

# “Making It Real” Campaign: Human Face of Budget Cuts

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## *Brooklyn*

### **Impact of Department for the Aging cut to Case Management for Homebound Elderly Residents of Brooklyn**

**Council of Senior Centers and Services of New York City, Inc., November 2010**  
**Document Coordinator: Kerry Sullivan & Ana Betsabe Soto**



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# CSCS

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# Case Management Anecdotes

November, 2010

## Brooklyn

|       |                           |
|-------|---------------------------|
| CM=   | Case Manager              |
| HC=   | Home Care                 |
| HMDL= | Home Delivered Meals      |
| MOW=  | Meals on Wheels           |
| APS=  | Adult Protective Services |

| Agency   | Council Member |
|--|----------------|
| Rhonda Grand: 718.257.1600<br><br>LMSW, Executive Director<br><br>Special Services for Senior Citizens | Dilan, Mealy   |

**Anecdote**

**Council Member Dilan**

**Client # 1**

Ms. T. is a 78 y/o old divorced woman residing with her son as a tenant in a private home with an absentee landlord. She has no electricity, heat or hot water. During the Case Manager’s comprehensive in-home assessment, he found her son smoking crack cocaine. Ms. T. suffers with extreme painful osteoporosis in her back and arthritis in her legs. This combination limits her ability to perform housework, shop, prepare meals and personal care tasks. Her home is in major disrepair posing health and safety threats from leaking walls, cracked floors, vermin and roaches. Ms. T. spends most of her time lying on an old torn couch. She acknowledges feeling sad. Her main source of nutrition is snacks. The Case Manager immediately provided emergency meals-on-wheels and referred the client to Adult Protective Services. Since the Case Manager recognized other significant unmet needs, he pursued additional case management activities and discovered the client has Section 8 housing. Therefore, he used his case management skills to expedite relocating Mrs. T. to emergency Section 8 housing given her dangerous living conditions. She did not have moving expenses and through his case management efforts, obtained funds from HRA. Mrs. T. no longer resides in substandard housing, has a rent she can afford and is safe. She will receive case management services to ensure she remains stable in her home and community. According to Mrs. T. she stated her sadness lifted and feels she has a professional case manager upon whom she can rely for future case management assistance.

Case Management Hours: 11

Cost of Case Management: \$451.11

(cont.)

**Council Member Mealy**

| <b>Agency</b>  | <b>Council Member</b> |
|--|-----------------------|
| Rhonda Grand: 718.257.1600<br><br>LMSW, Executive Director<br><br>Special Services for Senior Citizens | Dilan, Mealy          |

**Client # 2** Ms. Y. is an 80 y/o old divorced female whose comprehensive in-home assessment disclosed she suffers from mental illness. The client's NYCHA studio is in considerable disrepair: walls held together by scotch tape, dirt, limited, torn furniture and roaches. Snacks are her primary source of nutrition. The client continually states, "People are stealing things from me and constantly watching me." The Case Manager first provided emergency Meals-on-Wheels, made referrals to a mobile mental health crisis team for a psychiatric evaluation, and APS. Although APS rejected this client, the Case Manager prioritized her case management needs and dealt with APS afterwards. The Case Manager contacted the NYCHA social worker to advocate for appropriate housing and successfully placed the client on the NYCHA waiting list for senior housing. Moreover, the Case Manager, in collaboration with the NYCHA social worker, obtained new furniture through NYCHA's emergency furniture program. To ensure the client remains at home and not in a nursing home, the Case Manager employed his case management skills to apply for and secure Medicaid Homecare. Given the multiple major and rapid changes this client experienced, she accepted supportive counseling from the Case Manager to alleviate her fears and anxiety which enabled her to make choices in her best interests. Despite her history of mental illness, she accepted the supportive counseling because the Case Manager was the one constant and trustworthy professional in her life. Ultimately, the Case Manager built upon this case management foundation, and procured a NYCHA senior apartment the client willingly accepted.

