



Senate Office of Policy and Legislative Analysis

204 Coverdell Legislative Office Building
18 Capitol Square SW
Atlanta, Georgia 30334

Hayley Williams
Director
(404) 656-0015

FINAL REPORT OF THE SENATE COMMITTEE ON IMPROVING FAMILY CAREGIVER SERVICES (SR 393)

Committee Members

Senator Harold Jones II, Chairman
District 22

Senator Larry Walker III
District 20

Senator Chuck Hufstetler
District 52

Senator Ben Watson
District 1

Senator Kenya Wicks
District 34

TABLE OF CONTENTS

STUDY COMMITTEE CREATION, FOCUS, AND DUTIES.....	3
LIST OF MEETINGS AND SPEAKERS	4
LIST OF ABBREVIATIONS.....	5
BACKGROUND	7
DEMOGRAPHIC INFORMATION	7
HISTORICAL OVERVIEW	10
FAMILY CAREGIVING STRUCTURES	11
SUMMARY OF TESTIMONY AND DISCUSSION	17
BACKGROUND AND DEMOGRAPHIC INFORMATION	17
ISSUES FACING FAMILY CAREGIVERS	23
GEORGIA’S FAMILY CAREGIVING LANDSCAPE	38
PROGRAMS AND SERVICES OFFERED IN OTHER STATES	48
REPORT ADOPTION	58
FINDINGS AND RECOMMENDATIONS	59

STUDY COMMITTEE CREATION, FOCUS, AND DUTIES

The Senate Study Committee on Improving Family Caregiver Services was created by Senate Resolution 393 during the 2025 Legislative Session of the Georgia General Assembly.¹ The Study Committee was tasked with determining policy goals and identifying legislative actions to improve family caregiving.

Senator Harold Jones, II of the 22nd served as Chair of the Study Committee. The other Senate members were Senator Larry Walker, III of the 20th, Senator Chuck Hufstetler of the 52nd, Senator Ben Watson of the 1st, and Senator Kenya Wicks of the 34th.

The following legislative staff members were assigned to the Study Committee: Josselyn Hill, Office of Policy and Legislative Analysis, Sydney Horwitz, Senate Press Office; Emily Elder, Senate Budget and Evaluation Office; Sabrina Wise, Office of Senator Harold Jones, II; and Holly Carter, Office of Legislative Counsel.

¹ S.R. 393, 157th Gen. Assemb., Reg. Sess. (Ga. 2025), <https://www.legis.ga.gov/legislation/71355>.

LIST OF MEETINGS AND SPEAKERS

The Committee met five times from August to December 2025 on the following days with the following speakers:

- Meeting One: August 27, 2025, located at Augusta University in Augusta, Georgia:
 1. Central Savannah River AAA (Ms. Debra Minor);
 2. AARP (Mr. Wallace White);
 3. Via Cognitive Health (Ms. Jennifer Pennington);
 4. Emory's Roybal Center for Dementia Caregiving Mastery (Dr. Ken Hepburn);
 5. Georgia Chapter of the Alzheimer's Association (Ms. Alexis Williams);
 6. Ohio State University (Dr. Karen Moss);
 7. Alzheimer's Association (Ms. Beverly Berry); and
 8. Duke University (Dr. Robert Turner);
- Meeting Two: September 17, 2025, located at the Georgia State Capitol in Atlanta, Georgia:
 1. DHS (Ms. Melody DeBussey and Ms. Breanna Sims);
 2. Primecare Homecare Services (Mr. Faris Flournoy);
 3. GHF (Ms. Whitney Griggs);
 4. DBHDD (Commissioner Kevin Tanner);
 5. GCDD (Ms. D'Arcy Robb, Ms. Brook Kubick, and Ms. Tais Keyser);
 6. GDVS (Mr. Edwin Berry and Ms. Belinda Boldoe);
 7. Rand Corporation (Ms. Vanessa Parks); and
 8. Elizabeth Dole Foundation (Ms. Madison Moore and Ms. Steph Smith);
- Meeting Three: October 16, 2025, located at the Georgia State Capitol in Atlanta, Georgia:
 1. DCH (Ms. Brandy Sylvan, Ms. Maxine Elliott, and Ms. Taesha Ward);
 2. Carter Center's Rosalynn Carter Mental Health and Caregiving Program (Dr. Ke Wang and Ms. Sarah Philips);
 3. ARC AAA (Ms. Connie White and Ms. Cara Pellino); and
 4. Georgia Chapter of 9to5 (Ms. Jasmine Bowles, Ms. Joanna Jackson, and Ms. Ogechi Oparah);
- Meeting Four: November 6, 2025, located at the Georgia State Capitol in Atlanta, Georgia:
 1. NCSL (Ms. Kathryn Costanza, Mr. Joe Livingston, and Ms. Glenn Jacoby);
 2. Minnesota DHS' CFSS Program (Ms. Erin Huldeen and Ms. Jeanine Wilson);
 3. Washington DSHS' MAC and TSOA Programs (Ms. Aime Fink, Ms. Dana Allard-Webb, and Ms. Mandy Weeks-Greene);
 4. Careforth (Dr. Carla Pennington and Mr. Mike Adams);
 5. FreedomCare (Mr. Andrew Luu);
 6. A Better Balance (Ms. Feroza Freeland);
 7. Colorado's Paid FMLI Program (Ms. Tracy Marshall and Mr. David Gallivan);
 8. Colorado Chapter of 9to5 (Ms. Kaitlin Alton);
 9. Connecticut's Paid Leave Authority (Ms. Erin Choquette); and
 10. Washington's PFML Program (Ms. Rebecca Grady); and
- Meeting Five: December 11, 2025, located at the Georgia State Capitol in Atlanta, Georgia, to adopt the Committee's Final Report with recommendations.

LIST OF ABBREVIATIONS

AAA	Area Agency on Aging
AANHPI	Asian American, Native Hawaiian, and Pacific Islander
AARP	American Association of Retired Persons
ACL	Administration for Community Living
ADLs	Activities of Daily Living
ADRC	Aging and Disability Resource Connection
AGI	Adjusted Gross Income
ANE	Abuse, Neglect, and Exploitation
APS	Adult Protective Services
ARC	Atlanta Regional Commission
BIPOC	Black, Indigenous, and People of Color
CCSP	Community Care Services Program
CFSS	Community First Services and Supports
CMS	Center for Medicaid and Medicare Services
CNA	Certified Nursing Assistant
COMP	Comprehensive Supports Waiver
CRA	Community Residential Alternatives
DAS	Division of Aging Services
DAWN-R	Determination of Need-Revised
DBHDD	Department of Behavioral Health and Developmental Disabilities
DCH	Department of Community Health
DHS	Department of Human Services
DSHS	Department of Social and Health Services
EDWP	Elderly and Disabled Waiver
ELAP	Elderly Legal Assistance Program
ER	Emergency Room
FAMLI	Family and Medical Leave Insurance
FMLA	Federal Family and Medical Leave Act
FMS	Financial Management Service
FSA	Flexible Spending Account
GARD	Georgia's Alzheimer's and Related Dementias State Plan
GCDD	Georgia Council on Developmental Disabilities
GDVS	Georgia Department of Veteran Services
GHF	Georgians for a Healthy Future
GMN	Georgia Memory Net
HCBS	Home- and Community-Based Services
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICWP	Independent Care Waiver Program
I/DD	Intellectual and Developmental Disability
LPN	Licensed Practical Nurse
LTSS	Long-Term Service and Support
MAC	Medicaid Alternative Care
MAO	Medical Assistance Only
MCO	Managed Care Organization
NASHP	National Academy for State Health Policy
NCSL	National Conference of State Legislatures
NFCSP/OAA Title III-E	National Family Caregiver Support Program
NOW	New Options Waiver
OAA	Older Americans Act
PAMMS	Policy and Manual Management System
PCA	Personal Care Assistant
PCAFC	Program of Comprehensive Assistance for Family Caregivers
PERS	Personal Emergency Response System
PFML	Paid Family and Medical Leave

Q&A	Question and Answer
RAISE	Recognize, Assist, Include, Support, and Engage
RFP	Request for Proposals
RN	Registered Nurse
SFC	Structured Family Caregiving
SNAP	Supplemental Nutrition Assistance Program
SOURCE	Service Options Using Resources in Community Environment
SSBG	Social Services Block Grant
STEADI	Stopping Elderly Accidents, Deaths, and Injuries
SUA	State Units on Aging
TCARE	Tailored Caregiver Assessment and Referral
TSOA	Tailored Supports for Older Adults
UNG	University of North Georgia
US	United States of America
UTI	Urinary Tract Infection
VA	US Department of Veterans Affairs

BACKGROUND

Family caregiving is the unpaid assistance provided by a family member or close friend to someone who is ill, disabled, or aging. Family caregivers include parents, friends, neighbors, and even children. They span across all ages; races and ethnicities; incomes; and communities. They assist care recipients with basic mobility, personal care, financial management, complex medical tasks, and more.

DEMOGRAPHIC INFORMATION

On July 23, 2025, AARP and the National Alliance for Caregiving released the [Caregiving in the US 2025 report](#) that found that 63 million American adults provided ongoing care to adults or children with a medical condition or disability. They represent almost one-quarter of all adults in the US. Of these 63 million caregivers, 59 million care for an adult (18 plus) with a complex medical condition or disability. (See chart below).

Table 1. Estimated Number of Family Caregivers and Prevalence of Family Caregiving by Age of Care Recipient, Trend 2015–2025

Types of Care Recipients	2015	2020	2025
Total Family Caregivers (of adults or children with medical conditions or disabilities)	43.5 million (prevalence: 18.2%)	53.0 million (prevalence: 21.3% ↑)	63.0 million (prevalence: 24.0% ↑)
Family Caregivers of Adults Age 18+	39.8 million (prevalence: 16.6%)	47.9 million (prevalence: 19.2% ↑)	59.0 million (prevalence: 22.5% ↑)

↑↓ Significantly higher or lower than prior wave.

1. Nationwide Demographic Information

According to the [2020 US Census](#), the US has a population of approximately 331,449,281 with a median age of 30.2 years old. The US population [65 years old and older](#) is approximately 59,307,056² (or 17.7 percent of the US population). Moreover, the total number of people who are 60 years and older is 80,983,092³ (or 24.2 percent of the US population), which is almost a fourth of the US population. According to the Caregiving in the US 2025 report, the average caregiver is 51 years old. A demographic breakdown of these caregivers is as follows:

- Latino/Hispanic represent 16 percent;
- African American/Black represent 13 percent;
- AANHPI represent 6 percent; and
- Non-Hispanic white represent 61 percent.

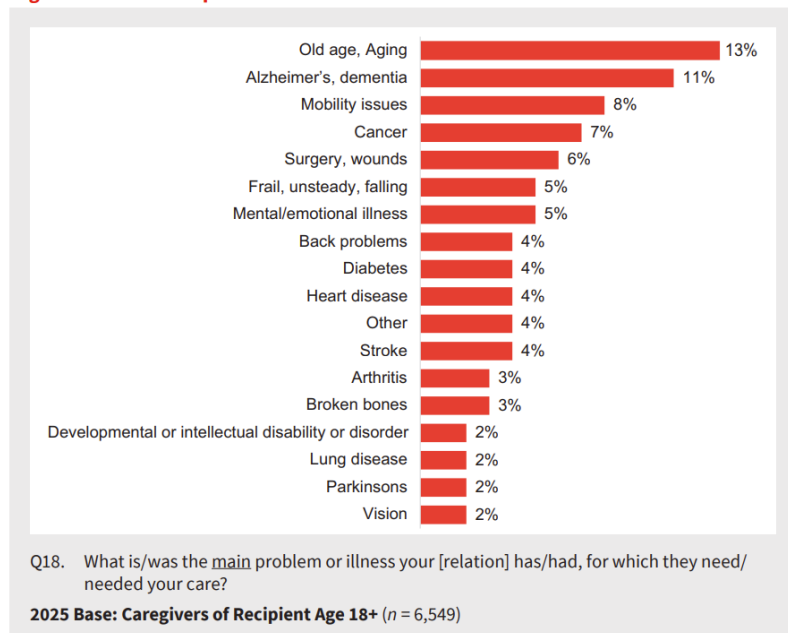
Women still account for the majority of caregivers (61 percent). Additionally, 22 percent of caregivers live in rural areas. Twenty-four percent of family caregivers support more than one care recipient. Most are caring for relatives, especially parents or spouses, but 11 percent are caring for nonrelatives such as friends or neighbors. Older caregivers tend to care for spouses, whereas younger ones are more likely to care for older generations.

The report also provided demographic data on family caregivers who receive payment for care that they provide to an adult family member or friend under Medicaid HCBS self-direction waivers, Veterans Affairs, or other state programs. (See chart on the below). In total, 11.2 million family caregivers report that they were paid for care in 2025. Most of these 11.2 million caregivers indicate that they provided both unpaid care and paid care. According to the report this suggests that they were paid for only part of the care hours they provided. Only 1.9 million of 59 million caregivers are solely paid family caregivers. Paid family caregivers tend to be younger than unpaid caregivers. The majority of paid family caregivers tend to be ages 18 to 44 years old (52 percent vs. 34 percent of unpaid caregivers) with the minority being ages 65 and older (14 percent vs. 24 percent of unpaid caregivers). Many of the other demographic differences observed among paid family caregivers tend to correlate with younger ages. Paid family caregivers are

² With a margin of error of 25,771.

³ With a margin of error of 65,205.

Figure 6. Care Recipient's Main Condition or Illness



main condition requiring care. Family caregivers most commonly cite “old age” or aging; followed by Alzheimer’s or other dementias; mobility issues; cancer; and surgery or wounds. Together, the top five conditions account for nearly half of all primary reasons for care. (*See chart on the left*). Mental or emotional illness ranks seventh, with younger caregivers twice as likely to provide this type of care (seven percent of caregivers under age 50 compared with four percent of caregivers age 50 or older). The report noted that a caregiver’s perceptions may differ from clinical diagnoses or population health statistics.

2. Georgia Demographic Information

According to the 2020 US Census, [Georgia](#) has a population of approximately 10,711,908. The median age in Georgia is 37.9 years old. Georgia’s population that is [65 years old and older](#) is approximately 1,699,250⁴ (or 15.4 percent of Georgia’s population) and its 60 years old and older population is approximately 2,370,455⁵ (or 21.5 percent of Georgia’s population). Georgia’s over 60 years old population is lower than the nationwide number; however, this demographic group still makes up almost a fourth of Georgia’s overall population.

3. Family Caregiver Demographic Information from Other States

To determine what interventions will best assist a particular caregiver, it is useful to separate caregivers’ functions into general types: hands-on care and close supervision, household care, and care coordination. In addition, caregivers both give and need social support. More than one type of care and one kind of intervention may be needed within the same care situation.⁶ This section provides family caregiver demographic information for other states.

more often Hispanic/Latino, Black/African American, or AANHPI and less often have a four-year college degree or have health insurance, compared with unpaid caregivers.

The report noted care recipients themselves are mostly older adults; nearly half are age 75 or older and most of these older adults face multiple chronic health conditions. Common primary conditions include age-related decline; Alzheimer’s or other dementias; mobility limitations; cancer; and postsurgical recovery. Cognitive issues are prevalent: 27 percent of caregivers report that their care recipient has Alzheimer’s, dementia, or another memory-related impairment. Caregivers under 50 are more likely to manage short-term or mental health conditions, whereas older caregivers typically support those with long-term physical health issues.

The report asked family caregivers to identify the

Table 3. Demographic Comparison of Paid Family Caregivers and Unpaid Family Caregivers of Adults

		Paid Family Caregivers (n = 1,498)	Unpaid Family Caregivers (n = 5,051)
Age (mean)		45.4↓	51.9
Sandwich Generation Family Caregivers (have children)		36%↑	27%
Students		19%↑	7%
Race/Ethnicity	Non-Hispanic white	44%↓	65%
	Hispanic/Latino	23%↑	15%
	Black/African American	21%↑	11%
	Asian American/Native Hawaiian/Pacific Islander	6%↑	4%
Education	High school degree or less	44%↑	32%
	Some college or associate's degree	31%	33%
	Bachelor's degree or higher	25%↓	35%
	Have health insurance	83%↓	90%

↑↓ Significantly higher or lower than unpaid caregivers.

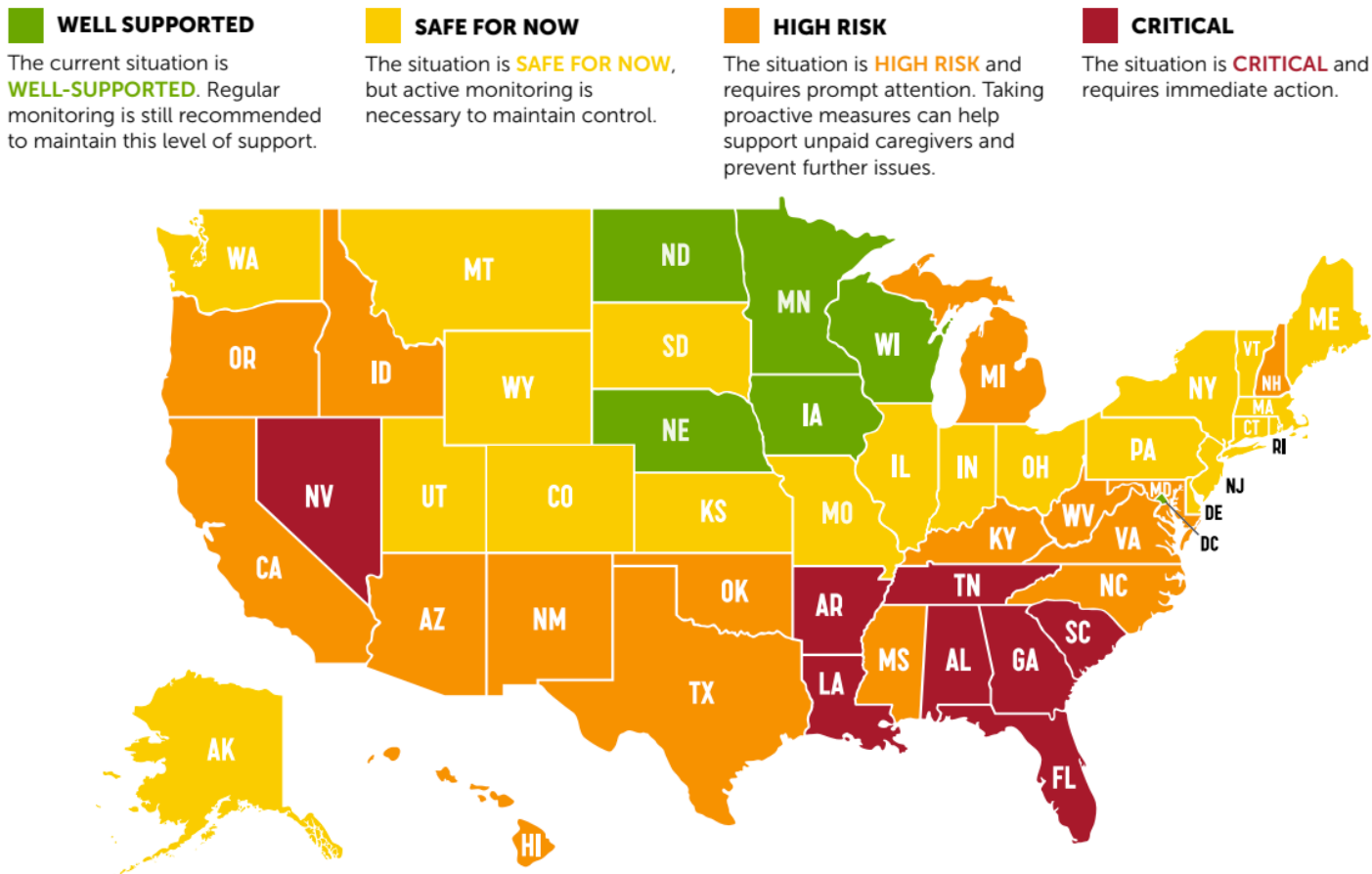
⁴ With a margin of error of 4,960.

⁵ With a margin of error of 12,709.

⁶ [Historical Overview](#).

