

Home and Community-Based Services for Florida's Seniors: Case Management¹

Muthusami Kumaran, Katlyn Diamond, and Rachel Gatto²

Introduction

This publication is part of the Home and Community-Based Services for Florida's Seniors series, a collection of educational resources designed to inform the public about home and community-based support services available to seniors in Florida.

The Older Americans Act of 1965 (OAA) provides a variety of home and community-based services for eligible older Americans (those aged 60 years or older, as defined by the OAA) that are channeled through the Administration on Aging (AoA) and state-level units on aging. In the state of Florida, these services are administered and implemented through Florida's Aging Network, which comprises the Florida Department of Elder Affairs (DOEA) and a host of 58 nonprofit organizations.

As the older adult population of Florida continues to grow rapidly, it is increasingly important that the state's seniors, their caregivers, other stakeholders, and the general public understand the home and community-based services and protections available through the 58 nonprofits — 11 Area Agencies on Aging (AAAs) and 47 Community Care for the Elderly (CCE) lead agencies — that make up Florida's Aging Network.

What Is Case Management?

Case management is a central component of Florida's Aging Network. It refers to the ongoing coordination of services that help older adults maintain independence and remain in their homes, avoiding costly institutional care. Under Florida Statute Chapter 430, case management is a mandated service and is a critical entry point for clients seeking long-term care assistance (The Florida Senate, 2024). Case managers play a key role in assessing needs, planning care, arranging and monitoring services, and connecting older adults and their families to a wide range of community-based resources (Florida Department of Elder Affairs, 2016). According to a

government report by the Administration for Community Living (2021), about nine out of 10 service recipients stated that their case management helped them age in place at their homes.



Figure 1. A professional talks with two older adults.

Credit: © Africa Studio/Adobe Stock.

What Does a Case Manager Do?

Case managers are at the heart of Florida's Aging Network. They ensure that each client receives the right mix of services at the right time, based on an individualized assessment of needs. Their work goes beyond referrals. Case managers act as connectors, advocates, planners, and monitors (Florida Department of Elder Affairs, 2016).

Key responsibilities include the following.

- **Assessing needs:** Case managers conduct in-depth, face-to-face assessments using standardized assessment tools such as the DOEA 701B form and others. These assessments evaluate a client's physical and mental health, nutrition, daily functioning, caregiver status, social support, and home environment.
- **Developing a care plan:** Once a client is found eligible, a personalized care plan is developed within 14 business days. The care plan identifies what services are

needed, who will provide them, and how often they will be delivered. Clients, caregivers, and family members are involved in this process to ensure the plan reflects the client's goals and preferences.

- **Arranging services:** After the care plan is in place, the case manager works with the county government to connect the client to both formal providers (such as meal delivery, personal care, or adult day care services) and informal supports (such as help from neighbors or faith-based groups). Service options may vary depending on location.
- **Coordinating with other agencies:** Case managers work with a wide network of community partners, including hospitals, doctors, the Department of Children and Families, and the Veterans Administration, to ensure that clients receive the broadest range of support available.
- **Monitoring and follow-up:** Case managers check in with clients regularly to make sure services have started and are working as intended. Every six months, they conduct home visits to review the care plan, assess whether needs have changed, and make updates as necessary.
- **Reassessing annually:** At least once a year, the case manager performs a comprehensive reassessment to determine whether current services are still appropriate, or if new interventions are needed.
- **Modifying or ending services:** If a client improves, worsens, moves away, or no longer wishes to receive services, the case manager will modify or close the case, always involving the client and caregivers in the decision.
- **Protecting vulnerable adults:** Case managers are required by law to report suspected abuse, neglect, or exploitation to the Florida Abuse Hotline (The Florida Senate, 2024).

Overall, case management should aim to promote self-sufficiency, ensure quality and efficiency, and support continuum of care (Florida Department of Elder Affairs, 2016).



Figure 2. An older couple meets with a professional.

Credit: © SKW/Adobe Stock.

The Care Planning and Coordination Process

Care planning is a structured, collaborative process that transforms assessment results into a practical action plan for services. After completing the initial face-to-face assessment, the case manager works with the client — and often with their caregiver or family — to develop a written care plan within 14 business days. This plan serves as a roadmap to meet the client's needs while supporting their independence and well-being (Florida Department of Elder Affairs, 2016).

The care plan outlines the following.

- **Which services** the client needs (e.g., meal delivery, transportation, respite care [temporary relief provided to primary caregivers]).
- **How often** they are needed (e.g., weekly, daily).
- **Who will provide them** (e.g., local contracted providers, informal helpers such as a neighbor or church group).
- **How the services address specific challenges** identified in the assessment (e.g., medication management, mobility issues, caregiver fatigue).