Case Management Hours: 13

Cost of Case Management: \$ 520.13

FOR BOTH CLIENT EXAMPLES :The Quality of Life Improved

Case Management Services Complies with NYS Most Integrated Setting Law

| Agency  | Council Member  |
|---|---|
| Amy Chalfy:<br><br>JASA<br><br>AChalfy@jasa.org | David G. Greenfield, Mathieu Eugene, Michael Nelson ,Lewis A. Fidler, Dominic Recchia |

**Anecdote**

**JASA Storefront Case Management Program  
 NYC Council Members: David G. Greenfield  
 Mathieu Eugene**

**Mr. M** is aged 66 is retired and lives alone in Brooklyn. In his working life he provided case work services for adolescents. He is divorced and unfortunately estranged from his adult children. Mr. M suffers from emphysema and other symptoms of chronic obstructive pulmonary disease. This health condition often prevents him from leaving his apartment. The initial home visit conducted by a social worker from JASA’s Storefront Case Management Program revealed that Mr. M was struggling to care for himself and maintain a healthy living environment. The apartment was dusty and roach infested. Based on JASA’s assessment, Mr. M is receiving home delivered meals and EISEP housekeeping services. With these services in place, he is eating a more nutritional diet. He has also been able to maintain a clean and vermin free apartment (He was able to have the apartment exterminated once the home was cleaned properly).

Mr. M has limited income and resources. Based on his eligibility, the JASA social worker helped him apply for SCRIE, Food Stamps, and HEAP. Several calls were needed to follow the progress of these applications through the system. Mr. M missed his in-home Food Stamps phone interview and the social worker helped him secure another appointment. He was ultimately approved for Food Stamps. Mr. M recently complained to the social worker about his teeth but reported that he didn’t have the funds for the care. JASA connected him to a local free dental care provider (Donated Dental Services) and helped Mr. M complete the application for services. Although on a waiting list for a short time, Mr. M subsequently received the dental care. He reports that overall, his well being has improved and he has a renewed sense of self-dignity.

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| Agency   | Council Member  |
|--|---|
| Amy Chalfy<br><br>JASA<br><br>AChalfy@jasa.org | David G. Greenfield, Mathieu Eugene, Michael Nelson ,Lewis A. Fidler, Dominic Recchia |

**JASA Sheepshead Bay Case Management Program**

**NYC Council Members: Michael Nelson**

**Lewis A. Fidler**

**Ms. B** is aged 86 and widowed. She lives alone and is a client of JASA's Sheepshead Bay Case Management Program. Ms. B suffers from depression, respiratory problems (COPD), poor mobility, cataracts, and has a history of cancer. She uses a walker. Ms. B's adult children live out of state. She has a neighbor with whom she maintains regular contact, but she is isolated. Ms. B receives home delivered meals. The social worker provided supportive counseling around aging issues, explored long-term care options, and arranged for her to receive nutritional counseling through DFTA. JASA also conducted a referral to the Jewish Community Council of Greater Coney Island for participation in its Friendly Visiting program (a volunteer visits her weekly and a referral to the Red Cross Telephone Reassurance program through which she receives weekly calls.

Recently, the Friendly Visiting Volunteer noted that Ms. B was losing weight and seemed sad. She reported this to the JASA social worker. The social worker contacted Ms. B immediately and learned that she was not taking her medication for depression (prescribed by her primary doctor). Ms. B reported that she did not feel comfortable talking about her feelings with her doctor. The social worker determined that Ms. B was not at risk for suicide but did need additional support. With the client's permission, the social worker contacted Brookdale Hospital's Homebound Elderly unit, followed up with the client's medical doctor, referred her to VNSNY for a nursing assessment and medication management. Ms. B is now visited by a psychiatric social worker provided by Brookdale Hospital. She also receives monthly visits from a registered nurse to monitor her medications. She is now doing much better.

**JASA South Brooklyn Case Management Program**

**NYC Council Member: Dominic Recchia**

**Ms. L** is aged 72. She lives alone in an apartment in Coney Island. Ms. L suffers from heart disease, diabetes, renal disease and must use a motorized scooter to get around outside and a walker in her home. Her son lives in Pennsylvania and her daughter, although residing nearby, is too ill herself to help care for her mother. Ms. L contacted

(cont.)

| Agency                                 | Council Member  |
|--|---|
| Amy Chalfy<br>JASA<br>AChalfy@jasa.org | David G. Greenfield, Mathieu Eugene, Michael Nelson ,Lewis A. Fidler, Dominic Recchia |

JASA's South Brooklyn Case Management Program to get home delivered meals. Based on JASA's assessment, Ms. L began receiving meals immediately. The social worker also completed an application for Medicaid and food stamps. While Medicaid was pending, the social worker conducted several calls to the Medicaid office to verify its status. Within the next few months, it appeared that Ms. L was having increasing difficulty managing personal care and household chores. The social worker discussed Medicaid home care with the client and with her permission contacted her doctor for completion of the appropriate form (M11Q). As with the Medicaid application, the social worker conducted several calls with the local CASA office to insure appropriate processing of the application. Ms. L is now assisted by a home attendant funded through Medicaid.