According to findings released in April 2025 from a new study conducted by Columbia University Mailman School of Public Health, and sponsored by [Otsuka America Pharmaceutical, Inc.](#), nearly half of US states (48 percent) are on the brink of an unpaid family caregiving emergency. The [study](#) shows unpaid family caregiving is either *critical* or at *high risk* in 24 states. The new report includes an illustrative state-by-state heatmap based on a scorecard of the family caregiving landscape to raise awareness for the value of family caregivers. (See graphic below).

THE STATE OF FAMILY CAREGIVING HEATMAP



The data shows that in several states, the equivalent value of labor generated by unpaid family caregivers surpasses the economic value generated by cornerstone industries. For example, Florida, categorized as *critical* on the scorecard, has a caregiver valuation of \$60.6 billion, surpassing the economic impact of Walt Disney World Resort. California, categorized as *high-risk* on the scorecard, leads the nation with a state caregiving valuation of \$122.3 billion, more than double the state's \$59 billion agriculture industry. Texas, categorized as *high-risk* on the scorecard, has a caregiver valuation of \$62.4 billion, more than four times the size of the state's \$15.5 billion cattle industry.

According to this study, the epidemic of unpaid family caregiving is increasing and dementia care is driving a significant portion of the national family caregiving valuation, contributing to over \$340 billion of labor, especially those in states with aging and high-risk populations. This study found that even a 10 percent increase in dementia care hours would add another \$62 billion in unpaid labor nationwide. The study also found that caregiving is especially challenging in states with more rural communities. In the 32 states with predominantly rural populations, unpaid family caregivers contribute over \$375 billion in labor. Yet, a shortage of healthcare workers makes it challenging for families to access necessary support. For example, Georgia, categorized as *critical* on the scorecard, has one of the largest shortages of home health aides in the country, with only a fraction of the number of home health aides per 1,000 residents over 65 compared to the national average.

HISTORICAL OVERVIEW

The legislative history of family caregiving services in the US reflects the growing recognition of the important role family caregivers play in the realm of long-term care and the increased understanding of their needs. This section contains a brief history of major federal legislation that directly addresses family caregiver services and a brief overview of relevant Georgia laws on family caregiver services.

1. Federal Laws

In 1965, Congress enacted OAA which built a national aging network and funded community services for older adults which created the Administration on Aging and, later, the AAAs.⁷ The OAA Amendments of 2000 established Part E of OAA Title III which created the NFCSP.⁸ The NFCSP was the first dedicated federal service program for family caregivers. This program funds state-run AAA systems that must (at a minimum) offer: information services; assistance; counseling, support groups, and training; respite care; and supplemental services such as equipment and minor home modifications. Congress also created a parallel caregiver program for Tribes and Native Hawaiian organizations under OAA Title VI which authorized grants for nutrition, support services, and caregiver support tailored to Tribal communities.⁹ The Supporting OAA of 2020 which reauthorized OAA eliminated the cap on the share of the NFCSP funds that a state could devote to older relative caregivers; expanded the caregiver-related definitions (including caregiver assessment); and officially tasked the ACL with carrying out the RAISE Family Caregivers Act of 2018.¹⁰

The Omnibus Reconciliation Act of 1981 converted Title XX into a capped block grant referred to as the SSBG.¹¹ SSBG allows states to use grant funds for a variety of social services (including respite care and family support). Each year, the federal government allocates funds to states/territories to support social services for vulnerable children, adults, and families through the SSBG. States have broad discretion in the specific services they support with SSBG funds and may tailor these funds over time to changes in the needs of their populations. However, the social services funded by the states/territories must be linked to one or more of SSBG's five statutory goals which are:

- Achieve or maintain economic self-support to prevent, reduce, or eliminate dependency;
- Achieve or maintain self-sufficiency, including reduction or prevention of dependency;
- Prevent or remedy neglect, abuse, or exploitation of children and adults unable to protect their own interests or preserve, rehabilitate, or reunite families;
- Prevent or reduce inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- Secure referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

In 1993, Congress enacted the federal FMLA which provides job-protected leave to care for a spouse, parent, or child with a serious health condition and up to 26 weeks for a covered service member.¹²

In 2006, Congress enacted the Lifespan Respite Care Act which authorized competitive grants to states to build statewide respite systems that serve family caregivers across the lifespan of the care recipient.¹³

The Caregivers and Veterans Omnibus Health Services Act of 2010 directed the VA to create the PCAFC and other supports for caregivers of eligible veterans.¹⁴ The VA Mission Act of 2018 expanded and modernized the PCAFC in phases via rulemaking.¹⁵

The RAISE Family Caregivers Act of 2018 directed federal HHS to develop a National Family Caregiving Strategy and created the Family Caregiving Advisory Council to help create a federal framework to align programs like NFCSP, CMS, HCBS, and VA supports.¹⁶

⁷ 42 U.S.C. § 3001 *et seq.*

⁸ 42 U.S.C. § 3030s *et seq.*

⁹ 42 U.S.C. § 3057k-11.

¹⁰ 42 U.S.C. § 3030s *et seq.*

¹¹ 42 U.S.C. § 1397.

¹² 29 U.S.C. § 2612.

¹³ 42 U.S.C. § 201.

¹⁴ 38 U.S.C. § 1720G.

¹⁵ *Id.*

¹⁶ 42 U.S.C. § 3030s *et seq.*

CMS waiver programs allow states to offer customized programs for populations needing long-term care and to support their caregivers. These waiver programs include a waiver that allows states to deliver HCBS (including respite care) without meeting certain requirements to targeted groups to avert institutionalization;¹⁷ Community First Choice lets states cover attendant services and supports (often self-directed) in community settings, with person-centered planning;¹⁸ and [SFC programs](#) that allows payment to eligible family members for providing care at home.

2. Georgia Laws

Georgia created a structure that lets the state-run federal aging programs (like the OAA) and coordinate services for older adults via Georgia's DHS DAS.¹⁹

Georgia laws that directly apply to family caregiver services are located under Chapter 6 of Title 49 relating to Services for the Aging.²⁰ This chapter statutorily established DAS.²¹ It also created the Council on Aging, which advises the Governor, the General Assembly, the DHS Board, DHS, and all other state agencies in matters related to the elderly.²² The CCSP establishes a system of coordinated community care and support services for the elderly such as in-home supports, case management, respite services, and adult day services.²³ The Adult Day Center for Aging Adult Licensure Act requires adult day centers and adult day service providers to be licensed.²⁴ Adult day centers are an essential component in providing family caregivers respite. In 2018, Georgia created the State Plan and Advisory Council to mobilizes a statewide response to Alzheimer's and dementias including caregiver supports.²⁵

Georgia adopted a comprehensive caregiver statute before the federal NFCSP existed. The Georgia Family Caregiver Support Act created a state caregiver program to "marshal and integrate" resources for caregivers of chronically dependent adults allowing respite, supplemental services, home modifications, assistive devices, and reimbursements under state-set caps.²⁶

The Georgia Medical Assistance Act established Georgia's Medicaid authority through which HCBS and waivers that support family caregivers are financed.²⁷ The Georgia Program of All-Inclusive Care for the Elderly established additional opportunities within Georgia's Medicaid program to provide comprehensive, integrated acute and long-term healthcare services to qualifying individuals who require skilled nursing care so that such individuals can continue living in the community.²⁸ Additionally, Georgia uses Medicaid HCBS (*e.g.*, EDWP/CCSP, SOURCE, ICWP, NOW/COMP) to deliver services that directly relieve or complement family caregiving.²⁹

The Georgia Caregivers Act requires hospitals to provide patients with the opportunity to identify lay caregivers to be involved in the discharge planning process.³⁰ O.C.G.A. § 34-1-10 requires employers that already offer paid sick leave to let eligible employees use up to five days per year of that leave to care for an "immediate family member" (child, spouse, grandchild, grandparent, or parent).

The Georgia Family Caregiver Tax Credit gives taxpayers a nonrefundable credit of 10 percent of caregiving expenses, up to \$150.00, for a qualifying relative who is 62 or older or disabled. Eligible expenses include home health, personal care, homemaker services, adult day care, respite care, and certain medical supplies, if purchased from a non-relative. The credit cannot be refunded, carried forward, or claimed for expenses already deducted from taxable income.³¹

FAMILY CAREGIVING STRUCTURES

All federal OAA funds including Title III Part E funds are distributed to state units on aging (SUA) by formulary. This section discusses how the funding for family caregiver services is distributed in Georgia highlighting DAS, the

¹⁷ 42 C.F.R. Part 441.

¹⁸ *Id.*

¹⁹ O.C.G.A. § 49-6-2.

²⁰ See O.C.G.A. §§ 49-6-103.

²¹ O.C.G.A. § 49-6-5.

²² O.C.G.A. § 49-6-21.

²³ O.C.G.A. § 49-6-60 *et seq.*

²⁴ O.C.G.A. § 49-6-80 *et seq.*

²⁵ O.C.G.A. § 19-6-90 *et seq.*

²⁶ O.C.G.A. § 49-6-70 *et seq.*

²⁷ See O.C.G.A. § 49-4-140 *et seq.*

²⁸ O.C.G.A. § 46-100 *et seq.*

²⁹ O.C.G.A. § 49-4-140 *et seq.*

³⁰ O.C.G.A. § 31-36B-1 *et seq.*

³¹ O.C.G.A. § 48-7-29.2.

AAAs, and other organizations that receive funding along with a brief overview of other states that offer different programs or services.

1. Georgia³²

In Georgia, the SUA is DHS' [DAS](#).³³ DAS then distributes by formulary to all 12 AAAs in the state. Each AAA then creates Notifications of Funding Availability or RFP to distribute the funding within their region. The [12 AAAs](#) and the areas that they serve in Georgia are as follows:

Location Name	Areas Served
ARC AAA	Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale
Coastal Georgia AAA	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh
CSRA AAA	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes
Heart of Georgia AAA	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox
Legacy Link Georgia Mountains AAA	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White
MI/DDle Georgia AAA	Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson
Northeast Georgia AAA	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton
Northwest Georgia AAA	Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield
River Valley AAA	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster
Southern Georgia AAA	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware
Sowega Council on Aging Southwest Georgia AAA	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth
Three Rivers AAA	Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup, Upson

According to DHS' PAMMS on [caregiver services](#), all AAA must offer at least one service in each of the five core caregiver service categories, which are:

- Information for caregivers about available services;
- Assistance to caregivers in gaining access to services;
- Caregiver education/training, individual counseling and support groups;
- Respite care;³⁴ and
- Supplemental services: services provided on a limited basis to complement the care provided by caregivers.³⁵

[Empowerline](#), who is part of Georgia's ADRC network in Georgia, publishes a table which provides guidance on services and resources available to the aging, caregivers, and care recipients. Services and resources include, but are not limited to, providing individuals with end-of-life planning information, connecting individuals with personal care home providers, and providing information regarding signs to identify abuse and/or neglect.

Georgia's ADRC Network

Each AAA must have an ADRC to: assist with screening for potential services in the home; provide educational materials; provide information on transportation, housing, etc.; and promote successfully caring for a loved one. ADRC is a coordinated system of partnering organizations that are dedicated to:

- Providing accurate information about publicly and privately financed long-term supports and services;

³² The information in this section was primarily provided by the ARC AAA from a Caregiver resource that they complied for OPLA.

³³ O.C.G.A. § 49-6-5.

³⁴ A service which offers temporary, substitute supports, or living arrangements for care recipients to provide a brief period of relief or rest for caregivers. Respite care can be in-home care or out-of-home care such as adult day centers.

³⁵ Supplemental services may include, but are not limited to, transportation, material aid, home modifications, assistive technology (AT), and telephone reassurance. AT can help individuals live more independently. AT may also make a caregiver's job easier and more enjoyable. Concerns relating to the falling, wandering, or getting lost of a care recipient, can be eased with certain types of AT help which make ADLs, such as dressing, bathing, grooming, eating, toileting, and tracking a little easier for said care recipient.

- Offering a consumer-oriented approach to learning about the availability of services in the home and community;
- Alleviating the need for multiple calls and/or visits to receive services; and
- Supporting individuals and family members who are aging or living with a disability.

Georgia's ADRCs serve older individuals, individuals with disabilities of all ages, families, caregivers, and professionals. ADRC offers respite care for caregivers. It also helps individuals find support groups for caregivers. Services vary by location, but there are some programs in Georgia that allow family members to receive payments for providing care. These programs include SFC through Medicaid waiver programs and Support Options, a non-Medicaid consumer-directed care program.

Dementia Program overview in GA under DHS DAS

Dementia programs may or may not involve caregivers depending on the level of impairment of the individual. The PAMMS chapter on [dementia programs overview](#) provides DAS' dementia programs and initiatives, which include:

- GMN;
- GARD;
- Dementia Friends; and
- Dementia Care Specialist Program.

The goal of these programs and initiatives is to make Georgia more dementia capable. Detailed information on each of these programs and initiatives is provided below:

- **GMN:** GMN is a statewide early diagnosis and care program for Alzheimer's disease and related dementias, supported by DHS' Georgia Alzheimer's Project. GMN established five clinics in 2018 with \$4 million in state health funds. GMN-supported outreach and training activities provide resources to Georgia physicians and medical professionals on how to use the Medicare-supported annual wellness visit to screen for early memory loss and cognitive decline. Primary Care Physicians (PCPs) are encouraged to refer patients who demonstrate signs of memory loss and cognitive decline to a regional GMN Memory Assessment Clinic. At each Memory Assessment Clinic, trained clinicians do comprehensive diagnostic assessments and care planning. Each Memory Assessment Clinic has a Community Services Educator (CSE) who works with AAA, the Alzheimer's Association and other organizations to educate and support Georgians living with Alzheimer's disease and related dementias, as well as their care partners. The Memory Assessment Clinics share diagnoses and care recommendations with the patient's PCP, so the provider is better prepared to treat the patient's memory issues and cognitive decline;
- **GARD:** In June 2014, Governor Nathan Deal signed the GARD into action, and the Task Force became an Advisory Council. With a plan in force, the Advisory Council is ready to call for the early, accurate detection of dementia; willing to battle stigma and misinformation; and able to provide an incomparable web of support to families that need it. Georgia's recommendations cover a range of topics, including research, services, policy, public safety, workforce development, and public education. Underpinning all of these areas is the importance of partnerships—creating a deeply coordinated statewide team of agencies, nonprofits, businesses, and organizations. Currently, the GARD collaborative is comprised of six different workgroups that are tasked with making strides toward the goals and objectives outlined in the State Plan. Those workgroups are: workforce development; service delivery; outreach and partnerships; policy; public safety; and healthcare, data, and research collection;
- **Dementia Friends:** In Georgia, 188,000 people are living with dementia. Dementia Friends is a social action movement seeking to improve society's understanding of dementia. The program's goal is to help everyone in a community understand five key messages about dementia, how it affects people, and how each of us can make a difference for people living with dementia; and
- **Dementia Cares Specialist:** Each AAA-statewide is required to employ one full-time equivalent of a dementia care specialist. The purpose of the dementia care specialist is to increase dementia awareness, expand community education and partnerships, and strengthen available resources and programming for care partners and People Living with Dementia (PLWD) by building a strong communal network care partners will have the resources, skills, and support to keep the individual living with dementia residing in their current environment for as long as possible.

SFC

SFC is an approved service that supports family members who live with and provide 24-hour care for an elderly or disabled family member. For example, SFC provides health coaches and a daily stipend. The service supports live-in family caregivers unable to work outside of the home because of caregiving responsibilities. It is a service provided under CCSP and SOURCE waiver programs. To be eligible to participate in the SFC service, a CCSP or SOURCE

member must meet the following qualifications: be an adult at least 18 years of age; require at least 5 hours of daily personal care services (the hours of care need not be provided contiguously); and live with a family member who provides the hours of care. To be eligible to participate in the SFC services, the family caregiver of a CCSP or SOURCE member must meet the following qualifications:

- They are at least 18 years of age;
- They are related to the CCSP or SOURCE member;
- They live in the home with the CCSP or SOURCE member;
- They pass a criminal background check via GA Criminal History Check conducted by the SFC agency; and
- They are willing to work with the SFC provider's health coach, including entry of daily notes for the coach's review, participation at least monthly in a coaching session, and participate in joint semi-annual home visits with the health coach and CCSP or SOURCE case manager.

However, spouses, legal guardians, and conservators are not eligible to be caregivers under SFC. Services that can be provided to waiver members who receive SFC include: adult day health services of up to two full days per week; home delivered services; emergency response service (if the caregiver must be out of the home for short periods for errands and the member is cognitively intact and capable of recognizing an emergency); and out of home respite. The SFC Services agency will provide monitoring, coaching, education, and support for the family caregiver, as well as payment of the per diem stipend to the caregiver at no less than 60 percent of the total unit rate.

EDWP

EDWP is part of SOURCE and CCSP. Both SOURCE and CCSP assist individuals who are elderly and/or functionally impaired to remain in their homes and/or communities. EDWP offers community-based services as an alternative to nursing facility placement. DCH administers and operates the EDWP. These are the services available through this program:

- *Adult Day Health* which offers daytime care and supervision in an adult day center, nursing and medical social services, planned therapeutic activities, physical, speech, and occupational therapy, and meals including prescribed diets;
- *Alternative Living Services* that include alternative residence for persons unable to remain independent in their own homes and meals, personal care, and supervision;
- *Emergency Response Services* that include in-home electronic support system providing two-way communication between isolated persons and a medical control center and service available 24 hours a day, seven days a week;
- *Home-Delivered Services* that include skilled nursing services, physical, speech and occupational therapy, medical social services and home health aide assistance, and personal care and assistance with meals;
- *Personal Support Services* that include assistance with meal preparation, hygiene and nutrition, light housekeeping, necessary errands, and other support services, and in-home respite care provided by an aide;
- *Consumer-Directed Personal Support Services* which includes the same services as Personal Support Services, except, the consumer hires and supervises worker(s) of choice and clients enrolled in the option are required to choose a Financial Management Services provider that will issue paychecks and adhere to federal and state tax laws on behalf of the client;
- *SFC* which provides support, education and oversight on behalf of waiver members whose family caregiver lives in the home with the member. Live-in family members work with SFC provider's health coach while supporting the member to maximize the highest level of independence for the member by providing necessary care and support; and
- *Out-of-Home Respite Care* which offers out-of-home overnight respite care in an approved facility with 24-hour supervision, home delivered meals prepared outside the home and delivered to the client, case management (enhanced and traditional) processes which include assessing, implementing, coordinating, monitoring, evaluating options and services required to meet individual needs and making referrals as needed.

The eligibility criteria for EDWP include the following:

- Individuals who are 21 and over;
- Functional impairment caused by physical limitations;³⁶
- Unmet need for care;
- Approval of an intermediate level of care;
- Certification for nursing home placement;
- Approval of care plan by client's physician;

³⁶ Please note that under this waiver, Alzheimer's and dementia are considered physical conditions.

- Medicaid eligible or potentially eligible after admission to EDWP;
- Client chooses community-based, rather than institutional services;
- Services fall within the average annual cost of Medicaid reimbursed care provided in a nursing facility (*e.g.*, health and safety needs can be met by EDWP);
- Participation in one waiver program at a time;
- Medicare, home health services or hospice (Medicare or Medicaid) does not meet consumer need for services;
- Home Delivered Meals are not the only service needed; and
- Home environment is free of illegal behavior and threats of bodily harm to other persons.

However, a client is not required to be homebound to receive EDWP services. The following information summarizes the financial eligibility criteria for the EDWP. The SSI category refers to persons who receive Supplemental Security Income and are eligible for medical assistance.

	SSI Income Limits: ³⁷	Waiver Medicaid/ MAO Income Limits:	SSI and Waiver Medicaid Resource Limits:
Individual	Below \$967/ Month	\$2,901/month	\$2,000 or less
Couple (both in EDWP)	Below \$1,450/ Month	\$2,901/month per individual	\$3,000 or less
Individual in EDWP, <i>But married</i>	Below \$1,450/Month	\$2,901/month	\$2,000 or less for SSI \$159,920 (combined) or less for EDWP Medicaid ³⁸

The Social Security Administration takes applications for SSI. The MAO category includes persons who do not receive cash benefits under the SSI program, but may qualify for medical assistance under another Medicaid category. The county Departments of Family and Children Services take applications for MAO. MAO participants may have to pay toward the cost of services.