Coordination is key. Case managers do not just refer clients to services — they ensure that services are delivered on schedule, do not overlap unnecessarily, and are adjusted if the client's condition changes. Case managers communicate regularly with providers, caregivers, and other agencies. This coordination helps to prevent service gaps and ensures a smooth experience for clients, especially when they are juggling the stress of multiple health or support needs (Florida Department of Elder Affairs, 2016).

Case managers must also follow up after arranging services to confirm that they have started and meet the client's expectations. They monitor satisfaction, safety, and progress, revisiting the care plan every six months and performing a full reassessment at least once a year. If a client's needs increase or decrease, or if the client refuses a service, case managers document changes and revise the plan accordingly.

Ultimately, the care plan is a living document designed to balance the client's goals, available resources, and the least restrictive path forward. It reflects a team effort that includes the case manager, client, caregivers, and the broader community.

According to guidelines from the Florida Department of Elder Affairs (2016), effective case management is guided by the following core principles.

- **Gatekeeping:** The case manager serves as a knowledgeable guide who links clients to the most appropriate and least restrictive services available.
- **Client-centered approach:** Services are coordinated based on each client's individual needs, goals, and preferences, regardless of which agency provides them.
- **Service flexibility:** Case managers should never limit services to only those offered by their own agency. They should ensure that clients receive the most suitable care options.
- **Coordination:** Case managers coordinate services across multiple providers to prevent duplication and ensure timely, efficient support.
- **Linking systems:** Case managers connect clients to both social service programs and healthcare systems, such as hospitals, physicians, and nursing homes.
- **Support for informal networks:** Informal supports, such as family members, neighbors, and religious groups, are considered vital. Case managers help clients identify and build upon these networks.
- **Family engagement:** Families are encouraged to participate in care decisions and are connected with services such as respite care.
- **Caregiver training:** Family members may also receive training in caregiving techniques to better support their loved ones.

Conclusion

Case management is a cornerstone of Florida's Aging Network, helping older adults remain safe and independent in their homes while connecting them with essential services and support systems. Through thorough assessments, collaborative care planning, and continuous coordination, case managers ensure that each client receives personalized care tailored to their unique circumstances. By involving family, leveraging both formal and informal resources, and maintaining ongoing communication with service providers, case management enhances the quality of life for older Floridians and supports the long-term sustainability of home and community-based care. As Florida's older population continues to grow, a clear understanding of case management benefits all stakeholders, from caregivers to policymakers, and reinforces the value of person-centered, coordinated care.

Seniors or caregivers who believe they may benefit from case management services can begin the process by calling Florida's Elder Helpline at 1-800-96-ELDER (1-800-963-5337), which connects them to their local Aging and Disability Resource Center. It is important to remain patient because there may be a wait. A formal screening — typically conducted over the phone using [DOEA Form 701S](#) — is required to determine eligibility. Once screened, clients may be assigned a case manager who will conduct an in-person assessment (using the [701B form](#)) and begin developing a personalized care plan (Florida Department of Elder Affairs, 2016).

References

- Administration for Community Living (ACL). (2021). *Overview of Older Americans Act Title III programs*. Administration for Community Living. https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/OAA%20Title%20III%20Report_2018_FINAL_WEB_VERSION_508.pdf
- Florida Department of Elder Affairs. (2016). *DOEA programs and services handbook — Chapter 2: Case management*.
- The Florida Senate. (2024). Chapter 430: Elder affairs. 2024 Florida Statutes (including 2025C). <https://www.flsenate.gov/Laws/Statutes/2024/Chapter430>

¹ This document is FCS3482, a publication of the Department of Family, Youth and Community Sciences, UF/IFAS Extension. Original publication date September 2026. Visit the Ask IFAS website at <https://ask.ifas.ufl.edu> for the currently supported version of this publication. © 2026 UF/IFAS. This publication is licensed under [CC BY-NC-ND 4.0](#).

² Muthusami Kumaran, associate professor, nonprofit management and community organizations, UF/IFAS Department of Family, Youth and Community Sciences, Gainesville, FL; Katlyn Diamond, clinical director, Council on Aging of Martin County, Stuart, FL; Rachel Gatto, undergraduate research intern, UF College of Agricultural and Life Sciences, Gainesville, FL; UF/IFAS Extension, Gainesville, FL 32611.

The Institute of Food and Agricultural Sciences (IFAS) is an Equal Opportunity Institution authorized to provide research, educational information, and other services only to individuals and institutions that operate in compliance with applicable federal and state non-discrimination laws and policies. For more information on obtaining other UF/IFAS Extension publications, contact your county's UF/IFAS Extension office. U.S. Department of Agriculture, UF/IFAS Extension Service, University of Florida, IFAS, Florida A&M University Cooperative Extension Program, and Boards of County Commissioners Cooperating. Andra Johnson, Dean for UF/IFAS Extension.