#### **Anecdote**

##### **Councilwoman Sara Gonzalez**

| Agency  | Council Member                  |
|---|---------------------------------|
| Judy Willig: (718) 596-8789<br>LCSW<br><br>Executive Director<br>Heights and Hills, <i>Supporting Brooklyn's Older Adults</i><br><br>jwheightsandhill@aol.com | Sara Gonzalez, Jumaane Williams |

MJ is a 93 year old widowed female living alone on the third floor in a walk-up Sunset Park. She has a fixed, low-moderate income. MJ had been receiving home delivered meals since 2005. When her Social Worker (SW) first visited her last summer, he found she had a minimal support system and had not visited a physician in many years. She had a mobility impairment and also appeared to exhibit possible signs of early stage dementia. The SW first facilitated a physician visit via house call to examine the client. He then referred the client to a Medicaid managed care program to address her ADL and IADL needs in the home and community. The SW also went to the store to purchase a fan for the client's home as the client had no air conditioning or fans in the home. Additionally, this SW assisted the client in applying for HEAP's free air-conditioning program. The client now has a primary care physician, medication and medication monitoring, a home attendant, mobility devices, and a cooler home when needed. These interventions are vital to ensuring the client's continued safety at home and in the community.

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| Agency  | Council Member                     |
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| Judy Willig: (718) 596-8789<br>LCSW<br><br>Executive Director<br>Heights and Hills, <i>Supporting<br/>Brooklyn's Older Adults</i><br><br>jwheightsandhill@aol.com | Sara Gonzalez, Jumaane<br>Williams |

**Councilman Jumaane Williams**

Mr. J is an 80-year-old man who was referred to Heights and Hills by Visiting Nurse Services for home-delivered meal service. Mr. J resides in a multi-story private home that his daughter owns. Mr. J and his daughter do not have a close relationship and he is unable to rely on her to assist with his needs. Mr. J has multiple health issues including heart problems and an enlarged prostate that requires the use of a catheter. Upon meeting Mr. J for the first time, it was clear that home-delivered meal service was just one of many services that he would benefit from. Mr. J informed the social worker that he was not receiving his food stamp benefits as one of his children was using the benefits for their own purpose.

The Social worker worked with Mr. J and the food stamp office to ensure that Mr. J would receive the food stamp benefit he is entitled to. The Social worker also assisted Mr. J with getting new documents including a new social security card and Medicare card so that Mr. J could apply for Medicaid benefits. Social worker assisted Mr. J in applying for Medicaid through a Medicaid Managed Care Program. Mr. J now has both Medicaid and Medicaid homecare. Mr. J's home attendant is able to accompany him to his medical appointments, help him sort through his mail, and do the housekeeping and laundry on a regular basis. Although Mr. J was referred to Heights and Hills for home-delivered meal service, there were many other areas in his life that required attention, assistance, and support. The Social worker has done multiple home-visits and phone conversations to ensure that Mr. J is able to remain safely in his home and community.

| Agency  | Council Member     |
|---|--------------------|
| Sandra Christian:718-821-0254<br><br>Ridgewood Bushwick Senior Citizens Council<br><br>srchrist10@gmail.com | Vann, Reyna, Levin |

**Anecdote**

**Council Member Vann**

1). Ms. W. is a 72-year-old single Caucasian female who is the youngest of twelve children. Client witnessed her mother being abused by her father and informed Case Manager about she too being abused by her father as well. As a result, client experience great difficulty with trusting others however she appears to have confidence/trust in Case Manager.

Client has two children. However, she doesn't have any relationship with them. She reported giving them up for adoption while they were young. Client doesn't have any relationship with any of her family members. Client has no informal supports available to her. Client suffers from emphysema and uses a walker to ambulate.

Client continues to survive on a very limited income of \$761.00 a month. Client was self referred (06/02/2009) to our Agency- Ridgewood Bushwick Senior Citizens Council in order to obtain HMDLs.