2. Overview of Other States' Programs

This section provides other states' programs that differ from Georgia. The information in this section is not exhaustive but provides a wide range of programs and services not offered in Georgia.

State PFML

[Thirteen](#) states including Washington, D.C., run insurance-style PFML that pays a portion of wages while caring for a seriously ill family member (*e.g.*, CA, NJ, NY, RI, WA, CT, MA, OR, and CO; however, MD, ME, MN, and DE's benefits begin 2026). While Georgia has no PFML, it does offer a 5-day "use your existing sick leave" rule as noted above. Caregivers in PFML states can temporarily replace income while providing care.

Long-Term Care Social Insurance

Washington's WA Cares Fund³⁹ is a payroll-funded Long-Term Service and Support social insurance that pays a lifetime benefit usable for services that also help unpaid family caregivers (including training).

Stand-alone, State-funded Respite Programs

New Jersey's Statewide [Respite Care Program](#) is a state-funded benefit that purchases respite, adult day, homemaker, even short facility stays for relief—separate from OAA and Medicaid. The program gives a short-term or periodic break to family (or other caregivers) from the demands of daily care for functionally impaired persons, including older adults. The sliding scale ranges from 0 to 25 percent of the cost of services, based on the care recipient's (and spouse's) income. This respite may be provided for a short time, or once in a while. Georgia does not operate a separate, non-OAA/non-Medicaid statewide respite entitlement; instead, respite flows through OAA Title III-E and Medicaid/CCSP.

State Cash-Like Benefits or Statutory Reimbursements for Caregivers

Pennsylvania, Wisconsin, and Maine have state cash-like or statutory reimbursements for caregivers outside of OAA and Medicaid. Pennsylvania's [Caregiver Support Act](#) is a long-standing, state-created program that reimburses

³⁷ These limits change when the Social Security Administration increases Social Security and SSI.

³⁸ If the EDWP Medicaid applicant has a spouse who is neither in EDWP nor in an institution, the assets of the spouse **must** be considered in the eligibility determination. The **combined** total of **countable** assets of the individual and the spouse must be \$159,920 or less. The EDWP client must transfer assets in their name in excess of \$2,000 to the community spouse within one year from the month Medicaid eligibility begins. A waiver Medicaid eligible person may divert up to \$3948.00 per month of income to a legal spouse who is neither in the EDWP nor an institution. The legal spouse's income is deducted from the \$3948.00 limit before determining the amount of income to divert.

³⁹ Wash. Rev. Code Ann. § 50B.04 *et seq.*

caregivers for goods/services (with assessments, care plans, and monthly caps). Georgia authorizes reimbursements through its Family Caregiver Support Act, but does not operate a separate state entitlement of this type. Wisconsin's [Alzheimer's Family and Caregiver Support Program](#) provides state funds to counties/tribes to pay for caregiver goods/services (often including respite) with minimum annual respite funding requirements. The program was expanded in August 2025. Georgia has no dementia-specific, statewide statutory fund like Wisconsin. Maine's [Alzheimer's Respite Care Fund & "Respite for ME" grants](#) created a dedicated Respite Care Fund for dementia-related respite. The state also runs Respite for ME caregiver grants (which are federally-funded). Georgia does not operate a dementia-specific respite fund by statute.

Statewide Caregiver Resource Center Network

California funds a statewide network of [Caregiver Resource Centers](#) that provide specialist counseling, legal/financial consults, short-term counseling, and respite vouchers through 11 regional nonprofits as an additional layer alongside AAA. Georgia relies on the AAA network and does not run a parallel caregiver resource center system.

Statutory Caregiver Assessment Standards

Washington law codifies a comprehensive Family Caregiver Support Program, including caregiver assessment of needs/abilities and eligibility for respite even when the care recipient is not on Medicaid.⁴⁰ Georgia practices caregiver assessment through AAA program policy, but it is not set out in a dedicated statute like Washington.

Paying Spouses and Parents as Medicaid Caregivers

Minnesota's [Community First Services and Supports](#) allows a spouse or parent of a minor to be the paid worker. New York's Consumer Direct Personal Assistance Program likewise permits many family members to be the paid worker.⁴¹ Georgia's SFC generally excludes spouses and legal guardians and has a live-in requirement through provider agencies.

Direct Caregiver Stipends and Allowances Outside of Medicaid

Hawaii's [Kūpuna Caregivers Program](#) provides a state allowance for working caregivers to purchase services so they can keep their jobs while caring for an elder. The initial benefit is up to \$70.00 per day. Georgia does not have a work-linked caregiver allowance.

Arizona's [Family Caregiver Reimbursement Program](#) operates as a state reimbursement. The state grant reimburses 50 percent of qualified expenses up to \$1,000 per care recipient. Georgia's statute also authorizes reimbursement, but it is administered within AAA programs with different caps and processes (not a uniform statewide grant portal).

⁴⁰ Wash. Rev. Code Ann. § 74.41.

⁴¹ 18 N.Y.C.R.R. § 505.28.

SUMMARY OF TESTIMONY AND DISCUSSION

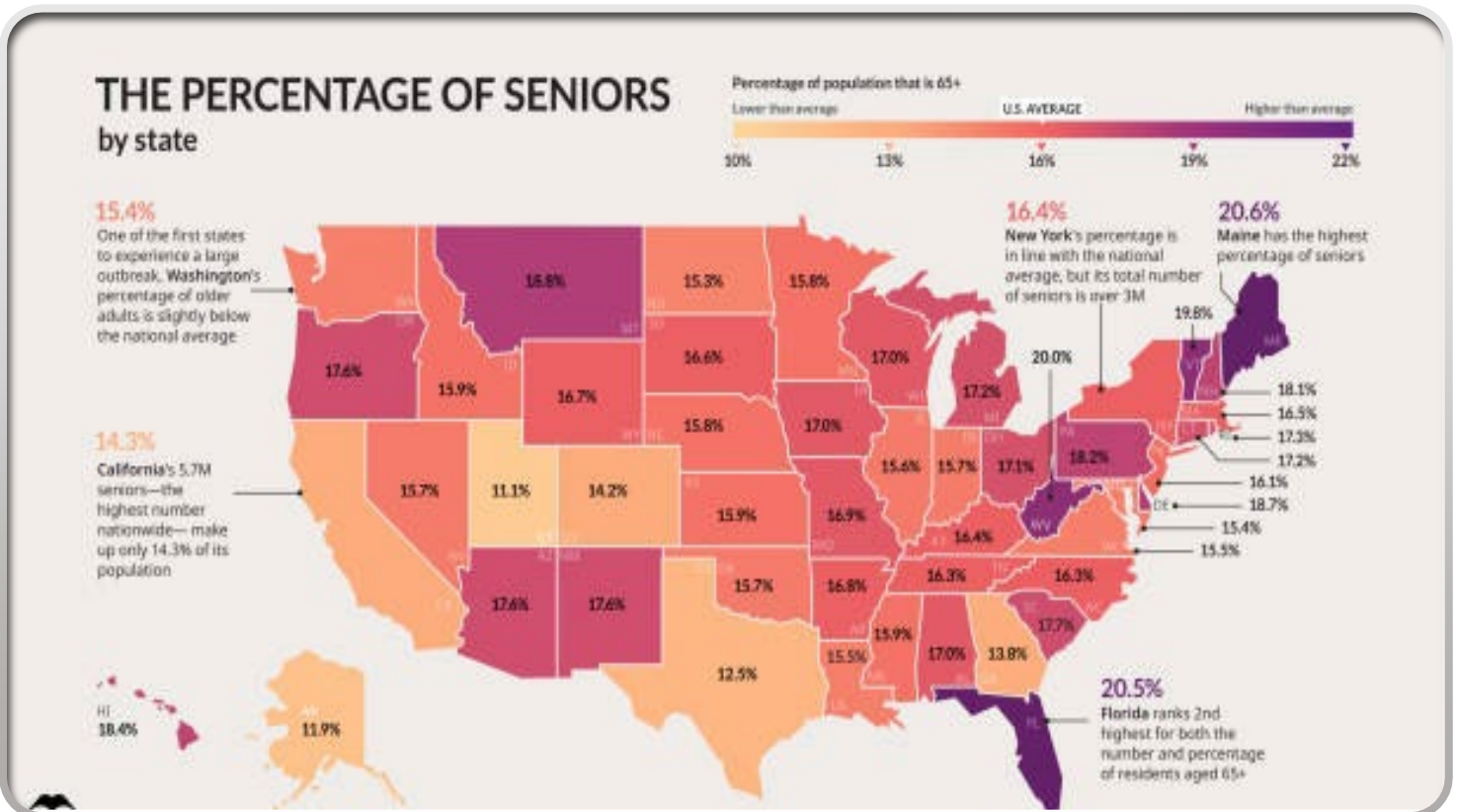
The committee met five times beginning in August of 2025 and ending in December of 2025. During this time, the committee met with over 30 organizations, governmental agencies, businesses, and constituents here in Georgia and around the US. The committee studied for primary themes: (1) background and demographic information; (2) issues facing family caregivers; (3) Georgia's family caregiving landscape; and (4) programs and services offered in other states.

BACKGROUND AND DEMOGRAPHIC INFORMATION

The first theme analyzed the demographic information of Georgia and the US in the area of family caregiving and its respective aging populations. This theme provided background and context for the committee to understand the scope of impact that family caregiving has on Georgia and the US.

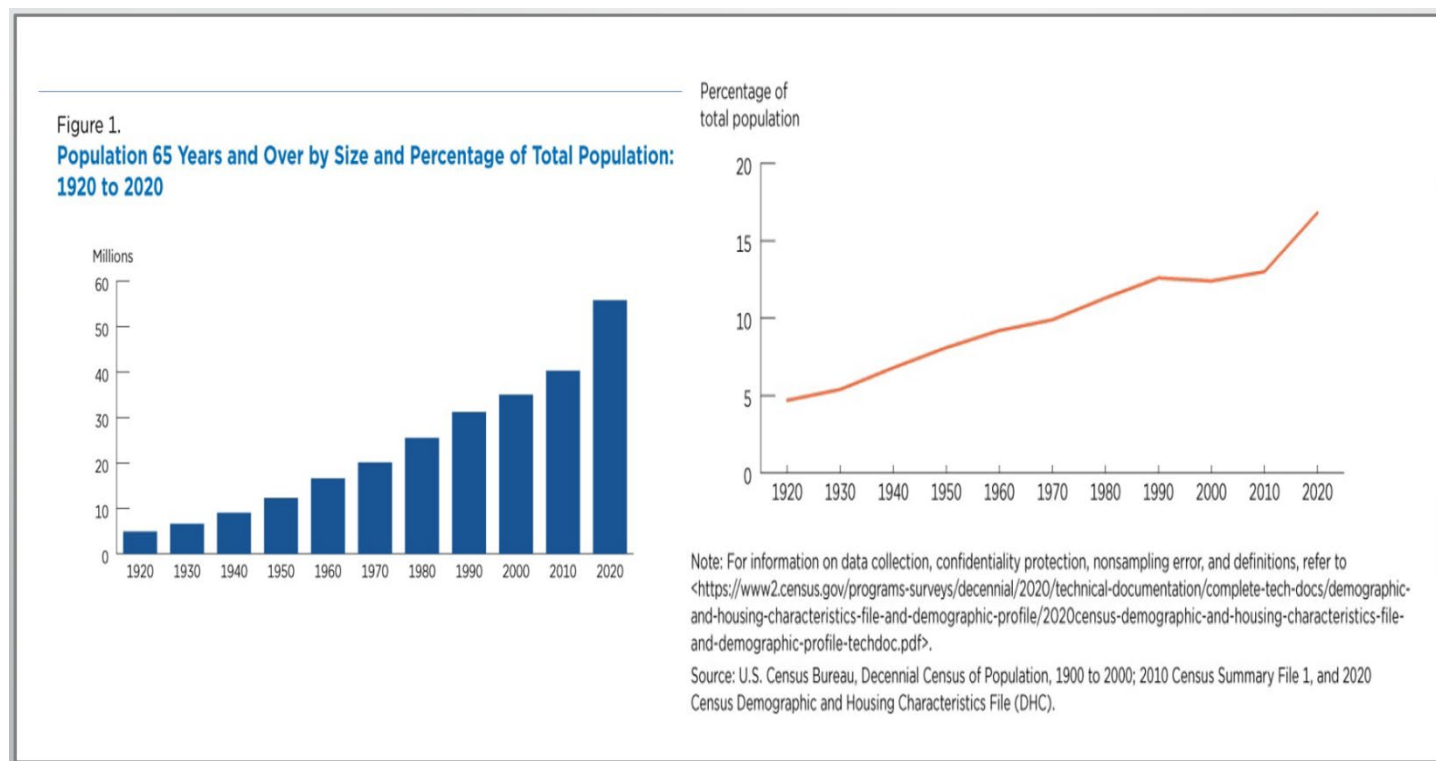
1. Central Savannah River AAA (Ms. Debra Minor)

Ms. Deborah Minor, Aging Services Director for the Central Savannah River AAA, began with an overview of AAAs. AAAs are nonprofit regional entities responsible for coordinating services that help older adults remain in their homes. Georgia has 12 AAAs serving all 159 counties, and their programs—including personal care, adult day care, respite services, and personal care homes—are primarily funded through the OAA, Medicaid, and supplemental grants and donations.

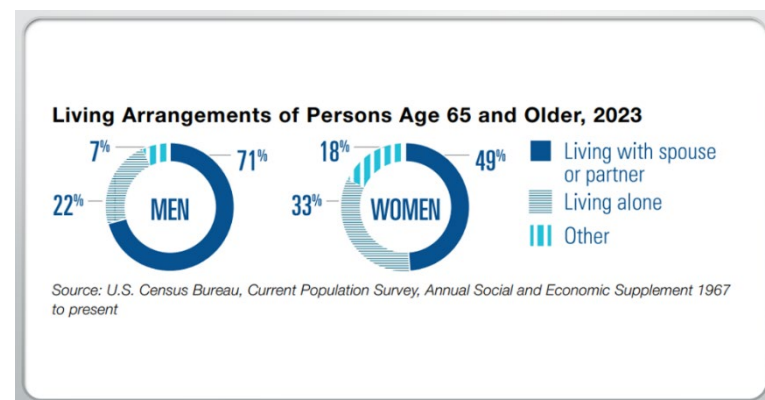


Ms. Minor then provided demographic data of the US' aging population. The national demographic data showed a striking acceleration in population aging. (See chart above). According to the 2020 Census, 13.8 percent of Georgia's population and one in six Americans nationwide were age 65 or older. Between 2010 and 2020, the 65 plus age group experienced the largest and fastest increase since the 1880s. It grew five times faster than any other age group. This growth was driven largely by baby boomers entering older adulthood beginning in 2011. She also noted a 50 percent increase in centenarians since 2010 and highlighted that the male population aged 70 plus now exceeds the number

of women in that age bracket, a reversal of historical patterns. The *chart below* shows that the population aged 65 plus has more than doubled between 1940 to 2020.



Ms. Minor then discussed a graph depicting poverty rates among adults 65 and older by race and Hispanic origin. The graph demonstrated substantial disparities, with minority populations (particularly African American and Hispanic seniors) compared to White seniors. She noted that poverty is linked to negative health outcomes due to reduced access to medications, transportation, nutritious food, and consistent medical care. All of which increase risks of disability and social isolation.



A subsequent Census-chart on living arrangements among adults 65 plus showed two primary categories—living alone and living with others. (*See chart on the left*). The chart showed that the dominating male category was men living with a spouse or partners; while, women were far more likely to be living alone. She stressed that living alone is strongly associated with rising health risks including depression, reduced self-care, worsening nutrition, increased alcohol consumption, smoking, and sleep disorders. She linked these trends with the concurrent demographic shift that the US is

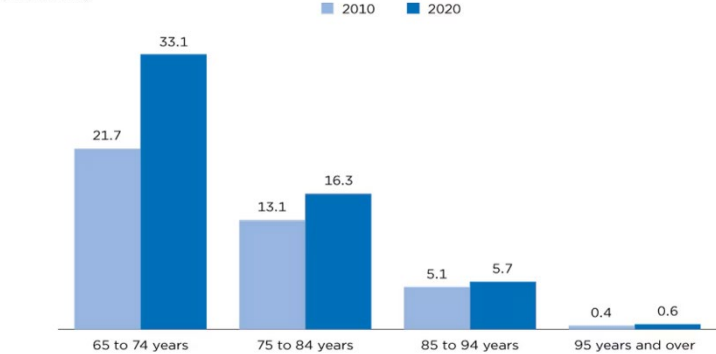
experiencing: the under-18 population (especially the under-five group) is declining, while the 65 plus population has grown by 38.6 percent.

Another chart from the 2020 Census compared the growth of age groups between 2010 and 2020. (*See chart below on the right*). It highlighted that the 60 plus population experienced the single largest numeric gain of any decade on record. Within that, the 65 plus group showed the highest percentage-point increase in its share of the total population. Ms. Minor explained that as baby boomers continue to age, the most rapid growth will occur in the 75–84 age bracket, as those currently aged 65–74 shift into the next category. The chart also showed significant growth among the 95 plus population and continued expansion of the 100 plus centenarian population which indicates increased longevity nationwide. Forward-looking projections estimate that by 2030, all baby boomers will be 65 plus, and by 2040, 78.3 million Americans will be 65 or older.

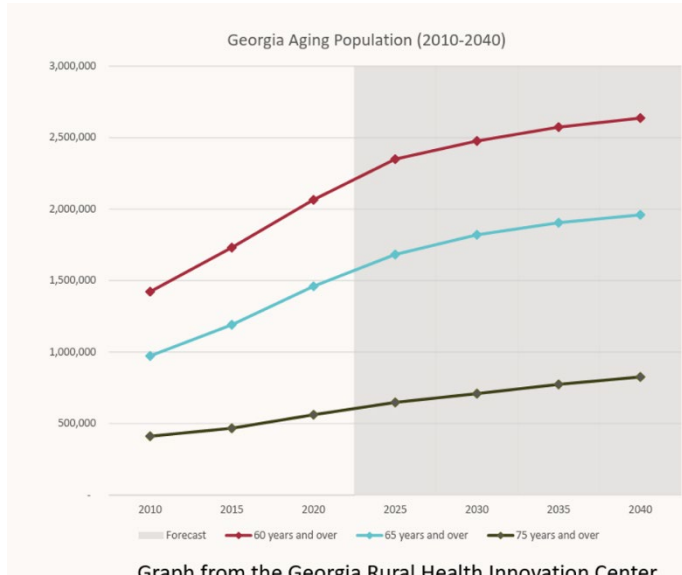
Turning to Georgia-specific data, Ms. Minor highlighted that Georgia has the 9th fastest-growing population of adults aged 60 plus. By 2030, more than 20 percent of Georgians will fall into that age group, which is a rise of nearly 34 percent. The Georgia Rural Health Innovation Center’s data showed the current statewide proportion of adults 65 plus at 14.6 percent. (See chart below).

She emphasized that rural counties skew much older. In rural Georgia, 19 percent of the population is currently 65 plus. This number is projected to rise to 22 percent by 2030. The chart below on the right illustrates the steep growth trajectory in rural counties. She noted that 94 of Georgia’s 100 oldest counties are rural, increasing not only the number of older adults but also the number of older

Figure 3.
Population Size of Older Age Groups: 2010 and 2020
(In millions)



Note: For information on data collection, confidentiality protection, nonsampling error, and definitions, refer to <https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/complete-tech-docs/demographic-and-housing-characteristics-file-and-demographic-profile/2020census-demographic-and-housing-characteristics-file-and-demographic-profile-techdoc.pdf>.
Source: U.S. Census Bureau, 2020 Census Demographic and Housing Characteristics File (DHC).

