Illinois CARE Connections

What is Illinois Care Connections?

The Illinois Department on Aging (IDoA) and the Illinois Department of Human Services (IDHS) received $1.7 million through the CARES Act from the Department of Health and Human Services, Administration for Community Living to provide services to older adults and persons with disabilities who are socially isolated as a result of the COVID-19 pandemic. Illinois Care Connections will provide technology devices such as iPads or Tablets to participants to help facilitate social connections with family and friends on a first come first serve basis.

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Who is eligible to receive technology devices through Illinois Care Connections?

- Participants receiving services through IDoA, IDHS-DD and IDHS-DRS providers and programs are eligible if they have been socially isolated as a result of the Coronavirus and are experiencing loneliness and a lack of connectedness.

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Are there any financial eligibility requirements for participants?

- No

Can individuals complete the application process themselves?

- No. Only IDoA, IDHS-DD or IDHS-DRS and/or their approved provider organizations statewide can submit an application on the participant's behalf.

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Which devices are being offered?

Apple iPad 32GB

Samsung TAB A 32GB

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What apps will be installed?

TeamViewer QS

FaceTime – iPad Specific

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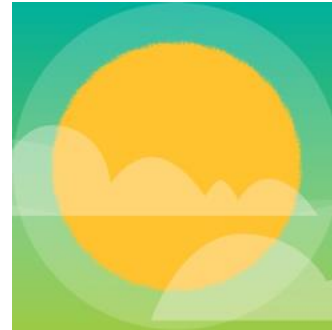
Installed apps continued

Zoom Cloud Meeting

COVID Coach



Installed apps continued: Android

Hangouts – Android Specific

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Where do you apply at?

https://care.iltech.org

https://www.iltech.org

Illinois CARE Connections Form

IATP Home | About IATP | Care Connections Home | Care Connection Request

IDoA Illinois Department on Aging | IDHS Illinois Department of Human Services | iatp Illinois Assistive Technology Program Independent Living Through Technology

Illinois CARE Connections

PLEASE NOTE: THIS REFERRAL FORM MUST BE COMPLETED IN ITS ENTIRETY IN ORDER FOR THE PARTICIPANT TO BE CONSIDERED FOR THE PROGRAM

Requests can only be made by an authorized agency with a valid Agency Code

* = required

Referring Agency

Referring Agency Code *:

Referring Agency Name *:

Referring Agency Point of Contact

First Name *:

Last Name *:

Address Line 1 *:

Contact

Address: 1020 South Spring Street Springfield, IL 62704

Voice: (217) 522-7985

TTY: (217) 522-9966

v/TTY: (800) 852-5110

email: iatp.care@iltech.org

Fax: (217) 522-8067

Hours

Monday - Friday

8:00 a.m. - 4:30 p.m.

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Asterisk *

- Means REQUIRED

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Referring Agency Information

Referring Agency

Referring Agency Code *:

Referring Agency Name *:

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Referring Agency Point of Contact

Referring Agency Point of Contact

First Name *:

Last Name *:

Address Line 1 *:

Address Line 2:

State *: Illinois

County *:

City *:

Zip *:

Phone Number *:

Email Address *:

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Is this participant new to your agency?

(The participant is the individual for whom the device is being requested)

Is the participant new to your agency? * ◯ **Yes** ◯ **No**

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Participant Information

First Name *:

Last Name *:

Address Line 1 *:

Address Line 2:

State *: Illinois

County *:

City *:

Zip *:

Phone Number (landline):

Phone Number (mobile):

Alternate Phone Number (Family, Friend, Support Staff):

Email Address:

Age *:

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Shipping Procedures

Notice: The Device Bundle will be shipped via UPS with a signature required. Will the participant be able to sign for the package? *

○ Yes ○ No

If No, the participant does not have someone that can sign

If no, is there an alternate address where the device can be shipped with signature requirement? *

○ Yes ○ No

Shipping Procedures continued

Please enter an alternate shipping address where someone will be available to sign for the package:

Ship To Name *:

Ship To Address Line 1 *:

Ship To Address Line 2:

Ship To City *:

Ship To State *: IL

Ship To Zip Code *:

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Selecting a representing agency: IDoA

Illinois Department on Aging

- Required information is this a CCP Participant if not has a referral been made?
- Required information is this a OAS Participant?

☑ Department on Aging

CCP Participant? *

○ Yes

○ No

OAS Participant? *

○ Yes

○ No

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Selecting a representing agency: DHS-DD

Division of Developmental Disabilities

- [x] Department of Human Services Division of Developmental Disabilities

Selecting a representing agency: DHS-DRS

Division of Rehabilitation Services

- Required information DRS case number

☑ Department of Human Services Division of Rehabilitation Services (Please Specify)

☐ Home Services Program (HSP)

☐ Vocational Rehabilitation (VR)

Case Number *:

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UCLA-3 Loneliness Scale

Along with providing equipment for participants through IDoA, DD, and DRS. This project has a study component that will be able to provide information to the participating agencies along with HHS/ACL about the successfulness of providing participants with devices to combat social isolation.

