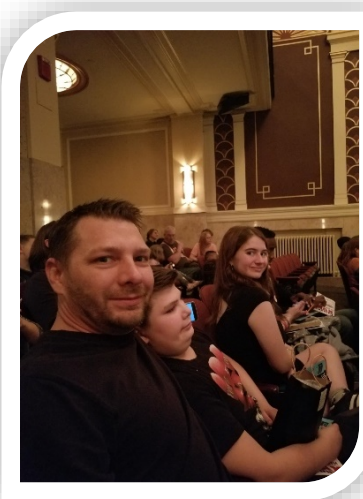
VETERANS SERVICES STORIES

ZACHARIAH’S (ZACH) STORY

Zach enlisted and served in the U.S. Army from 2003-2009 and was deployed to Iraq. He took an oath to serve his country and keep freedom in the world. Zach was trained to fix Hum V’s so the troops could utilize them in the cities and desert. Zach suffered physical and invisible injuries from his duty served. After his discharge, Zach lived and worked in Virginia and West Virginia. He was married and has two children.

In December 2017, Zach was abandoned by his wife and left him responsible for his daughter, who is 15 and a son, 10. They were homeless. Zach came to Hagerstown, MD where he hoped he could get help. Zach was referred for housing and other generic supports during the holiday season. The Supported Services for Veteran Families (SSVF) program, through Alliance, Inc., and SCI Veterans Case Management came to assist. Zach and the children received safe housing and financial supports through connections and referrals made to other non-profit charitable agencies and organizations in the Frederick and Hagerstown Veteran Support Network. SCI Case Management assisted in connecting Zach to other social services supports. Zach was also referred to SCI for DDA supports for his son, who has a diagnosis of Autism. Zach was able to get a car and develop a Person-Centered Plan to get his family stable again. With the rigor of being a single parent and varying laws in different states, Zach has needed continued case management to navigate support systems.

Zach has many skills that are transferable to civilian life and looks to get back into the workforce with the right opportunity. He is getting financial supports through the VA for his service-connected disabilities and continues to work on VA claims. Zach has also qualified for HUD-VASH housing which continues to assist with housing support and case management. Zach had a need for another car. Zach was introduced to a Vietnam era Army veteran that enjoys restoring cars and has a unique collection. Unfortunately, due to health issues he cannot continue that hobby. Zach has volunteered to restore one car for this veteran and his family to working order. The goal is to use the car for a summer vacation. In return, Zach is hoping to be gifted or negotiate a deal for a car for his use.

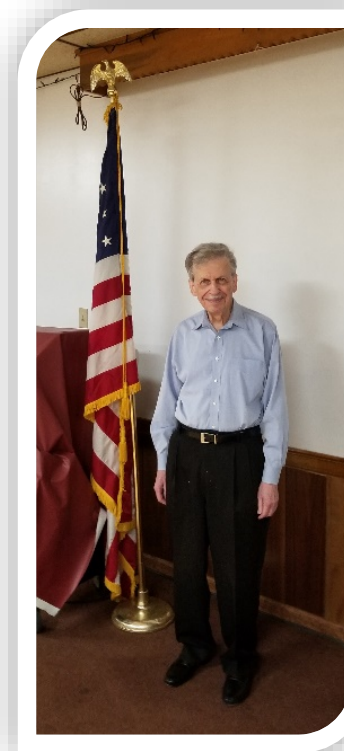


Zach and his family enjoying the Comedy and Magic show on April 7th at the Weinberg Center in Frederick. Dinner at Red Robin and tickets for the show were from an anonymous donor.