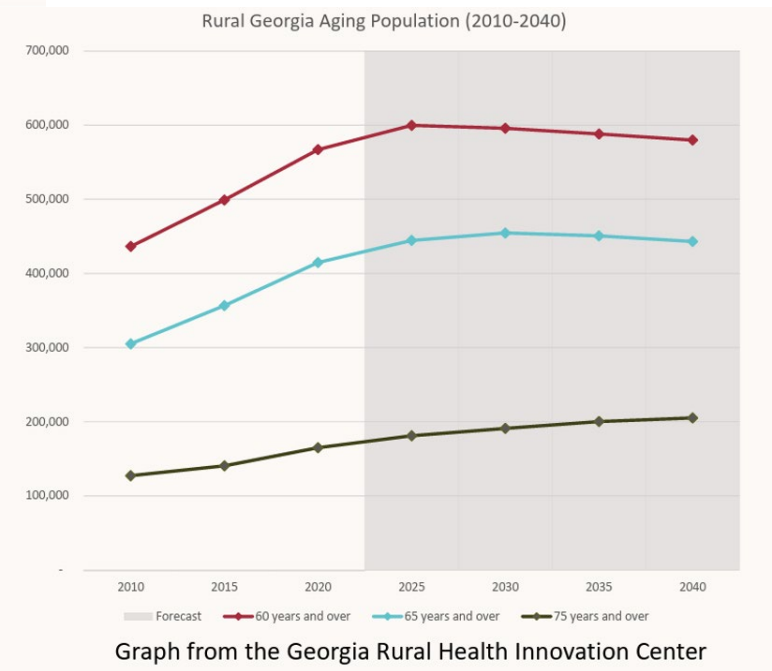


Graph from the Georgia Rural Health Innovation Center
During the panel discussion, Ms. Minor expanded on the challenges of caregiving and aging in rural Georgia, emphasizing the severe lack of infrastructure, services, and financial support. She shared her personal experience caring for her mother after a stroke, noting that even as a registered nurse, she was unprepared for the realities of rural caregiving—where services are scarce, transportation is limited, and many families are “land rich and money poor.” Without qualifying for public assistance yet unable to afford private care, families are forced to piece together solutions. She and her sister developed a family-specific care plan involving rotating caregiving schedules, pooled funds, and the purchase of a used accessible van. She stressed that every caregiving situation is unique and requires customized, flexible planning.

She also addressed Georgia’s ranking as one of the least healthy states for older adults, citing limited access to nutritious food, unaffordable medications, and early-onset chronic conditions in rural populations. She noted the need for greater advocacy, the inclusion of

caregivers who themselves face health challenges.

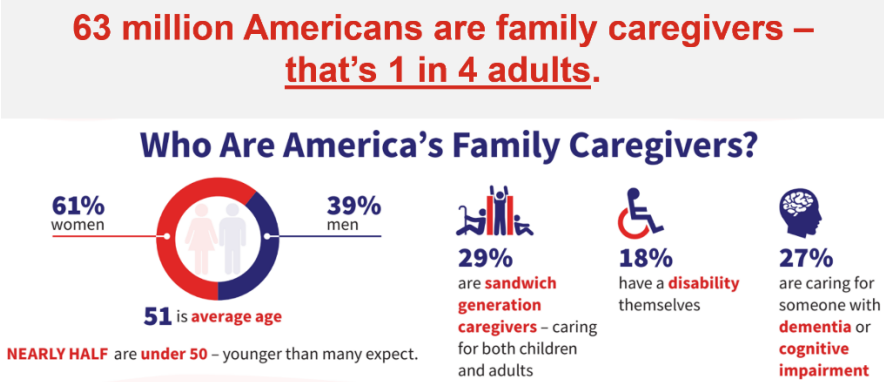
Georgia’s 65 plus population also faces specific socioeconomic and health vulnerabilities. As of 2022: 10 percent live in poverty, 92 percent rely on Social Security, 1 in 5 is still working, and 54 percent lack private retirement income. Rising healthcare costs compound these financial constraints, particularly as many seniors live on fixed incomes. Women continue to outnumber men, and the state has seen a 29 percent increase in depression among older adults. Most have at least one chronic condition, placing heavier demand on healthcare and long-term services. A recent national report indicated that an average 65-year-old can expect to live 18.9 additional years, but despite this longevity, Georgia ranks 39th in the nation, placing it in the bottom 24 percent for health outcomes among older adults.



caregivers in policy conversations, and more support services across the state. In response to a question about financial help for caregivers, the committee chair noted that upcoming meetings would explore compensation models—such as programs that pay family caregivers—highlighting Georgia’s lower reimbursement rates compared to other states.

2. AARP (Mr. Wallace White)

Mr. Wallace White, Associate State Director of Advocacy and Rural Outreach for AARP Georgia, opened by framing caregiving as both a professional issue and a deeply personal one. He grounded his presentation in Rosalynn Carter’s well-known quote about the four kinds of people in the world, those who have been, are, will be, or will need caregivers. He pointed out that virtually everyone in the room fits into one of these categories or knows someone who does. He then defined family caregivers as adults providing ongoing care over the past year to adults or children with complex medical conditions or disabilities, typically within pre-existing relationships such as parents, spouses, relatives, friends, or neighbors. He noted that many in the room likely have personal stories about caring for parents, and that caregiving often happens whether or not someone felt ready to assume that responsibility.

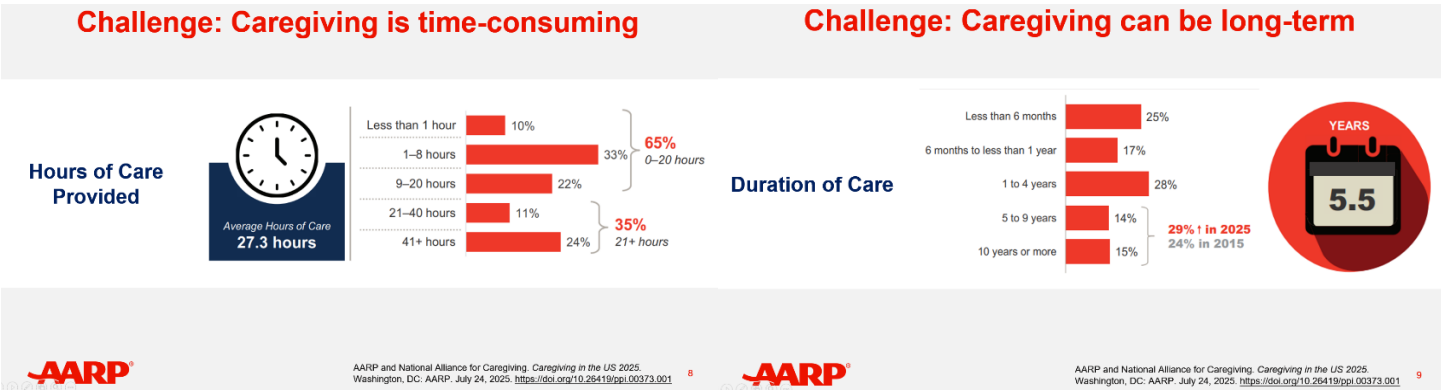


Mr. White then turned to new data from the 2025 edition of the Caregiving in the US report. The report was released in late July 2025 by AARP and the National Alliance for Caregiving. This report, first conducted in 1997 and now in its sixth edition, is one of the most authoritative national data sources on family caregiving. He explained that 63 million Americans are family caregivers which is one in four people. (See chart on the left). The chart broke down demographics: 61 percent of caregivers are women and 39 percent are men, and the average caregiver age is 51, even though

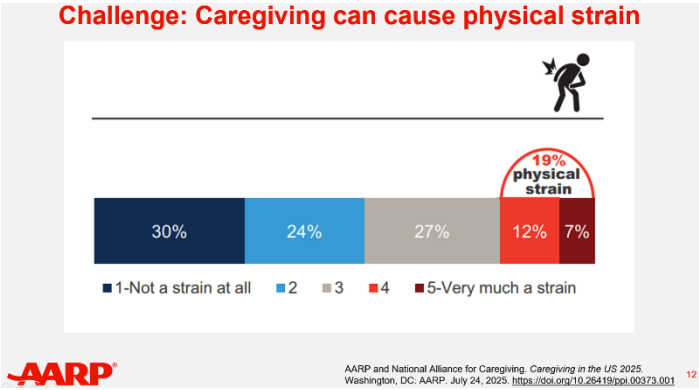
many caregivers are younger than 50. The “sandwich generation” composes 29 percent of family caregivers. This generation demonstrates the real-life scheduling conflict of choosing between caring for one’s children and aging parents. He added that 18 percent of caregivers have a disability themselves, and 27 percent are caring for someone with dementia or cognitive impairments, which adds extra emotional and practical strain. This initial chart gave a national snapshot of who caregivers are and how complex their roles can be.

Focusing on Georgia, Mr. White presented statistics from the AARP’s 2023 “Valuing the Invaluable” update. He explained that 1.2 million Georgians serve as family caregivers, collectively providing over 1.2 billion hours of care per year. The value of this unpaid labor is estimated at \$16.3 billion annually. He stated that this illustrates how much caregivers contribute to the state’s long-term care system without direct pay. He noted that caregivers incur substantial personal costs as well, paying over \$7,200 per year out-of-pocket on average for items like medical supplies, transportation, and home modifications.

He then described the day-to-day demands that these numbers represent. He cited the national report’s finding that caregiving is essentially a full-time job, with nearly one in four caregivers providing 40 or more hours of care per week. (See chart above on the left). Another metric indicated that almost one-third of caregivers have been providing care for



five or more years. He explained that this is often a long-term commitment rather than a short-term crisis response. (See chart above on the right).

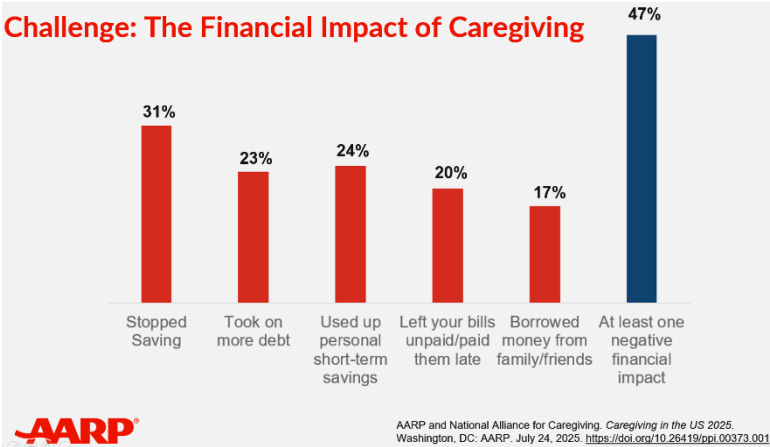


A chart on ADLs (such as eating, dressing, and bathing) showed that about 23 percent of caregivers say it is difficult to assist with these tasks. He also referenced Instrumental ADLs like grocery shopping and transportation, noting that caregivers frequently juggle these responsibilities alongside their own employment. He also highlighted the lack of preparation: only about 11 percent of caregivers receive any medical training, meaning approximately 89 percent receive none. Yet, they step in anyway when a loved one needs help.

Next, Mr. White addressed the physical and health toll of caregiving. Measuring physical strain on a scale where the

highest category—“very much a strain”—was especially prominent. (See chart above on the left). He explained that over 19 percent of caregivers report significant physical strain which reflects the cumulative impact of lifting, assisting, and being “on call” all the time. The report found that about one in five caregivers report being in poor or fair health, and nearly one in four say caregiving makes it hard to take care of their own health needs. He also cited that almost one in four caregivers report feeling socially isolated which shows how caregiving can cut people off from social and community life.

Mr. White then focused on emotional and financial strain. (See chart on the right). One emotional-stress graph showed that over 38 percent of caregivers report high emotional stress. He noted that women and caregivers of color are especially likely to report heightened worry, anxiety, and concern due to caregiving. He also broke down financial strain by race and ethnicity, explaining that African American, Hispanic, and Latino caregivers experience the highest financial burdens. They spend about 34–47 percent of their income on caregiving expenses. He emphasized that this proportion reflects not the care recipient’s resources, but the caregiver’s own income being redirected to cover costs. The chart below shows that 70 percent of working-age caregivers (18–64) are employed while caregiving and six in ten of those caregivers work full-time. This chart reinforces that most caregivers are trying to manage paid work and intensive care simultaneously.



He then described data from a 2024 AARP–S&P Global study on balancing work and caregiving. The study showed that 34 percent of surveyed caregivers identified balancing caregiving with their job as their biggest source of job-related stress, and 84 percent said caregiving had a moderate or high effect on their overall stress levels. Another data point showed 67 percent of caregivers reported at least some difficulty balancing work and life responsibilities. The

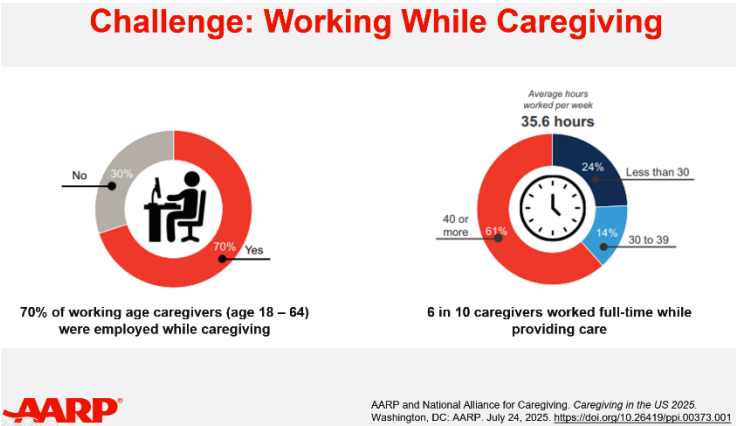
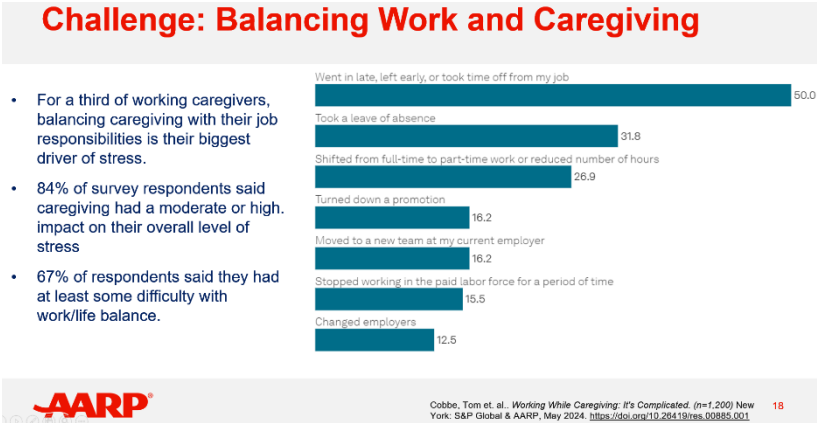


chart below detailed the specific work adjustments caregivers have made: 32 percent took a leave of absence, 27 percent reduced their work hours, 16 percent turned down a promotion, 16 percent moved to a new team, 16 percent left the workforce for a period, and 13 percent changed employers because their workplace did not accommodate caregiving demands.

During the Q&A discussion, Chairman Jones highlighted the financial strain caregivers face, noting that while they often incur new out-of-pocket expenses—such as the \$7,200 annually cited earlier—their job hours or income may simultaneously decrease,

creating a compounding stress cycle. He acknowledged that while Georgia allows some caregiver compensation through Medicaid programs, many caregivers feel isolated and unaware of available services, including support groups and respite care. He asked Mr. White how AARP helps raise awareness and connect people to those resources.

In response, Mr. White explained that AARP Georgia focuses on connecting individuals with localized support, especially through the Area Agencies on Aging, which serve as a “one-stop shop” for caregiving and senior services. He noted that while the AARP is a national organization, it partners closely with community networks to help people “connect the dots” when navigating caregiving responsibilities. Mr. White stressed the importance of real-world experience, noting that people often do not understand the weight of caregiving until they are in it. He cautioned that in the absence of reliable guidance, some may fall victim to fraudulent advertisements or scams. To prevent this, the AARP provides trusted resources not only within Georgia but also across states.



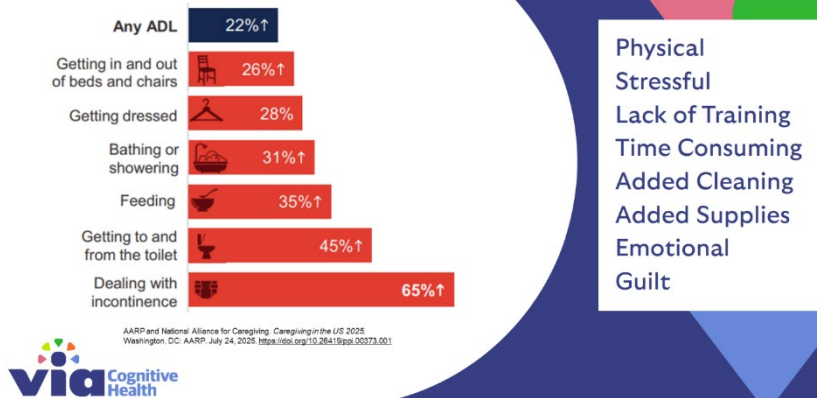
ISSUES FACING FAMILY CAREGIVERS

The second theme studied the issues facing family caregivers. Under this theme, the committee also studied the issues facing specific subgroups which have certain traits that increase or result in particular challenges for the caregivers and care recipients.

1. Via Cognitive Health (Ms. Jennifer Pennington)

Ms. Jennifer Pennington, Executive Director of Via Cognitive Health and Vice Chair of the Georgia Alzheimer's and Related Dementias Advisory Council, testified about the lived realities of caregiving, especially for families managing cognitive decline and dementia. Rather than presenting new statistics, she expanded upon data shared by Ms. Minor

Impacts of Providing Care



and Mr. White, using real-life caregiving scenarios to humanize the numbers. The *chart on the left* illustrated how caregiving affects every facet of life—physically, emotionally, financially, and socially. Ms. Pennington framed her testimony around six themes: physical burden, time constraints, caregiver diversity, emotional strain, financial pressure, and the need for comprehensive support systems.

She described several composite caregiver stories: a husband caring for his wife with dementia, grieving her memory while assisting with dressing and hygiene; adult siblings unevenly sharing the burden of their mother's

care; and a mother caught in the “sandwich generation,” raising children while also managing her parent’s medical needs. These stories reflected challenges that align with earlier-cited statistics, such as Mr. White’s reference to 29 percent of caregivers being part of the sandwich generation and nearly one in four providing over 40 hours of care per week. Ms. Pennington noted that caregiving is not a job with boundaries. It is a deeply personal relationship-based responsibility that carries lasting physical and emotional costs.

Ms. Pennington detailed the physical strain caregivers experience, especially when forced to lift or transfer loved ones without training. Tasks like cleaning, laundry, supply management, and lack of sleep compound the stress. She highlighted the emotional toll, naming common but often unspoken feelings: guilt, resentment, grief, helplessness, and anxiety. This mirrored data shared earlier in the hearing that 38 percent of caregivers report high emotional stress and over 19 percent report significant physical strain. She described a “day in the life” of a working caregiver—balancing parenting, caregiving, home management, and professional obligations—as a continuous, exhausting cycle where time becomes non-existent and health, relationships, and finances are all at risk.

Ms. Pennington closed by emphasizing that caregiving is a growing societal issue—made more urgent by Georgia’s rapidly aging population, a shortage of healthcare workers, and the rising cost of care.

2. ARC AAA (Ms. Connie White and Ms. Cara Pellino)

Ms. Connie White, Senior Manager and Assistant Director of the AAA at the ARC, and Cara Pellino, Access to Services Manager, explained ARC’s most recent policy brief. Caregiving costs US businesses over \$44 billion annually, up from \$33 billion in 2018—a \$10 billion increase in just seven years. This figure reflects an estimated 650,000 jobs lost each year as employees reduce hours or leave the workforce due to caregiving conflicts, while another 791,000 workers experience chronic absenteeism. A bar graph illustrated a caregivers’ declining personal well-being: 64 percent reported high emotional stress, 45 percent experienced physical strain, and one in five rate their own health as fair or poor. A separate pie chart depicted that 8 in 10 caregivers incur more than \$7,000 in out-of-pocket expenses annually, with 33 percent halting savings, 24 percent exhausting short-term funds, and 13 percent depleting long-term or retirement savings. The presenters emphasized how caregiving demands—combined with the rising cost of long-term care—undermine both caregivers’ health and economic stability, especially for working-age adults and women.