The UCLA-3 Loneliness Scale is a three question survey that requestors will need to answer. Their is no wrong answer to the survey questions, and the answers will not affect the participant getting a device.

UCLA-3 Questions

The responses to the questions will be scored as follows:

Response	Score
Hardly Ever	1
Some of the Time	2
Often	3

1. How often does the participant feel that they lack companionship? *:

2. How often does the participant feel left out? *:

3. How often does the participant feel isolated from others? *:

The score for each individual question is tallied together to give you a possible range of scores from 3 to 9.

Total Score: 0

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UCLA-3 Pre and Post Follow Up Survey

During the request process we will ask the requestor to answer the 3 UCLA loneliness scale questions.

After the participant has had the device for roughly 10 months IATP will be in contact to take a post follow up survey asking the same three questions and also including a satisfaction survey.

If the participant is difficult to get in contact with we may be asking the requestor for assistance to perform this post follow up survey.

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General Screening Questionnaire - Reason

What is the **main** reason for participant being referred? (choose one) *

- Social Isolation
- Communicate with family/friends
- Purchase food and other household items
- Recreation
- Other (please specify)

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General Screening Questionnaire – Tablet and Telephone

Does the participant currently use a tablet type device? * ○ **Yes** ○ **No**

What kind of telephone does the participant use? ○ **Landline** ○ **Mobile (Cell)**

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General Screening Questionnaire – Internet Access

- If you select Yes

Does the participant currently have Internet Access? * Yes No

If yes, who is the Internet provider?:

- If you select No

Does the participant currently have Internet Access? * Yes No

I have read and informed the customer that they will receive internet access for 12 months of and then they will be responsible for assuming the cost *

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General Screening Questionnaire – Support

Is there someone in the home or who otherwise is available to assist the participant with technical problems like resetting internet, rebooting or troubleshooting electronic equipment? *

Yes No

If No, Does the participant have family or friends that regularly come visit? (check all that apply)

- In the neighborhood
- Locally
- Within 50 miles
- Farther than 50 miles

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General Screening Questionnaire – Support Types

Would the participant be able to participate in technical assistance via the following modalities: (check all that apply)

- ☐ Phone
- ☐ Webinar
- ☐ Written instructions (paper or via email)

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Functional Assessment: Cognitive/Memory

Cognitive/Memory – Will the participant be able to do sequential memory tasks for turning device on/off, navigating menus and activating applications (apps)? *

○ **Yes** ● **No**

If no, how would you rate the participants' cognitive/memory skills? *

○ **Poor** ○ **Somewhat Limited** ○ **Good** ○ **Unsure**

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Functional Assessment: Motor Skills/Dexterity

Motor Skills/Dexterity – Will be able to find and manipulate buttons; can learn and perform gestures (i.e. tapping, swiping)? *

Yes   No

If no, how would you rate the participants' motor/dexterity skills? *

Poor   Somewhat Limited   Good   Unsure

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Functional Assessment: Hearing

Hearing – Will the participant be able to hear audio output of the device? *

○ Yes ● No

If no, how would you rate the participants' hearing/understanding speech? *

○ Poor ○ Somewhat Limited ○ Good ○ Unsure

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Functional Assessment: Vision

Vision – Will the participant be able to see and/or read the screen? *

- ○ **With magnification**
- ○ **Without magnification**
- ● **Unsure**

If unsure, how would you rate the participants' vision/reading text skills? *

○ **Poor** ○ **Somewhat Limited** ○ **Good** ○ **Unsure**

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Hardware

Hardware (please select one): *

- ○ iPad with case/stand
- ○ Android Tablet with case/stand
- ○ Not Sure (which device will best meet the participants needs)

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Accommodations

Possible Accommodations (check all that are needed):

- [ ] Siri Support
- [ ] External Keyboard
- [ ] Voice Over Training
- [ ] Step by Step Written Instructions (alternate language)
- [ ] Step by Step Written Instructions (Braille)
- [ ] Step by Step Written Instructions (Large Print)
- [ ] Headphones
- [ ] Other (please specify)

Submit Referral

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Recap

- To be eligible to receive a device the participant must be enrolled in your respective agencies services.
- Their are no financial requirement components to receive a device.
- Participants cannot submit requests only participating agency representatives.
- Each participant can only receive ONE device.
- The devices do not have any extended warranties or accidental breakage coverage.

Important addresses

Website: www.iltech.org

Refferal Website: https://care.iltech.org

Email: iatp.care@iltech.org

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