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***Case Manager was able to apply/advocate for the following Social Services:***

~ Deep Cleaning. Client's environment was filled with clutter, vermin, etc. therefore posing unsafe living conditions. Case Manager was also able to advocate for client in contacting NYCHA in order to put in a request to have client's apartment exterminated and painted.

~ Doctor Visit: Case Manager was able to encourage client to see a doctor. Client hadn't seen a doctor for well over a year. Through hard work and the collaboration with the Director for the Louis Armstrong Senior Center, Ms. Prince, Client visited her doctor. Case Manager arranged for transportation to and from the doctor.

~ Furniture Voucher: Once Heavy duty/ Deep Cleaning was complete, Case Manager was able to apply and obtain a Furniture voucher.

~ Case Manager then applied to CNH Long Term Care for HMPC Services (pending).

~ Case Manager continues to assist client with the recertification process (completion of applications, etc.) for services in which she

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| Agency  | Council Member     |
|---|--------------------|
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currently receives. She also continues to advocate for client as needed.

\*As a result of Case Manager's advocacy and hard work, Client now resides safely, in a clean environment, has visited her Doctor, and is in the process of obtaining HMPC Services.

Case Management Time: two year period, working on several issues.

Cost of Case Management: \$1250

**Council Member Reyna**

2). Mr. J. L. is a 75 year old African American male who **NOW** resides in safe - affordable housing due to the empowerment, advocacy, guidance, and support of his Case Manager. Client has no informal supports available to him. Also, client would not have reached out to the community in order to ask for help. Mr. L. was referred to our Agency- Ridgewood Bushwick Senior Citizens Council for HMDLs.

Mr. L.'s wife passed away approximately six years ago. Prior to her passing, they shared everything together; including their financial responsibilities. After Mr. L.'s wife's passing, he was forced to leave their apartment (due to his inability to pay the rent) and moved into a basement apartment (\$400.00 monthly).

CM M. R. and CM Supervisor conducted a joint visit and observed client's environment. This basement apartment consisted of unsafe and deplorable conditions (fumes from the boiler, inadequate heating, no ventilation, no windows, poor lighting, no cooking facilities, no telephone, vermin, etc). Due to client not having a telephone, Case Manager was required to go to client's home in order to provide assistance/advocacy and to ensure that he was ok (whenever he missed his meal delivery). Mr. L suffers for the following health conditions: foot problems, high blood pressure, diabetes, liver disease, chronic constipation and dental problems. Client survives on a very limited income \$746.00.

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***Case Manager was able to apply/advocate for the following Social Services:***

~Section 8 (twice, due to client's inability to find an apartment within the required timeframe).

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| Agency  | Council Member     |
|---|--------------------|
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~ One Shot Deal: Due to the passing of client's wife and the loss of her income, client experienced great difficulty with paying his monthly bills.

~ Life Net: Client now has a free cellular phone to make and receive calls.

~ Case Manager continues to assist client with the recertification process (completion of applications, etc.) for services in which he currently receive.

\*As a result of Case Manager's advocacy and hard work, Client now resides safely, in a one bedroom apartment - located at 1073 Broadway in Brooklyn, N.Y. Client also pays less for his monthly rent (\$154.00).

Case Management Time: two year period, working on several issues.  
Cost of Case Management: \$4077

**Council Member Levin**

3). Mrs. A is a 94 year old female that lives alone in a rent stabilized apartment. She is receiving SS, SSI, Medicare, Medicaid, Medicaid home care (12 hours a week) and HMDL service. She refuses to apply for Food Stamps. Client has been diagnosed with Alzheimer's and is exhibiting early signs of dementia, visually impaired due to glaucoma in the left eye and rheumatoid arthritis. She has a niece who acts as an informal support but she resides in Boston, Ma. Her assistance is limited to managing the client's finances. She often tries to call the client weekly and visit monthly but is not always able to make it to NYC due to her own limitations. Her work involves her traveling extensively.

Prior to start receiving Medicaid HC client was managing her ADL'S without assistance and receiving HMDL service. Client always reported attending doctor's appointments on a regular basis. After CM visited the client several times before she became aware that the client was experiencing a decline in her memory and in fact was no longer an accurate reporter. During a home visit CM observed various bottles of

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medications that were empty or that had expired. At that moment CM contacted client's PCP and confirmed that he had continued to provide prescript refills for her medications but in fact he had not seen her in over a year.