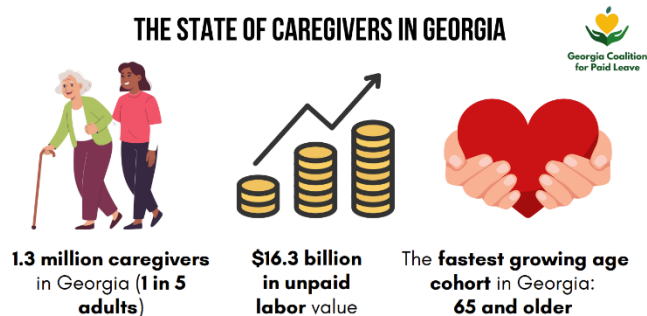
In the Q&A discussion, Chairman Jones asked ARC about two main issues: implementation of Senate Bill 61 (Family Care Act) in hospitals and the structure of mobile adult day care services. Chairman Jones expressed concern that many hospitals were not meaningfully complying with SB 61, noting that while some may mention available services briefly, true compliance would involve providing caregivers with comprehensive, hands-on guidance before discharge.

Ms. White agreed, explaining that many caregivers do not realize hospitals are legally required to involve them in discharge planning. She emphasized the need to educate caregivers about their rights, since generational attitudes—particularly among older adults who are reluctant to question medical authority—often prevent them from advocating for themselves. She said the recommendation for stronger hospital compliance originated from the National Strategy to Support Family Caregivers, and stressed that her agency could help raise awareness at the community level while policymakers explore mechanisms for requiring hospitals to document compliance.

Ms. White also elaborated on the mobile adult day care model, describing a pilot effort in Gwinnett County that combines a medical adult day health provider with a local church offering a social model of day programming. Under this approach, licensed staff from the medical provider travel to the church to deliver structured activities and oversight, allowing the church to serve as a satellite site for up to five smaller community-based programs. She explained that the social model is substantially less expensive than traditional medical adult day health—and both are far more affordable than hiring private in-home care. When asked whether the state could independently add Medicaid billing codes to fund caregiver consultations, Ms. White said she would need to research whether such changes require federal approval, but expressed willingness to follow up.

3. Georgia Chapter of 9to5 (Ms. Jasmine Bowles, Ms. Joanna Jackson, and Ms. Ogechi Oparah)

Ms. Jasmine Bowles, Executive State Director of 9to5 Georgia, began her presentation by explaining the scale and economic importance of family caregiving in Georgia. The *chart below on the right* illustrated that one in five Georgians—approximately 1.3 million people—serve as family caregivers. A corresponding economic impact graph showed that these caregivers provide an estimated \$16.3 billion worth of unpaid care labor annually for aging or disabled loved ones. Ms. Bowles noted that this labor forms the “invisible infrastructure” underpinning Georgia’s long-term care system. She further noted that this labor remains largely unrecognized, unsupported, and uncompensated. A demographic breakdown demonstrated that caregivers in Georgia are overwhelmingly women, many of whom work in low-wage or hourly jobs, balancing employment and caregiving duties simultaneously. She warned that as Georgia’s population continues to age, the need for caregiving will increase sharply, while existing systems fail to provide financial stability for those performing this essential labor.



Ms. Bowles then presented a series of comparative charts explaining the differences between paid family and medical leave and the federal FMLA. A comparison of FMLA and Paid Leave shows that FMLA provides 12 weeks of unpaid leave only for employees who have worked 1,250 hours in the past year at businesses with 50 or more employees, effectively excluding two-thirds of Georgia’s workforce, most of whom are employed by small businesses. She cited national survey data indicating that only 41 percent of men and 35 percent of women can afford to take six weeks of unpaid leave without experiencing serious financial hardship. She noted that unpaid leave is simply not a viable option for most Georgians. A line graph illustrated that family caregiving is the most common reason employees need leave but cannot take it, followed by personal illness and childcare. She explained that without paid leave, many caregivers face impossible choices between keeping their jobs and caring for their families, leading to heightened economic insecurity, increased turnover, and diminished workforce participation—particularly among women.

Ms. Bowles highlighted Georgia’s incremental but meaningful legislative progress in recent years, using a timeline that traced milestones from 2020 through 2024. The chart noted that during the height of the COVID-19 pandemic, Georgia workers briefly benefited from paid leave under the federal Families First Coronavirus Response Act. In 2021, Georgia passed its first paid parental leave law, granting three weeks of paid time off for state employees and public-school workers following childbirth, adoption, or foster placement. In 2023, the legislature removed the sunset provision on the Family Care Act, allowing private-sector employees to use accrued sick leave to care for family members. Most recently, House Bill 1010 (2024) doubled paid parental leave from three to six weeks, a bipartisan victory demonstrated by the legislative co-sponsors from both parties. She noted that Georgia remains one of only a handful of states without a comprehensive paid family and medical leave program accessible to all workers, leaving millions of workers without coverage.

Ms. Joanna Jackson, a 9to5 member and caregiver from Monroe and Albany, provided a personal narrative that illustrated the caregiving crisis in rural Georgia.

Ms. Bowles noted that rural Georgia has twice the poverty rate of Metro Atlanta and that 23 percent of rural residents live in federally designated healthcare professional shortage areas which is 13 percent higher than the national average. A bar chart illustrated that Georgia’s unpaid caregivers spend an average of \$7,000 per year in out-of-pocket costs, forcing many to deplete their savings. Ms. Bowles explained that Ms. Joanna’s story underscored the human and economic toll of delayed payments under Georgia’s SFC Program and the absence of paid leave for nontraditional workers.

During the Q&A portion, Chairman Jones asked 9to5 Georgia how they are engaging employers to show that paid family and medical leave is beneficial rather than burdensome. Ms. Bowles explained that one key strategy involves ensuring compliance with the notification requirement in House Bill 1010, which obligates employers to inform their employees about new paid leave benefits. She noted that awareness is critical—workers can only use benefits they know exist—and further noted that the policy has already shown success among state agencies and school districts. Her colleague, Ms. Ogechi Oparah, Organizing Manager for 9to5 Georgia, added that 9to5 Georgia partners with Small Business Majority and the Georgia Coalition for Paid Leave to educate small business owners. These efforts include hosting discussions that highlight how paid leave improves employee retention, reduces turnover, and levels the playing field for smaller employers competing with large corporations like Amazon that already offer robust benefits.

Chairman Jones also inquired into the large “care gap” between individuals eligible for programs such as SFC and those who cannot afford private care or in-home nursing. Ms. Bowles acknowledged this systemic shortfall, describing it as a fragmented structure that forces families to “splice together resources that don’t make them whole.” She explained that while incremental improvements—like reducing waiting lists and expanding home-care access—are necessary, the ultimate solution requires a comprehensive statewide caregiving policy. Ms. Bowles explained that Georgia must simultaneously strengthen rural healthcare infrastructure and adopt a unified framework for caregiver support, ensuring families have both the financial and logistical means to sustain care without falling into poverty.

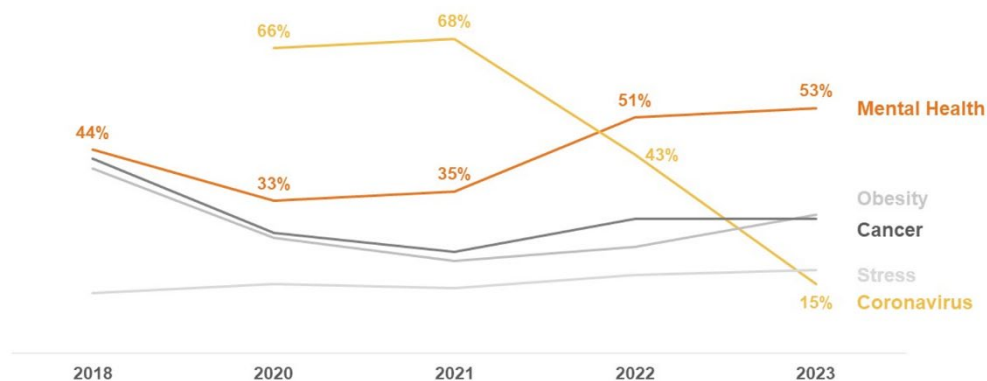
4. Carter Center’s Rosalynn Carter Mental Health and Caregiving Program (Dr. Ke Wang and Ms. Sarah Philips)

Ms. Sarah Phillips, Director of Public Policy for the Carter Center’s Rosalynn Carter Mental Health and Caregiving Program, began by providing an overview of the Carter Center’s mission and history. Founded in 1982 by former President Jimmy Carter and First Lady Rosalynn Carter, the Center’s core mission is to advance human rights and alleviate human suffering, with deep roots and ongoing commitment to improving lives within Georgia. She explained that Mrs. Carter’s lifelong advocacy for mental health and caregiving began during her time in the Georgia Governor’s Mansion and culminated in the creation of the Carter Center’s Mental Health Program in 1991. She announced that in July 2024, the Rosalynn Carter Institute for Caregivers, originally established in 1987, officially merged into the Carter Center—uniting Mrs. Carter’s two major legacies under one roof. This merger strengthens the Center’s capacity to work at the intersection of mental health and caregiving. Ms. Phillips reiterated Mrs. Carter’s enduring

philosophy: “There are only four kinds of people in the world: those who have been caregivers, those who are caregivers, those who will be caregivers, and those who will need caregivers.”

Waging Peace.
Fighting
Disease.
Building Hope.

Mental Health Tops the List of Health Problems Among Americans



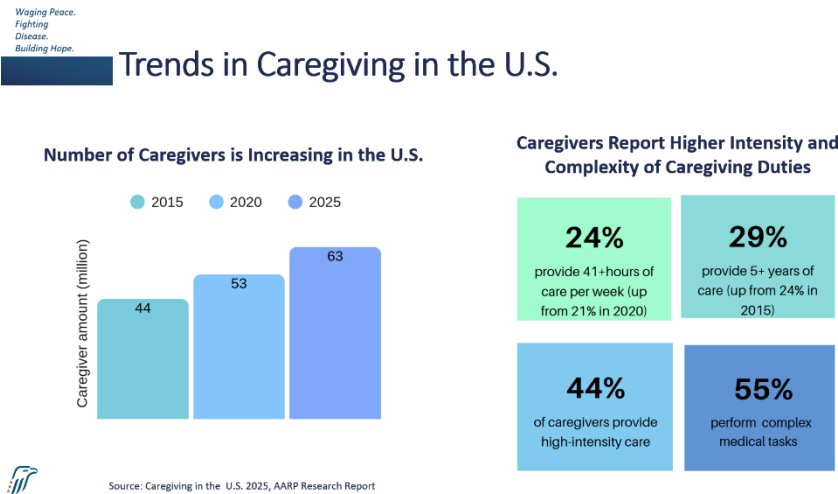
© Ipsos Sources: Ipsos 2023 Global Health Service Monitor
Note: Coronavirus was first included in 2020



Ms. Phillips provided data showing that the US is in the midst of a growing mental health crisis that intersects directly with caregiving responsibilities. (See chart above). A line graph illustrated how mental health surpassed all other health concerns among Americans, overtaking

COVID-19 in 2022 as the leading health issue and maintaining that position through 2024. According to the Carter Center’s data, 53 percent of Americans in 2023 identified mental health as the most pressing public health issue—up dramatically from 35 percent in 2021. One in five adults (20 percent) reported experiencing a mental health condition in 2024. The data also revealed clear gender disparities: 26.4 percent of women reported a mental health condition compared to 19.7 percent of men. Among youth, four in ten reported feeling persistently sad or hopeless in 2023, and one out of ten attempted suicide. While the percentage of individuals receiving treatment for mental health needs increased from 19.2 percent in 2019 to 23.9 percent in 2023, Ms. Phillips noted that these gains still lag far behind population need, leaving many without access to adequate support.

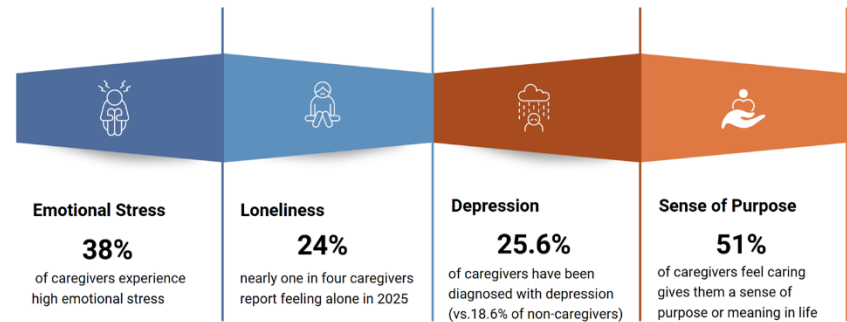
Dr. Ke Wang, Data Analyst with the Carter Center, presented detailed findings on national caregiving trends and their mental health implications. The *chart on the right* depicts the surge in caregiving over the past decade, showing an increase from 44 million caregivers in 2015 to 63 million in 2024—a 43 percent rise in just ten years. Dr. Wang noted that this figure includes only those who self-identify as caregivers, meaning the true number is likely even higher. She explained that many people providing daily or medical care for loved ones—especially those with dementia or chronic conditions—do not label themselves as caregivers, seeing their efforts instead as part of familial duty. A stacked bar graph illustrated the deepening intensity of care: 24 percent of caregivers now provide more than 41 hours per week, equivalent to full-time employment, while 29 percent have been in their caregiving role for five years or longer, up from 24 percent in 2015. Moreover, 44 percent of caregivers provide high-intensity assistance with multiple daily activities, and 55 percent perform complex medical tasks such as wound care or administering injections.



The presentation also included a heat map and stress index chart depicting the emotional and mental health burdens associated with caregiving. (See *chart below*). Dr. Wang reported that 38 percent of caregivers experience high emotional stress, and 25.6 percent show symptoms of depression, compared to 18.6 percent of non-caregivers. In addition, 24 percent of caregivers report feeling isolated, which the Carter Center identifies as a critical risk factor for mental health decline. However, a positive data point showed that 51 percent of caregivers also report finding a sense of purpose and meaning in their caregiving role—what Wang described as a “protective factor” that can help sustain emotional well-being over time. Correlational data from the Carter Center’s Mentoring and Career Program further revealed a strong link between caregiver loneliness and depressive symptoms, indicating that for many, emotional struggles are persistent rather than temporary.

Dr. Wang went on to explain the Carter Center’s Research-to-Impact Pipeline, an evidence-based framework designed to translate research findings into practical solutions and policy guidance. The model begins with identifying emerging caregiver needs, generating empirical data, and then evaluating interventions to determine which methods are most effective for improving well-being. She mapped this process—from needs identification to innovation and policy dissemination. She highlighted two of the Center’s landmark studies: one examining caregiving during natural disasters, which explored the combined effects of environmental and public health crises on caregiver stability; the other demonstrating that caregiver coaching can reduce anxiety among children living with disabled or injured

Mental Health of Caregivers



family members. She also discussed the development of the Carter Center Data Integration Platform, an innovation designed to merge internal caregiver data with external public datasets to overcome longstanding “data silos” that lead to fragmented understanding and duplicated efforts.

Dr. Wang also described several Carter Center initiatives that translate research into real-world support. She introduced the Caregiver Crisis Text Line, a 24/7 confidential service allowing caregivers to text 741741 to reach trained crisis counselors. The service provides a private outlet for caregivers who may be reluctant to discuss stress or burnout within earshot of their care recipients. The Center’s data revealed that 24 percent of users said it was the first time they had ever shared their struggles, and the line has already facilitated two suicide de-escalations and one emergency intervention, demonstrating its lifesaving potential. Comparative trend data between caregivers and youth text users showed similar reasons for distress—such as anxiety, stress, and depression—but different trajectories: caregivers’ crises were chronic and cumulative, while youth crises were acute and identity-based.

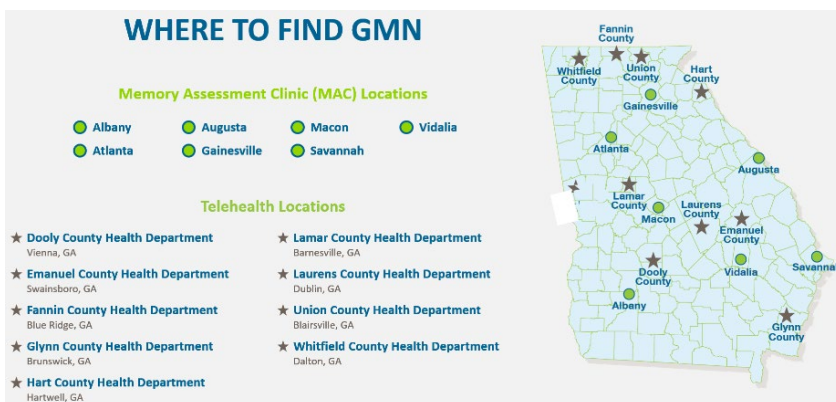
Issues Facing Caregivers of Individuals with Alzheimer’s, Dementia, I/DD, or Other Cognitive or Physical Impairments

During the committee’s study of family caregiving, the committee learned that caregivers of individuals who have Alzheimer’s, dementia, I/DDs or other cognitive or physical impairments tend to have an increase in challenges both in the type of issues they face and the number of issues they must handle. This subsection provides the information learned from the various speakers on these challenges.

5. Emory’s Roybal Center for Dementia Caregiving Mastery (Dr. Ken Hepburn)

Dr. Ken Hepburn, Professor at Emory University’s School of Nursing and Co-Director of the Emory Center for Dementia Caregiving Mastery, presented on the impact of dementia caregiving in Georgia, particularly in rural areas. He cited Alzheimer’s Association data showing that 12 percent of Georgians over age 65—nearly 190,000 individuals—are living with dementia-related illnesses. He noted that Dougherty County ranks seventh in the nation for dementia prevalence. He noted that dementia is not a single disease. But rather, an umbrella diagnosis resulting from over 80 different conditions. He highlighted that 85 percent of Georgians with Alzheimer’s also have at least one other chronic illness, making caregiving especially complex. Rural populations, he reported, have worse health outcomes and greater direct care burdens than their urban or suburban counterparts.

A central focus of his testimony was the GMN—a statewide initiative funded by the Georgia legislature that provides specialist assessments, definitive diagnoses, and caregiver support plans through a network of Memory Assessment Clinics. Dr. Hepburn presented a statewide map showing the distribution of the clinics across Georgia. (See the chart on the right). GMN’s process begins with a referral from a primary care provider, followed by an hour-and-a-half in-person or virtual assessment for the patient and a separate session for the caregiver. A diagnosis and care plan is shared with the referring provider, AAA, and Alzheimer’s Association, initiating a network of coordinated care.



Dr. Hepburn also described the Savvy Caregiver Program, which he co-developed over 30 years ago to train caregivers in how to navigate the progressive and unpredictable nature of dementia. The program, available virtually through GMN, involves six weekly two-hour group sessions, combining instruction, applied home exercises, and coaching. He explained that caregivers are taught to understand the cognitive and behavioral losses associated with dementia and to create engaging tasks and daily structures that maintain a calm, safe, and pleasant environment. Results from federally supported clinical trials show that Savvy Caregiver significantly improves caregivers’ self-confidence and emotional resilience, while reducing depression, stress, and burden. He explained that workshops fill quickly due to strong demand.

Finally, Dr. Hepburn previewed several current and proposed initiatives. A pending grant with the National Institute on Aging would expand TeleSavvy training for caregivers in Albany, Gainesville, and Vidalia, with a special emphasis on addressing rural barriers such as workforce shortages, lack of home health infrastructure, and cultural stigma

around asking for help. He also described ongoing projects through the Roybal Center for Caregiving Mastery, including programs tailored for Latino, Black, Korean, and Appalachian caregivers, as well as "Caregiver Boot Camps," "Keeping on Course" workshops for families dealing with mild cognitive impairment, and a "Caregiver Navigator" program that assists families in managing medical, legal, and interpersonal caregiving challenges. He concluded by stressing that family caregivers are unpaid healthcare workers, deserving of structured training, emotional support, and policy recognition.

During the Q&A following Dr. Ken Hepburn's testimony, a constituent highlighted key barriers to training, navigation, and early intervention. Dr. Hepburn acknowledged that some caregivers resist training when a loved one seems temporarily stable, but emphasized the importance of early preparation. He praised the Georgia Memory Net and its Community Service Educators and AAA dementia care specialists, who help families understand the value of early caregiver education. Other constituents, including a longtime nurse and a board chair with the Alzheimer's Association of Georgia, noted that primary care physicians and hospitals are often the first point of contact, but many fail to provide adequate guidance post-discharge. They cited a lack of dementia education in medical training, especially among rural physicians, and supported the expansion of Georgia Memory Net as a critical solution to specialist shortages, particularly in rural counties beyond metro Atlanta.