WILLIAM'S (BILL) STORY

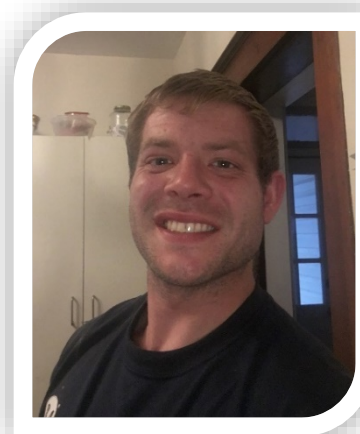
Bill Grob grew up in Baltimore, MD and entered military service out of high school. He is a Navy veteran who served our country through the Korean War from 1951 to 1956. Bill served on a naval vessel monitoring radar. He also served with the European Army of Occupation in France and Germany. After an honorable discharge from the Navy, Bill went into a successful career in sales. He met his wife, Judith while she was on a business trip in Laurel, MD in the 1990's. They decided to marry after long-distance courting and settle in Montgomery County, Maryland. In 2004 they sold their residence and bought a condominium in Frederick, Maryland where they currently reside. Bill retired in 2012 from sales from a company in Rockville, MD.

Bill enjoys fine dining and listening to Jazz music. He was referred to SCI Veterans Services through the Department of Aging, Senior Services Division in August 2018. An intake was completed, and a person-centered plan was developed for the veteran. Bill is currently receiving Veterans Case Management Services. He is receiving assistance with navigating through the VA benefits claims system for service-connected compensation. He has signed up for the VA healthcare benefit and was linked with the local VFW Post 3285, which assisted Bill with some costly medical expenses. Since Bill has decided to no longer drive a vehicle, he applied and is using the Frederick County Transit Plus program and the Taxi Assistance Program. Bill also enjoys going to the local Amvets Post #2 for a casual lunch. When asked how his case manager has impacted his life so far, Bill responded "he has helped curtail my drinking and gambling." Bill has a wonderful sense of humor.



STEVEN'S STORY

Steven Parks served in the U.S. Army from January 2012 to June 2017. Steve suffered several injuries while serving his country. Steven arrived in Frederick in late 2017. He was invited to stay with a friend until he could gain stability. In March 2018 Steve found himself homeless, with no means of support, after a disagreement with this friend. Steve was referred to SCI Veterans Case Management Service. SCI Veterans' Case Manager worked with Steve to get him into a local veteran housing provider in Brunswick, MD in which he was eligible. Steve was determined to overcome his circumstances. After a quick adjustment period and a plan put in place, Steve found a job through the linkage with DLLR. Unfortunately, after a few weeks of work, Steve was injured on the job and could not continue to work. Steve was able to utilize Workman's Compensation to keep his financial commitments and needs. While healing, Steve desperately needed to improve his oral health. He was experiencing a lot of pain. He was linked to the University of Maryland Dental School where he was able to have a large amount of dental work completed for the fraction of the cost at a traditional dentist practice. The financial officer provided Steve with a convenient payment plan, in which he has paid in full. Steven is very proud of his smile. After being out of work for two months, Steve felt well enough to acquire another job near his residence. He initially got a bike and road it to work through the winter and has been in this position for about 10 months. After managing resources, Steve was referred and acquired a vehicle through Second Chances Garage, and now has transportation. Steve has a goal of becoming a Nationally Certified Personal Trainer and is in the process of completing his final exam. He wants to become a Black Hat Trainer at Soldier Fit. Steve is currently looking to leave the veterans housing agency to make room for someone else. He says it's time to live independently. Steve says he owes much of his success over the past 14 months to SCI Case Management Services.



PARTNERS

SCI successes and day-to-day operations would not be possible without a strong team of organizational and program partners. The strong relationships SCI has established and built with these external partners allows us to carry out our mission. Below is a short list of our partners.

DDA & DD COALITION:



HUMAN RESOURCES:



ORGANIZATIONAL:



<https://www.medicaid.gov/medicaid/managed-care/ltss>



<http://standardsforexcellence.org>



<https://www.ceoreport.com>



<https://www.fcbsd.com>



<http://marylandnonprofits.org>

INFORMATION TECHNOLOGIES



<http://dell.com>



<http://www.samsung.com>



<http://www.microsoft.com>



<https://www.verizon.com>



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We work in communities throughout Maryland to support more than 13,350 individuals.

With our fully mobile workforce, we work in areas of the state that are most convenient and important to you, including your work or home. We provide our case management services to individuals residing in the Southern, Central and Western Regions of Maryland.

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