CM took immediate action and contacted client's niece. She updated her in regards to client's medical care and her observations and emphasized client's memory deficit and her need for assistance. Client's niece was very surprised to hear the news and expressed how overwhelming it's for her to take care of her aunt while she resides in another state. She is not familiar with resources in the community and services available to the client. She authorized CM to arrange for client to see a doctor as soon as possible because she did not know how to proceed. CM got in contact with a doctor that makes house calls in order to visit the client. CM arranged for this service and within days the client had received a doctor's visit and had new set of medications. Client was also assisted at that time with the completion of an MIIQ. CM assisted client with gathering all the necessary documentation in order to expedite her MCAID HC application. At this moment client is receiving MCAID HC services. Client and her niece feel more comfortable now that the client is receiving the assistance that she deserves at home. Client will continue to be monitored by CM in order to arrange additional hours of MCAID HC if necessary.

Case Management Hours: 18

Cost of Case Management: \$994

**Council Member Reyna**

4).Mr. S is an 87 year old widow male that lives alone in a Mitchell Lama building. He is receiving SCRIE benefits, Social Security, Pension and Medicare. He has refused to apply for any other entitlement due to his worries about monthly payments to credit card companies. His monthly rent payment is \$697.00. He is also receiving 12 hours of personal care and 7 HMDL in order to meet his unmet needs. Mr. S has been diagnosed with the following illnesses: anemia, severe hearing and mobility impairment, constipation, arthritis in the lower extremities, back and hands. He also needs laser surgery for cataracts in his eyes. The client has also been diagnosed with general weakness, shortness of breath, and borderline diabetes. Client has serious skin problems; He has red, scaly skin rashes and two ulcers in right leg area.

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Client stated he is unable to visit his dermatologist who is affiliated with the Wound Clinic Center of Kings brook Jewish Hospital because he can't afford to pay the \$20.00 copayment for each visit. Client also shared that the cost of medication is also a serious problem for him.

Client also suffers water retention, bone deficiency and swollen feet. He also has arthritis, poor blood circulation and seasonal allergies. Client required a medical examination by otolaryngologist to determine the cause of his current hearing loss. Client postponed most of medical appointments due to financial hardship due to high credit card debt with high interest rate (27%).

Client has a daughter who resides nearby and visits the client weekly. However, her assistance is limited to visiting the client and spending time with him only. No other involvement has been reported. The client does not trust her to manage his financial matters and feels more comfortable being served by an official organization helping seniors in NY. He considers his home care worker and Case Manager his strongest supports.

Client was placed in Kingsbrook Jewish Medical Center on August 19, 2009 and discharged on August 24, 2009 due to ulcers on his legs. Client takes 12 medications according to medication regimen prescribed by his doctor. Client is able to perform all tasks involved with the use of medications. Client stopped to visit Wound Clinic Center of Kingsbrook Jewish Hospital due to financial hardship. Client's financial situation negatively impacted his overall medical care. Client also stopped paying his rent on a regular basis and his SCRIE benefit was impacted by this.

CM was able to refer the client to a physician who makes home visits and deal with immediate wound care needs. CM tried several times to provide the client with different alternatives to assist in addressing his financial worries. It took time and effort, numerous phone calls and visits on behalf of the Case Manager to develop the necessary trust in order for client to accept CM assistance and begin addressing his financial matters. Client was resistant, anxious and hesitant to allow other individuals to address his financial issues with the credit card companies. Client did not know who to call or how to proceed. It appears that he had gotten to the end of the road and that's why he had started to neglect his medical care in order to make his credit card

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|---|-----------------------|
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payments. After having several conversations with the client and advocating on his behalf. Client made the decision to follow his CM recommendations and accepted the cm's assistance and allowed cm advocate and create the necessary linkages to several agencies in regards to address his financial matters. CM referred the client to the CSCS' Bill Payer Program and Legal Aid Society Brooklyn Office for the Aging. The Bill Payer volunteer referred client to the Financial Management International Program. These programs are currently addressing all of his financial concerns. Client has expressed that now he will be able to attend his medical appointments and pay for his medications without thinking that he has to make his credit card bills his priority so he doesn't feel harassed by them.

Case Management Hours: 18

Cost of Case Management: \$900





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