6. Georgia Chapter of Alzheimer's Association (Ms. Alexis Williams)

Ms. Alexis Williams, Program Manager for the Alzheimer's Association, began her presentation by sharing her personal connection to Alzheimer's which began when she lost her grandmother to the disease in 2017. As a public health graduate and former volunteer, she discussed how Alzheimer's and dementia affect countless lives, especially caregivers. She introduced the session's structure, noting that attendees would hear firsthand stories from two local caregivers.

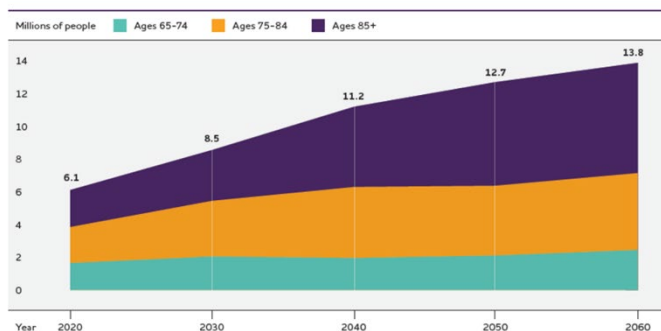
Mrs. Cheryl English shared a powerful multigenerational caregiving story that began with caring for her grandmother, whose dementia progressed to the point of violent outbursts, eventually requiring placement in a memory care facility. Later, Mrs. English and her husband cared for her mother, a fragile diabetic experiencing cognitive decline, in their Georgia home for three years—sacrificing income and social connections after her husband took early retirement to provide full-time care. She noted the emotional, physical, and financial strain of caregiving, noting that despite the challenges, they were grateful to have cared for her mother at home until her passing. Mrs. English urged the committee to support caregivers by funding financial assistance, respite care, local services and education, and by incentivizing employers to provide flexibility for employees with caregiving responsibilities.

Ms. Williams continued her presentation by framing the problem nationally: more than 7 million Americans are currently living with Alzheimer's disease, and their needs ripple out to roughly 11 million unpaid care partners. Ms. Williams noted that "dementia" is an umbrella term, with Alzheimer's accounting for an estimated 60–80 percent of cases, alongside vascular dementia, Lewy body dementia, frontotemporal dementia, Huntington's, and mixed dementias. Two risk patterns were underscored: (1) age as the strongest known risk factor—because the disease is progressive and often changes the brain 20 plus years before symptoms—and (2) population disparities, with African Americans about twice as likely and Hispanic Americans about 1.5 times as likely to develop Alzheimer's, while women represent roughly two-thirds of those affected.

Ms. Williams provided *the chart on the right* to help visualize the age distribution of people living with Alzheimer's. First, as US longevity increases (e.g., more centenarians), the upper-age bands widen, pushing prevalence and care needs upward. Second, because pathology often precedes symptoms by decades, today's "healthy" older cohorts already include individuals in prodromal stages, reinforcing the value of earlier detection and planning. She paired this with outcome ranges: after diagnosis at 65 and over, average survival is 4–8 years, but

Growing Number of Americans With Alzheimer's

The number of Americans age 65+ living with Alzheimer's is expected to double by 2060.



many live up to 20 years, lengthening the caregiving arc and total cost exposure.

The economic and workload burden was quantified next. Nearly 12 million Americans provide unpaid dementia care each year, representing about \$413 billion in imputed economic value. Demographically, two-thirds of caregivers are women and one-third are daughters; about one in three caregivers is age 65 or older (adding their own health risks), and over half care for a parent—often while raising children. Forty-one percent of caregivers report household incomes of \$50,000 or less, and about two-thirds live with the care recipient, magnifying housing and logistics pressures. Another cost illustration contrasted service prices: in 2020, a home health aide averaged approximately \$52,000 per year, while a private nursing home room averaged approximately \$102,000; a separate figure cited approximately \$196 billion in direct US medical spending for Alzheimer’s and related dementias in that year, illustrating how medical costs stack atop unpaid labor.

Georgia-specific graphs and tables translated these trends locally. Ms. Williams summarized “caregiving intensity” among Georgians aged 50 and older: 23 percent reported caregiving in the past 30 days; 26 percent reported caregiving for someone with cognitive impairment; 38 percent provided less than or equal to 20 hours/week; and 72 percent had cared for less than or equal to 6 months, depicting long-duration, high-hour commitments. She explained that 17 percent expect to become caregivers within two years, signaling rising near-term demand. Additional Georgia metrics enumerated 384,000 dementia caregivers delivering approximately 775 million hours of care annually—valued at approximately \$13.3 billion. Survey slices from Georgia Memory Net’s Memory Assessment Clinics showed who does the work: approximately 40 percent adult children, approximately 35 percent spouses, and only approximately 10 percent patients primarily self-managing care. A companion graphic on burden sources noted two dominant stressors: juggling caregiving with other responsibilities and uncertainty about “how to do it right.”

A schematic of the GARD laid out six workgroups—Workforce Development, Service Delivery (with an emphasis on person-centered care plans that adapt hour-to-hour), Outreach & Partnerships, Policy, Public Safety (abuse/neglect/scams recognition and justice-system training), and Healthcare Data & Research—showing how they interlock. She noted that the 2014 plan and the new House Bill 571 requirement (for a data report every four years) corroborated CDC data which determined a need to increase caregiving hours for ADRC.

Ms. Williams’ presentation ended with a personal caregiving testimony from Ms. Lita Jenkins. Ms. Lita Jenkins, a baby boomer and full-time caregiver, shared her heartfelt story of moving her 90-year-old mother into her home on Mother’s Day—a moment that marked a profound shift in their relationship. She described the emotional and practical challenges of caregiving, including juggling a full-time job, caring for a college-aged child, and managing her mother’s daily needs, all while trying to find humor and love in the midst of dementia’s unpredictability. Ms. Jenkins emphasized the emotional toll, financial strain, and social isolation that caregivers face, noting the importance of support groups, online resources like AARP, and legislative efforts.

In the closing portion of the Alzheimer’s Association presentation, Senator Wicks raised two important questions related to multigenerational caregiving and home modifications for individuals with Alzheimer’s. First, she asked about the accessibility of child-care resources for caregivers balancing responsibilities for both aging parents and younger children. Ms. Williams responded that while the issue has not been frequently raised, it is a growing concern. She explained that in many multigenerational households, children often spend time with grandparents who may have dementia while parents are at work. As the condition of the older adult progresses, families may need to turn to external resources like after-school programs and Boys & Girls Clubs, which create additional financial strain.

Senator Wicks also inquired about available resources to support home modifications, given the high care demands of Alzheimer’s. Ms. Williams recommended resources like *The 36-Hour Day* and *Living Your Best Life with Early Stage Dementia* which offer practical advice. She noted the value of involving occupational therapists, who can visit the home, assess risks (e.g., rugs, furniture placement, bathroom access), and suggest tools or adaptations, such as researchers, stove safety switches, or relocating door locks. She stressed that since each caregiving situation is unique (e.g., some individuals may wander while others engage in risky nighttime behaviors) customized in-home evaluations are the most effective way to create a safe environment.

7. GCDD (Ms. D’Arcy Robb, Ms. Brook Kubick, and Ms. Tais Keyser)

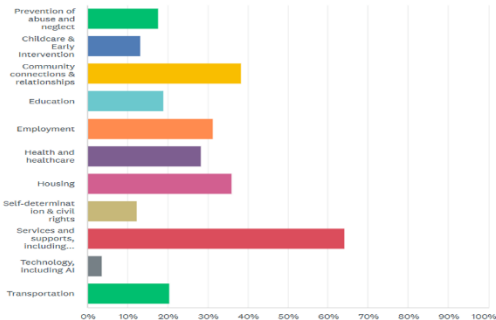
Ms. D'Arcy Robb began her presentation with statewide survey data from nearly 400 Georgians in the disability community. (See chart below). She noted that over two-thirds identified “services and supports (including the NOW/COMP waiver)” as the top need, and over half within that group ranked “making it easier to get a NOW/COMP

waiver” as the most important fix. She reported that Georgia has roughly 226,000 people with an I/DD, about 75 percent of whom live with a family caregiver. Despite the stringent eligibility bar for Georgia’s waivers, there remain approximately 8,000 people on the waiting list. Within that, approximately 4,700 are adults aged 23 and older. Also, 23 children (≤18) are currently served by NOW/COMP due to very high need. Ms. Robb noted that the ideal “on-ramp” for many is at their high-school exit



State of the State for I/DD

- GCDD’s 5-year Plan Survey asked what needs the most attention to improve the lives of Georgians with I/DD and their families:



★ 64% identified *services and supports* as an area of top need and, of that group, 55% said that the most important thing was to make it easier to get a NOW/COMP waiver.

Source: GCDD survey of 398 Georgians in Spring 2025

to avoid the “IEP cliff,” when school-based services end.

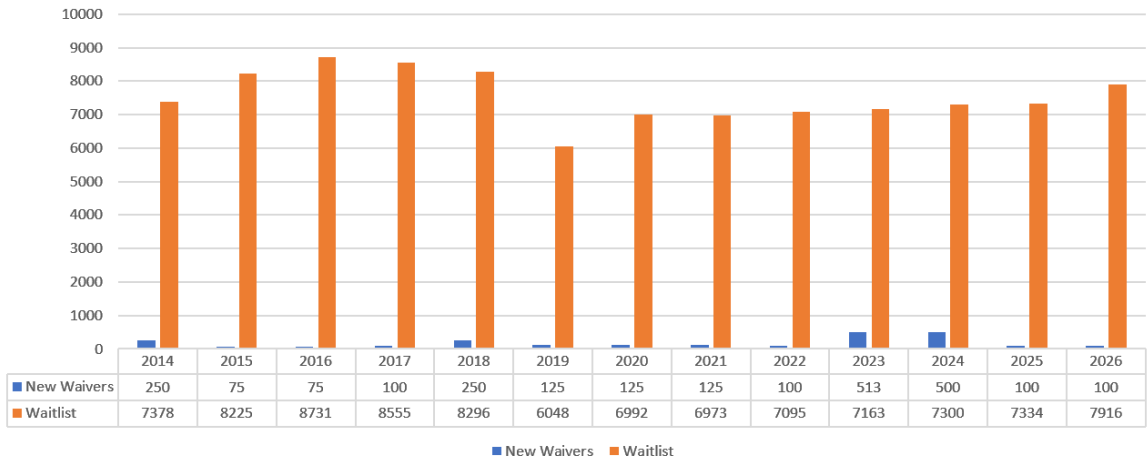
Ms. Robb provided a chart spanning 12 budget years (from part of FY2014 to FY2025) that contrasted people waiting. Typically, 6,000–9,000 individuals are waiting for a waiver with new waivers funded each year (approximately, 75 to just over 500). (See chart below). The chart showed that annual additions have not matched accumulated need (which signals) that there is structural underfunding rather than a temporary spike. Ms. Robb contrasted Georgia with peer state. She noted that Oklahoma and Tennessee have recently shrunk or eliminated their I/DD waiting lists, underscoring that long wait times are not inevitable if policy and funding align.



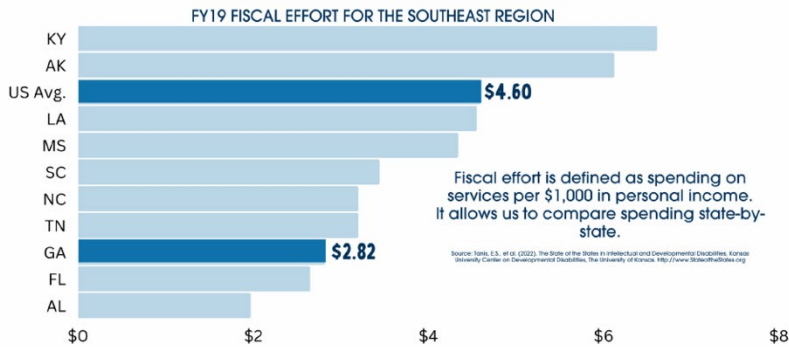
The Waiver Waitlist

- Over the past 12 years, Georgia has consistently underfunded our NOW/COMP waitlist, leaving thousands without services.

New NOW/COMP Waivers vs
Individuals on the Waitlist



The chart on the left shows the fiscal effort of states across the southeastern portion of the US and compared them to the national average demonstrating how they compare on state spending on I/DD services per \$1,000 of personal



income. The chart showed the US average at \$4.66, while Georgia sits at approximately \$2.52, placing the state second from the bottom in the region and at just over half the national effort. Ms. Robb explained that Georgia's comparatively low investment level results in a persistent waiting list and capacity limits.

Ms. Robb discussed budget implications. Funding 2,400 additional waivers would cost about 0.17 percent of the FY26 state budget. A cost comparison illustrated that HCBS waivers are less costly than institutional care

on a per-person basis, and can even yield a positive return on investment when factoring in secondary effects such as beneficiaries' increased ability to work or volunteer, caregivers re-entering the workforce, and wages paid to direct support professionals circulating in local economies.

Family testimonies grounded the numbers in lived experience through the testimonies of Ms. Brook Kubick and Ms. Tais Keyser. Ms. Kubick, a mother of five, four with disabilities, described her son Max, who has high-functioning autism with complex medical needs and achieved a perfect 36 ACT and 1600 SAT on first attempts, plus valedictorian status. Despite elite university interest, he cannot attend or thrive without Medicaid and HCBS supports (e.g., transportation, a DSP, power wheelchair). Ms. Kubick left full-time employment to provide care, pushing her family to the brink financially. She explained that no paid caregiving support meant "billions of hours" of unpaid care borne by families like hers and lost workforce and tax capacity for the state.

Ms. Tais Keyser detailed a four-year fight for her adult son Isaiah, who was diagnosed with autism and schizophrenia. He was denied the waiting list four times, forcing a lawsuit that cost over \$60,000. Before that, Ms. Keyser was both mother and full-time caregiver, straining their relationship and keeping her out of the workforce. With supports in place, Isaiah is thriving in a day program that now wants to hire him. Ms. Keyser has returned to work and helped more than 130 families navigate services.

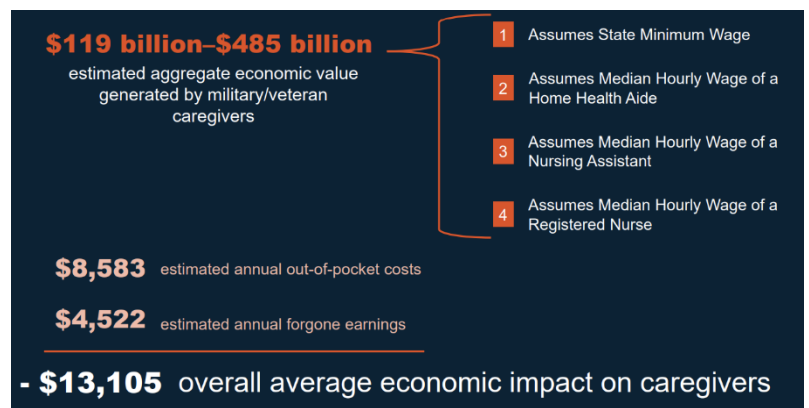
Issues Facing Caregivers of Service Members and Veterans

The committee also learned that caregivers of service members and veterans tend to face unique challenges when providing care.

8. Rand Corporation (Ms. Vanessa Parks)

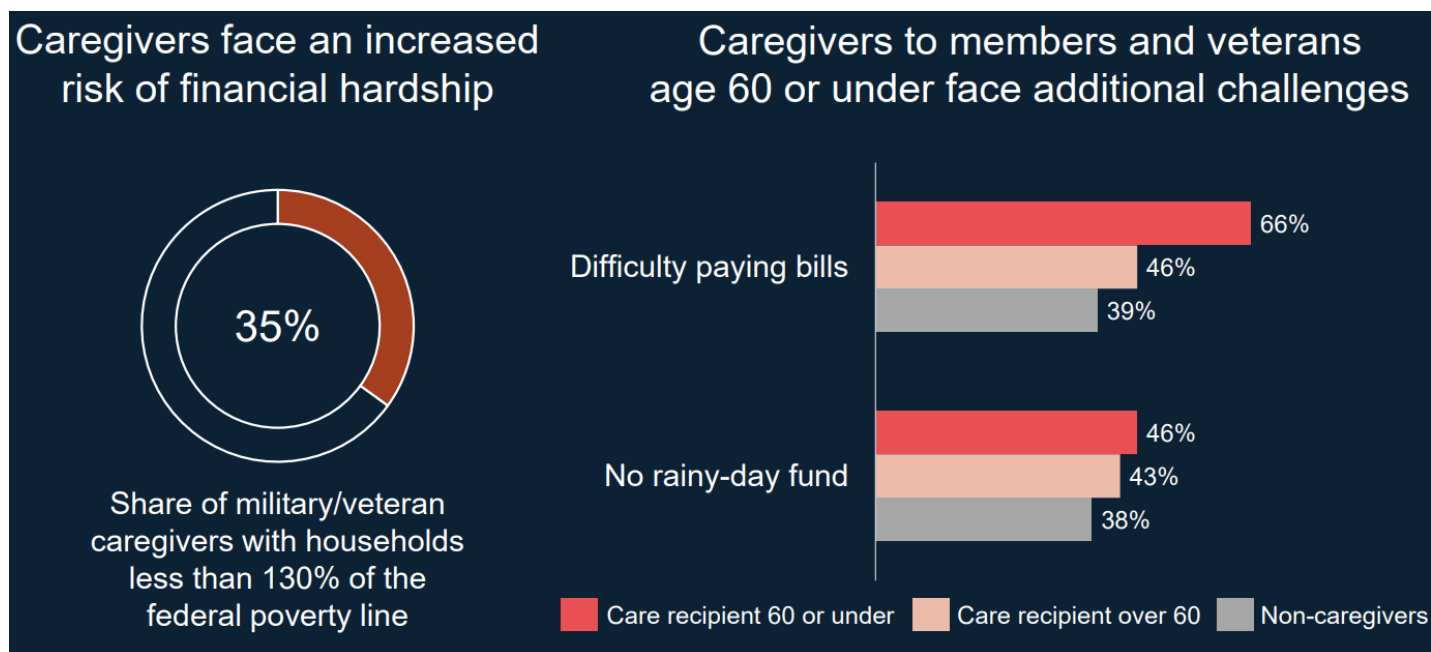
Dr. Vanessa Parks of Rand Corporation presented findings from a national study on military and veteran caregiving, with specific implications for Georgia and rural populations. She stated that 105.6 million Americans (about 40.5 percent of the adult population) are caregivers, including 14.3 million who care for someone with military service. This estimate is higher than past numbers because Rand used a task-based definition of caregiving rather than relying solely on self-identification. Georgia ranks 10th in the percentage of veterans with caregivers and 15th in the percentage of veterans with unmet caregiving needs, which is about 10 percent. The study found that caregiving relationships vary by age group, with adult children comprising 42 percent of caregivers for older veterans and spouses and extended family members providing most of the care for younger veterans. Rural caregivers were noted to be more prevalent among those caring for younger veterans.

Dr. Parks highlighted significant economic burdens facing military and veteran caregivers. (See chart above). If compensated, their work would be valued between \$119 billion and \$485 billion annually. On average, caregivers spend over \$8,000 annually in out-of-pocket expenses and lose \$4,500 in income



due to work disruptions. This results in a \$13,000 loss in discretionary income per year.

Over a third of these caregivers (roughly 35 percent) have household incomes 130 percent below the federal poverty line, with 46 percent struggling to pay bills and 43 percent having no savings. (See chart below). Dr. Parks recommended educating Georgia-based caregiver organizations about benefit programs like SNAP, and maintaining or expanding initiatives like the Medicaid SFC program, which only 11 states, including Georgia, currently offer.



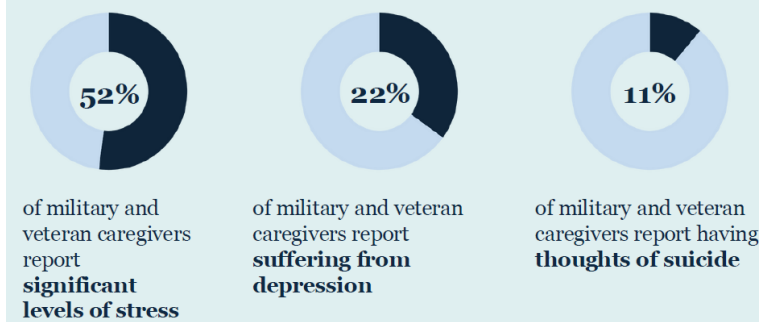
The prevalence of mental health challenges among caregivers was another major theme of Dr. Parks' presentation. Among caregivers to veterans aged 60 and under, 22 percent reported suicidal thoughts in the past year and 43 percent met the clinical criteria for depression, which is much higher than non-caregivers. A significant barrier to accessing mental health services was time – not cost – and many caregivers feared being involuntarily hospitalized if they disclosed their struggles. Dr. Parks described supportive programs, including respite care via the Wounded Warrior Project, and financial grants from the VA and the Elizabeth Dole Foundation's Hope Fund. However, she warned that uptake of these programs depends heavily on broadband access. She noted that only 76 percent of rural caregivers have internet compared to 84 percent of urban caregivers. In Georgia, 11.6 percent of households lack broadband access. She recommended strategies like telehealth, asynchronous counseling, mobile apps, and broadband expansion to improve service access.

Dr. Parks stressed the need for a more caregiver-inclusive healthcare system. Only a third of caregivers felt heard by providers or included in healthcare planning. Few providers asked about caregivers' own needs. One veteran's caregiver said she only earned respect from healthcare professionals after adopting their language and terminology.

9. Elizabeth Dole Foundation (Ms. Madison Moore and Ms. Steph Smith)

Ms. Madison Moore, Senior Strategic Advisor for the Elizabeth Dole Foundation and Steph Smith, a Dole Caregiver Fellow from Columbus, Georgia, provided a national perspective on the military and veteran caregiver population, highlighting some of the most pressing challenges facing this group, what the foundation is doing to address them, and how the committee might consider supporting caregivers here in Georgia.

Caregiving often places significant strain on caregivers and increases their risk for developing physical and mental health conditions.



Ms. Moore began by expanding on Dr. Parks' remarks. She explained that there are approximately 14.3 million people across the country—spouses, children, parents, siblings, grandchildren, neighbors, and friends—serving as military and veteran caregivers. In Georgia, Ms. Parks shared an estimate of 127,000. She explained that the foundation uses a slightly larger number because national estimates often undercount caregivers by a factor of four to five because many people who perform caregiving duties do not self-identify as caregivers.

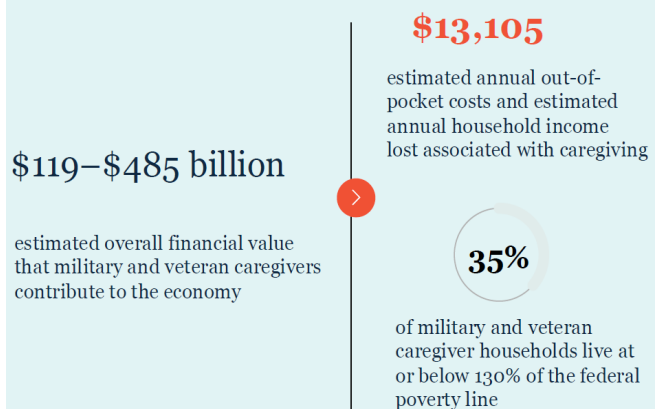
Caregivers not only support the health and well-being of their loved ones, but they also contribute significantly to their own families and communities. Over the past 13 years, inspired by their founder Senator Elizabeth Dole's experience caring for her late

husband Bob Dole, the foundation has worked to understand this population. Through research with Rand and the lived experience of caregivers like Ms. Steph Smith, the foundation has raised awareness, built cross-sector coalitions, advocated at every level of government, and developed direct service programming for caregivers.

She noted that all this work, alongside the Rand report, shaped their new strategic plan, which focuses on four key areas: (1) mental and emotional well-being for caregivers; (2) growing and sustaining economic mobility; (3) improving support and outcomes for caregiving youth and families; and (4) fostering supportive care ecosystems for caregivers and veterans.

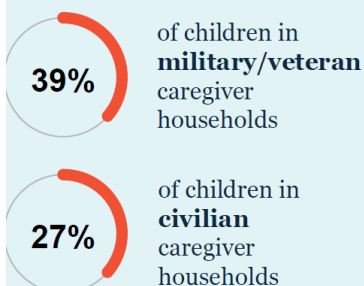
Caregiving places significant mental strain on caregivers. She explained that they see high levels of stress, depression, and even suicidal ideation in this population. (See chart above on the left). Financial hardship is also a major issue that affects long-term stability for this population. Caregivers contribute an estimated \$119 to \$485 billion annually in unpaid care. At the same time, many face out-of-pocket costs and must step back from employment. She noted that these combined burdens make economic mobility difficult. (See chart on the right).

Caregivers face an increased risk of financial hardship, affecting economic mobility and asset ownership round.



Around 40% of military/veteran caregivers are also raising a child

The children of military/veteran caregivers are more likely to help with at least one caregiving task than children of civilians



Children who take on caregiving responsibilities are

- More likely to have missed school because of illness
- At increased risk for poor child behavioral outcomes
- At increased risk for conduct problems, such as losing one's temper and fighting with other children

Ms. Moore explained that a particular area of focus for the foundation is youth caregivers. (See chart on the left). About 40 percent of military and veteran caregivers are raising children, and these children are more likely than their peers to assist with caregiving tasks. Unfortunately, they are also more likely to miss school due to illness or caregiving demands and to experience behavioral challenges. The foundation's HI/DDen Helpers initiative connects these children to peer support, educational accommodations, and healthcare access to help them thrive.

Finally, care ecosystems (whether clinical, in the home, or community-based) are often not inclusive of caregivers. Caregivers are frequently excluded from treatment rooms, discharge planning, or decisions about care, even though they often know more than the patient. The foundation's research shows that military and

veteran caregivers are more likely to live in resource-scarce neighborhoods with fewer hospitals, grocery stores, or public transportation options.

To address these needs, the foundation offers several programs such as emergency financial assistance to help with food insecurity, rent, and urgent repairs; their own personalized resource navigation which helps caregivers connect to services for mental health, VA benefits, and homelessness; and peer support is offered through their online HI/DDen Heroes community and through leadership programs like their Dole Caregiver Fellows, of which Ms. Smith is a part. They also run group-based mental and financial wellness programs and lead three major advocacy coalitions. The HI/DDen Helpers Coalition focuses on supporting youth caregivers. The Face the Fight Coalition is aimed at reducing veteran suicide. Lastly, the Campaign for Inclusive Care is their initiative with the VA to make care delivery more inclusive of caregivers. The foundation currently partners with over 200 jurisdictions to implement caregiver-friendly policies. Effective strategies include creating centralized resource networks, hosting community listening sessions, fostering public-private-nonprofit partnerships, and ensuring that efforts are not duplicated.

Ms. Steph Smith presented on the financial, educational, and legal challenges faced by military and veteran caregivers like herself. She discussed the limitations of Georgia's partial property tax waiver for disabled veterans, noting that while her family currently benefits from it, they are considering moving just six miles across the state line to Alabama, where property taxes are fully waived. Alabama also offers tuition-free college to children of 100 percent disabled veterans, a benefit that her family considered but declined due to Georgia's stronger K–12 public education. However, she noted that her daughter and son-in-law, also a veteran family, leaving Georgia to take advantage of Alabama's college benefits, suggesting that Georgia risks losing veteran families without more competitive support.

Ms. Smith also noted the lack of educational accommodations for caregivers in Georgia. As a student at Columbus State University, she pointed out that while parents and individuals with disabilities are offered excused absences, caregivers receive no such flexibility. Even when managing crises related to a spouse's PTSD or mandatory VA appointments such flexibility is not provided. This lack of support also extends to K–12 schools, where families struggle with attendance policies that do not recognize the unique burdens of veteran caregiving.

In addition to education and taxation, Ms. Smith addressed the gaps in legal aid access. She shared the story of a fellow caregiver in Valdosta whose husband, at age 40, became permanently incapacitated due to a car accident. Because he was neither a minor nor over age 65, Georgia Legal Services could not help the family secure guardianship, and the risk of filing paperwork incorrectly was high, given the potential three-year wait for reapplication.

Issues Facing African American Caregivers

The committee further studied challenges that African American caregivers face. This subsection provides the information learned from various speakers who testified on these challenges.

10. Ohio State University (Dr. Karen Moss)

Dr. Karen Moss, an associate professor and nurse scientist at Ohio State University, centered her presentation on the disproportionate burden of dementia and caregiving within African American communities—especially among African American men. She noted that African American individuals face the highest risk for dementia, which in turn places African American family caregivers at the highest risk for adverse physical, mental, psychosocial, and financial outcomes. Dr. Moss underscored a persistent undercounting issue: African American men are less likely to self-identify as caregivers or ask for help due to stigma and concerns about community perception, meaning actual need likely exceeds what surveys capture. She also noted that African American men already experience some of the poorest baseline health profiles in the US, so layering caregiver duties onto existing risk magnifies the likelihood of negative outcomes.

Dr. Moss highlighted multigenerational dynamics and the “sandwich generation,” stressing that caregiving responsibilities span young adults to older adults and often include simultaneous care for children and aging relatives. She cited national data indicating that 13 percent of families report child or adolescent caregivers—youth who may conceal caregiving duties from schools, risking academic or behavioral consequences and reduced participation in sports or extracurriculars. She cautioned that these hidden roles intersect with elevated suicide risk among young African American men, arguing for targeted attention, screening, and supportive services. She also pointed to grandparents—grandfathers included—who are raising grandchildren, noting the added intergenerational challenges (e.g., social-media-driven contexts) they must navigate.

In discussing solutions, Ms. Moss profiled community-based efforts designed to “meet men where they are.” Examples included the National African American Male Wellness Agency’s health-screening events (e.g., Columbus, OH; an Atlanta walk scheduled for September 20), and Melanin-Minded, a program founded by a former male caregiver that trains community members to recognize dementia symptoms, supports safe transportation, and empowers youth caregivers. She described an ultra-brief “Hoops for Health” courtside talk as a low-barrier model to prompt men to report caregiving status, confirm recent checkups, and receive quick self-care guidance. Locally, she outlined the ADHOC alliance in central Ohio—a triad of an academic center, the Alzheimer’s Association chapter, and a grassroots African American wellness organization—that hosts an annual Brain Health Fair with on-site cognitive screening plus blood pressure, glucose, hemoglobin A1c, and cholesterol checks.

Turning to research and program design, Ms. Moss mentioned the ALTER program’s faith-based dementia supports and her team’s “Peer-to-Care” virtual peer-support intervention that pairs current caregivers with former caregivers who “get it.” In an initial local test, recruitment was unusually rapid, voluntary attrition was zero, and some caregiver health measures appeared to improve (though the pilot’s small sample size limits inference). She noted they are seeking funding from the National Institute on Aging to expand and, crucially, to intentionally enroll more men. Finally, Ms. Moss recommended operational fixes—flagging homes to first responders when a resident lives with dementia, and offering on-site older-adult respite at conferences just as child care is often provided—to convert awareness into practical access.

In a brief exchange, Chairman Jones asked Dr. Moss whether the efforts to address underreporting and stigma around African-American male caregivers are being tackled solely through community organizations or if there has been involvement from state government. Dr. Moss acknowledged that the challenge is widespread, including in Ohio, and noted that while research plays a role in encouraging African American men to acknowledge their caregiving roles and seek support, it is often not the most effective outreach method. Instead, she highlighted the importance of community-based engagement, particularly through culturally relevant organizations like the African-American Male Wellness Agency. These groups host large-scale events—such as health festivals—where men can be approached in familiar, non-clinical environments. Dr. Moss also stressed the power of peer-to-peer outreach, noting that African American men are more likely to feel comfortable discussing caregiving when the conversation is initiated by another African American male. This peer connection can help dismantle the stigma and allow men to seek support without guilt.

11. Alzheimer’s Association (Ms. Beverly Berry)

Ms. Beverly Berry, Director of Diversity, Equity, and Inclusion Engagement at the Alzheimer’s Association’s national office, presented data from the Association’s 2021 Special Report on Race, Ethnicity, and Alzheimer’s Disease. The report, though published in 2021, remains highly relevant and continues to inform current community engagement and caregiver support initiatives. The research included survey responses examining access to care, trust in healthcare providers, participation in clinical trials, and caregiving experiences across racial and ethnic groups. Ms. Berry noted that caregiving, particularly in African American communities, is an “invisible force”—an essential yet under-recognized aspect of the healthcare system.

Ms. Berry highlighted that over 11 million Americans provide unpaid care for someone with Alzheimer’s or a related dementia, with African Americans disproportionately represented. African American families are twice as likely to step into caregiving roles compared to white families, often starting earlier in the disease progression and continuing longer into advanced stages. This results in African American caregivers providing more weekly hours of care for longer periods, frequently with fewer financial and community resources. A key data point from the report indicated that 50 percent of African American respondents identified discrimination as a barrier when seeking care for a loved one, highlighting persistent systemic inequities. Furthermore, nearly two-thirds of African Americans surveyed believe medical research is biased against people of color.

Additional statistics from the presentation noted the intersectional burden on African American women. More than 60 percent of Alzheimer’s and dementia caregivers are women, and nearly two-thirds of Americans living with Alzheimer’s are women. When race and ethnicity are considered alongside gender, Ms. Berry noted that African American women face particularly acute burdens in caregiving. Compared to white caregivers, African American caregivers are more likely to provide care with higher physical, emotional, and financial costs, use fewer outside services, and report higher levels of depression. These caregiving responsibilities often result in career disruption—caregivers may reduce hours, take extended leave, or exit the workforce entirely, leading to long-term economic consequences like lost income, retirement benefits, and health insurance coverage.

12. Duke University (Dr. Robert Turner)

Dr. Robert Turner, associate professor at Duke University and founding director of the African American Men's Brain Health Initiative, provided testimony on the critical health disparities facing African American male caregivers of individuals with dementia. He noted that African American men experience the worst health outcomes of any racial group in the US, with 21 million African American men disproportionately affected by limited healthcare access, poor health education, cultural barriers, poverty, and discrimination. Life expectancy for African American men has dropped to 67.7 years post-COVID-19—a stark decline from 70.7 years—according to CDC data. He also noted that African American men have higher death rates than women for all major causes of mortality and that 33 percent of men overall report not having a regular physician, with nearly 25 percent not seeing a doctor in the past year. He argued that these alarming statistics are vital when contextualizing the health burden of African American men already at risk who then assume the caregiving role.

Dr. Turner explained that there is an urgent need to improve African American male representation in Alzheimer's and dementia research. Currently, African Americans make up only 5 percent of all participants in Alzheimer's-related studies, and only 25 percent of that small group are African American men. This underrepresentation severely limits understanding of how factors such as hypertension, obesity, and substance use—which are more prevalent among African American men—affect dementia outcomes and caregiving strain. A visual highlighted these disparities, showing that male caregivers often delay seeking care or support due to cultural stigmas around masculinity and vulnerability. Dr. Turner shared a personal example of caring for both of his parents—his father with Alzheimer's and his mother with kidney disease—underscoring the physical and emotional toll, particularly when performing tasks that challenge cultural norms around masculinity, such as bathing or toileting a parent.

The presentation included data from Dr. Turner's "Black Men's Caregivers Study," a National Institute on Aging-funded project. The study recruited 40 African American male caregivers and 40 non-caregivers in the Washington, D.C., area and assessed neurocognitive performance, mental health, and saliva-based biomarkers. Participants completed surveys and cognitive testing remotely and received \$125 compensation. Among caregivers, results revealed significantly higher levels of depressive symptoms, sleep dysfunction, and impaired working memory and verbal recall. Many participants worried their cognitive issues were early signs of dementia. However, Dr. Turner explained that sleep deprivation and caregiving stress can impair cognitive performance even in the absence of disease. These findings were displayed in a bar chart illustrating the gap in self-reported depressive symptoms and memory strain between caregivers and non-caregivers.

To overcome recruitment barriers rooted in historical mistrust and stigma, Dr. Turner partnered with African American faith leaders through a "faith engagement initiative." Flyers, FAQs, and videos were co-designed with community input, and clergy were invited to participate in the study themselves. This approach countered the top reason African American men cited for never participating in research: "I was never asked." He noted shifting language from "study" to "project" to build trust and framed caregiving within the cultural context of multigenerational responsibility and spiritual strength. He described caregiving as the most challenging yet most rewarding experience of his life.

In response to questions about African-American male participation in clinical trials, Dr. Robert Turner clarified that the historically low representation stems largely from a lack of outreach rather than a refusal to participate. In his own research involving African American male caregivers, he found that once outreach was intentional and culturally responsive, participation rates significantly increased. He noted that African American men are indeed willing and enthusiastic to engage in research—such as his African American Men's Brain Health Conference, which draws over 2,000 participants annually—but they require tailored engagement strategies. These include building long-term, trust-based relationships and demonstrating cultural sensitivity. Dr. Turner noted that researchers must move beyond generic outreach methods, acknowledging that trust must be earned, particularly when asking participants to disclose personal health information or contribute biological samples.

In a follow-up question, Dr. Turner elaborated on why African American caregivers, particularly men, are often tasked with providing more hours of care than other groups. He explained that financial constraints frequently prevent them from hiring home health aides, and cultural norms often discourage them from asking for help. Additionally, the higher prevalence of Alzheimer's in African American women can mean fewer available family caregivers. Combined, these factors result in African American caregivers—already less likely to access formal support services—shouldering more caregiving responsibilities with fewer resources. This cumulative burden, Dr. Turner noted, underscores the

urgent need for culturally competent support systems and economic relief measures tailored to African-American caregiving communities.

GEORGIA'S FAMILY CAREGIVING LANDSCAPE

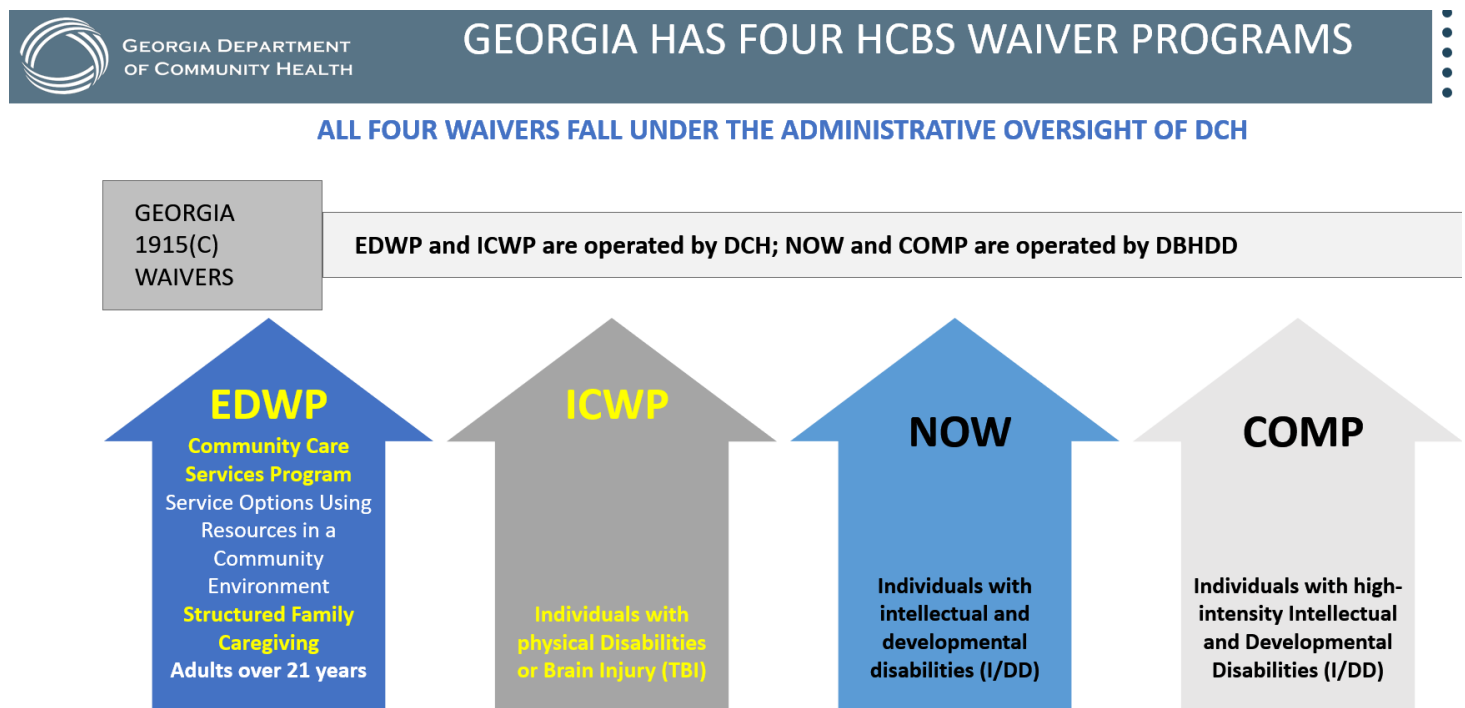
The third theme focused on reviewing and determining Georgia's current family caregiving landscape. This theme provided context and detailed information regarding the services, programs, government agencies, non-governmental organizations, and businesses that work in the family caregiving sphere.

1. DCH (Ms. Brandy Sylvan, Ms. Maxine Elliott, and Ms. Taesha Ward)

Deputy Executive Director Maxine Elliot of the Department of Community Health's Medical Assistance Plans Division delivered a comprehensive overview of Georgia's Medicaid waiver programs, focusing on the SFC service under the EDWP. She began by emphasizing DCH's mission to ensure access to affordable, quality health care for all eligible Georgians through effective planning, purchasing, and oversight. Ms. Elliot underscored the agency's commitment to strengthening Georgia's family caregiving infrastructure—describing caregivers as the backbone of the state's community-based long-term care system.

Ms. Elliot explained that Medicaid waivers (authorized under Section 1915(c) of the Social Security Act) allow states to use federal funds to deliver HCBS as an alternative to institutional care. A diagram outlined the federal review process. It demonstrated how each waiver must receive approval from CMS and be renewed every five years. She highlighted these waivers must remain cost-neutral, meaning the state cannot spend more on community-based services than it would for institutional placements. She explained that the average cost savings achieved under community care models versus institutional care show that community-based services are significantly more cost-efficient per member annually.

Georgia currently operates four 1915(c) waiver programs, each targeting a distinct population. (*See chart below*). Ms. Elliot detailed that EDWP serves adults aged 21 and older with disabilities, combining the CCSP and the SOURCE program. The ICWP supports individuals with physical or traumatic brain injuries, while the NOW and COMP serve individuals with I/DDs under the administration of DBHDD. EDWP has the largest participant base statewide. Ms. Elliot clarified SFC functions as a service within EDWP, not a standalone program. The program allows live-in family caregivers who already provide unpaid daily care to receive structured compensation and training through Medicaid-approved provider agencies.



To ensure accountability, Ms. Elliot explained that caregivers must reside in the same home as the Medicaid member and cannot be spouses, parents of minors, or legal guardians. They must pass background and abuse registry checks, complete training, and cannot maintain employment that interferes with caregiving duties. CMS has six federal assurances for waiver approval: (1) administrative oversight; (2) institutional level of care; (3) person-centered service plans; (4) qualified providers; (5) health and welfare protections; and (6) financial accountability. Ms. Elliot also

highlighted the HCBS Rule (42 C.F.R. §441.301(c)(4)), emphasizing its role to ensure that waiver participants have full community integration, personal autonomy, and dignity comparable to those not receiving Medicaid services.

Ms. Elliot concluded by addressing estate recovery, a federal requirement implemented in Georgia.⁴² She provided an overview of the estate recovery process timeline, from DCH's receipt of death notifications to family hardship waiver determinations. She clarified that recovery applies only to members aged 55 or older or those permanently institutionalized, covering services such as SFC, personal support, case management, and related medical costs. Exemptions exist for surviving spouses, dependent or disabled children, hardship cases, and low-value estates under \$25,000. Ms. Elliot closed by reaffirming DCH's commitment to supporting, training, and empowering Georgia's family caregivers, noting that programs like SFC represent a balance between compassion and accountability—preserving family stability while maintaining fiscal and regulatory integrity across the state's Medicaid system.

Following DCH's presentation, Senator Wicks asked what systems are in place to prevent caregiver burnout, particularly for individuals balancing the demands of full-time caregiving and personal responsibilities. Ms. Elliot explained that Georgia's waiver programs integrate case management and care coordination as core supports for members and their families. These components function within a broader "ecosystem of care" that includes Medicaid-approved provider agencies, which are responsible for supervision, documentation review, and ongoing support. Ms. Elliot noted that DCH requires family caregivers to undergo formal training to ensure competency and is currently working to upgrade training programs statewide, including planning a Family Caregiver Summit. She emphasized the emotional strain that caregiving can create, acknowledging from her own experience that compassion and dedication alone are not enough to prevent fatigue.

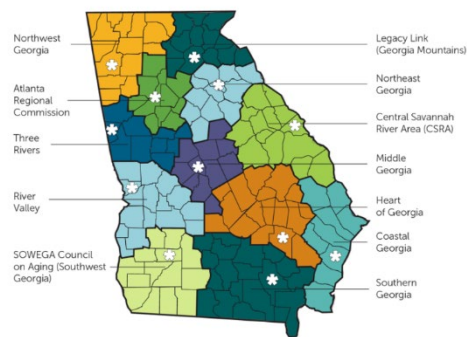
Senator Wicks also asked how often caregivers receive training updates and who provides these sessions. Ms. Taesha Ward, DCH's Director of Programs and Community Supports, explained that initial caregiver training is conducted by the Medicaid provider agency before services begin, and each caregiver is also assigned a health coach who can coordinate additional training or connect the caregiver to respite care resources when needed. While formal refresher training occurs annually at a minimum, ongoing education and support are available year-round through coordination between the provider agency and the case management team. Ms. Ward highlighted that respite care may include out-of-home placement in respite facilities, offering both socialization opportunities for the member and relief for the caregiver.

Chairman Jones' questions centered on federal restrictions and Medicaid's estate recovery policy. Ms. Elliot clarified that the prohibition against spouses, legal guardians, and parents of minors serving as paid caregivers arises from federal conflict-of-interest regulations, intended to maintain accountability and prevent potential misuse of funds. The discussion concluded with questions about the low-value and hardship exemption under Georgia's estate recovery law, which exempts estates valued under \$25,000 from repayment. Ms. Ward explained that the state may recover costs associated with a Medicaid member's long-term care, hospitalization, and community-based services, but families are notified through a formal letter of intent and typically have 60 to 90 days to respond. She added that the Estate Recovery Office often works collaboratively with families to arrange repayment or establish hardship waivers when appropriate, ensuring fairness and transparency in the recovery process.

Area Agencies on Aging (AAAs)

2. DHS (Ms. Melody DeBussey and Ms. Breanna Sims)

Ms. Melody DeBussey, Chief Policy Officer, and Brianna Sims, Deputy Commissioner for State Programs at the Georgia DHS, provided an overview of the state's aging services framework, which is managed by DAS. They explained that Georgia's aging infrastructure is built around 12 AAAs, which are designated to coordinate services for adults aged 60 and older, enabling them to remain safely in their homes. (See *chart on the right*). These services authorized under the OAA

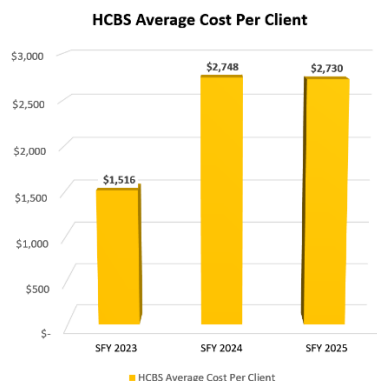
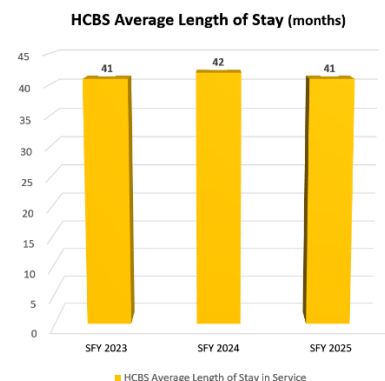


⁴² See O.C.G.A. §49-4-147.1.

Home and Community Based Services

include referrals, congregate and home-delivered meals, and caregiver support. A core component of their discussion focused on non-Medicaid HCBS, which support older adults and caregivers regardless of income.

They provided quantitative data that showed the cost-effectiveness and reach of non-Medicaid HCBS. A *chart on the left* shows that the average length of stay in the program from state fiscal years 2023 to 2025 is approximately 41 months. The data suggests that clients receive sustained support over multiple years. They noted that the average cost per client is

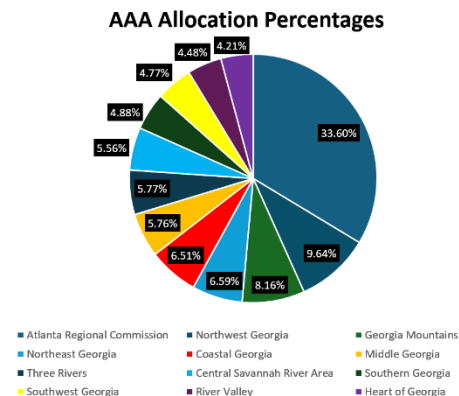


projected at \$2,730 for FY 2025, reflecting the relatively low cost of these community-based services compared to institutional care. They explained that these figures underscore the high return on investment that non-Medicaid HCBS provide to the state and to the populations served.

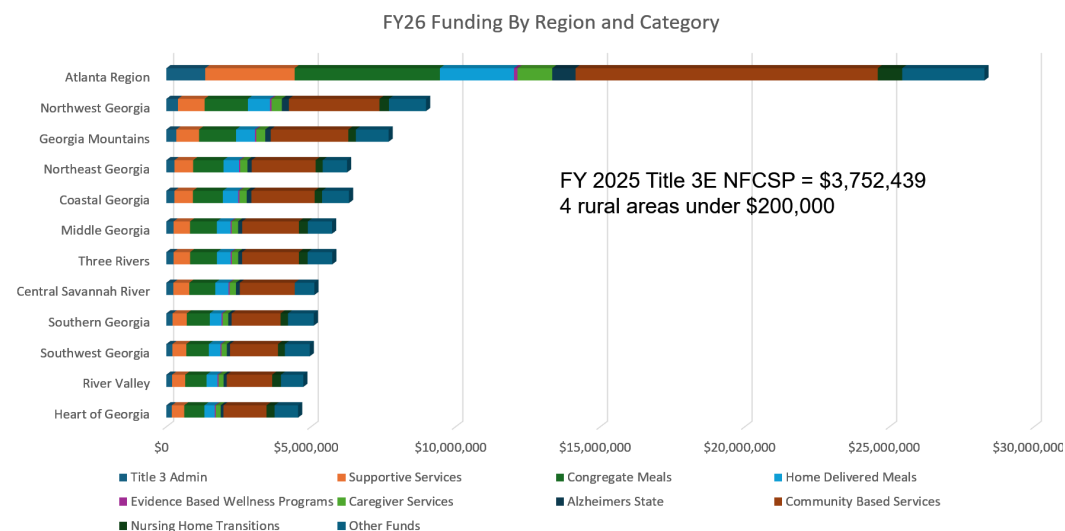
Eligibility for HCBS services is based on functional need rather than income, as the services are not means-tested. Clients are prioritized through a needs-based model using the DAWN-R scoring system, which assesses impairments in daily living activities. This approach allows individuals with greater care needs to move off the waitlist more quickly, rather than simply being served in the order they applied. Ms. DeBussey noted that this shift from a time-based to a need-based system is critical for equity and resource optimization.

The presentation also focused on the funding allocation structure. A detailed chart illustrated how state and federal funding flows to Georgia's 12 Planning and Service Areas through a weighted formula approved by the ACL. (*See chart on the right*). This formula incorporates multiple factors, including population, rurality, and the proportion of seniors living alone, all of which are detailed in Georgia's State Aging Plan.

Factors and weights	Current
Population 60+	10%
Population 75+	30%
Low-income minority 65+	13%
Rural 60+	15%
Disabled 65+	10%
Limited English speaking 65+	4%
Living alone 65+	8%



The Atlanta region was shown to receive the largest funding share, shown through the *chart below* that provided Title III components, such as, the NFCSP; congregate meals; and home-delivered meals with supportive services comprising the largest category.



the largest category. Additionally, Ms. DeBussey highlighted that AAAs must provide local matching funds for certain programs, adding another layer of complexity to regional funding disparities.

In her presentation, Ms. Brianna Sims, Deputy Commissioner for State Programs at DHS, provided an extensive overview of DAS programs aimed at protecting the rights, safety, and well-being of Georgia's older adults and adults with

disabilities. She began by discussing APS, which investigates ANE of disabled adults and elders outside of long-term care facilities. APS handled 49,892 reports of ANE in Fiscal Year 2025. As of September 1st, there were 869 active investigations. APS is supported by 184 budgeted case managers, and central intake staff are required to triage referrals within one business day of receipt. The most commonly investigated allegation is financial exploitation, followed by self-neglect, which, while not classified as a crime, is now federally mandated for investigation.

Ms. Sims then described the Temporary Emergency Respite Fund, a 24/7 emergency placement service exclusively accessible to APS, law enforcement, and regulatory agencies. It provides up to seven days of emergency shelter for adults whose caregivers are suddenly unavailable due to arrest, illness, or other crises. A small team, comprising of one supervisor, two case managers, and one program assistant, manage these cases across the entire state. She also detailed the Long-Term Care Ombudsman program, which operates as an independent advocate for residents of nursing homes and assisted living facilities, handling informal complaint resolution, education on residents' rights, and routine site visits to monitor facility conditions. In addition, the Forensic Special Initiatives Unit supports law enforcement and other responders through training, consultations, and the development of a Georgia ANE app, which allows users to access statutory references, crime definitions with enhanced penalties, and reporting resources in the field.

Legal support for older adults is provided through the ELAP, which offers free civil legal services through law firms contracted by AAAs. ELAP focuses on critical areas such as Medicaid and SNAP appeals, housing issues, healthcare access, age discrimination, and long-term care discharge protections. However, no criminal cases are handled under ELAP due to program restrictions. Ms. Sims also announced the renaming of the Public Guardianship Office to the Adult Guardianship Program to reflect that DHS staff cannot legally serve as public guardians under Georgia law. The Adult Guardianship Program supports 1,489 adults under guardianship as of September 1st, with services coordinated by 42 dedicated case managers who act as surrogate decision-makers and advocates for their clients' care and well-being.

Ms. Sims concluded by reviewing broader community-based services supported by DAS and Georgia's ADRC. Originally launched via a federal grant in 2004, ADRC has since expanded to all 12 AAA regions, covering all 159 counties. ADRC serves as a "no wrong door" access point for long-term care support, helping clients navigate both public and private programs through assessment, counseling, referral, and care transitions. Complementary services include Georgia State Health Insurance Assistance Program, which offers free Medicare counseling; home-delivered and congregate meals; physical fitness and nutrition counseling; in-home emergency response systems; chore and homemaker services; adult day programs; and kinship care support for grandparents raising grandchildren.

Ms. DeBussey concluded DHS' testimony by highlighting several forward-looking initiatives currently underway to strengthen caregiver support across the state. She outlined three key areas of development: (1) a UNG respite care study, (2) Georgia's participation in the NASHP Family Caregiving Learning Collaborative, and (3) the next State Plan on Aging, which will place an increased emphasis on the needs of family caregivers. These projects reflect the Division's commitment to data-driven planning, national collaboration, and inclusive policy development that centers caregivers as essential partners in long-term care.

One of the most critical data insights shared came from preliminary findings of the UNG caregiver study, which uses the DAWN-R scoring tool to assess functional impairment and service needs. Ms. DeBussey explained that a DAWN-R score of 15 with at least one unmet need typically qualifies an individual for nursing home placement. However, caregivers participating in the study are supporting individuals with much higher needs—scoring above 35, placing them in the 90th percentile of care intensity. This finding illustrates that these caregivers are sustaining individuals in the community who have significantly greater impairments than institutional placement thresholds. The study also noted geographic disparities among the rural and urban counties. Rural areas show a disproportionate concentration of high-need individuals who remain in the community without adequate services due to access barriers. Ms. DeBussey emphasized that every \$1 invested in these community-based services yields a \$1.41 return, reinforcing the economic and humanitarian rationale for enhanced support.

In addition to data analysis, Ms. DeBussey detailed Georgia's selection as one of 14 states to participate in NASHP's 2025 Family Caregiving State Policy Learning Collaborative, a program that will run for 18 months beginning January 2025. Georgia's team includes representatives from both DHS and DCH. Through this initiative, Georgia will receive technical assistance and access to national experts, as well as participate in virtual and in-person convenings.

The state has already set goals to improve access to community-based care and is preparing to launch a statewide caregiver coalition, with findings and recommendations to be publicly shared by spring 2026.

Finally, Ms. DeBussey previewed the upcoming State Plan on Aging, which will include a dedicated focus on caregiver supports as a strategic priority. She stressed the importance of incorporating the voices and experiences of family caregivers into the planning process and welcomed input from stakeholders across Georgia. The Division's intent is to embed caregiver goals into the broader aging services infrastructure, ensuring that supports are responsive, equitable, and sustainable.

3. ARC AAA (Ms. Connie White and Ms. Cara Pellino)

Ms. Connie White, Senior Manager and Assistant Director at ARC, presented an overview of ARC's role in supporting older adults, individuals with disabilities, and family caregivers across its 10-county metro Atlanta region. Their region includes Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Henry, Gwinnett, and Rockdale counties. Representing one of 12 Area Agencies on Aging in Georgia (and one of over 600 nationwide established under the OAA of 1965), ARC forms part of a broad state and federal network that plans for the needs of a rapidly aging population. ARC works in partnership with the Georgia DAS to convene regular interagency meetings with all 12 AAAs and representatives from DCH to align planning, grantmaking, and service delivery statewide.

ARC has a multipronged approach to promoting independence and supporting caregivers which included the Benjamin Rose Institute's "Care Consultation"—an evidence-based telephone counseling program—and TCARE, a technology platform that provides online support groups for caregivers unable to attend in-person sessions. "Powerful Tools for Caregivers," is a volunteer-led educational course teaching self-care and stress management techniques for caregivers. ARC also participates in the Veterans Directed Care Program, which assists veteran families. Through funding from DAS and the OAA, ARC distributes grants to counties and nonprofits to deliver home-delivered and congregate meals, personal care, transportation, wellness programs, and elder legal assistance. ARC also supports regional and county-level respite programs and kinship care programs for grandparents raising grandchildren—both identified as high-growth service areas.

4. GHF (Ms. Whitney Griggs)

Ms. Whitney Griggs, Director of Health Policy at GHF, presented on the critical need to address healthcare access barriers for unpaid family caregivers in Georgia. GHF, a statewide nonprofit focused on affordable healthcare access, launched the Georgia Caregiver Advisory Coalition in 2024 with support from the ACL. This coalition aimed to uplift caregiver voices, connect them with state resources, and inform policy through lived experiences. In its first year, GHF conducted extensive focus groups and listening sessions, revealing a common theme: caregivers consistently fall through the cracks of Georgia's healthcare and coverage systems. Ms. Griggs shared that this work became deeply personal when she herself became a caregiver for her terminally ill father while parenting young children.

Through interviews with caregivers across the state, GHF found that many are forced to reduce their work hours or leave their jobs entirely, often resulting in the loss of employer-sponsored insurance and, in many cases, becoming uninsured altogether. A critical finding from their outreach was that caregiving is not considered a qualifying activity under Georgia's Pathways to Coverage program, a Medicaid waiver that requires beneficiaries to work or volunteer at least 80 hours per month to maintain eligibility. As a result, unpaid full-time caregivers who are otherwise income-eligible are excluded from Medicaid, leaving them uninsured while caring for disabled children, aging parents, or adult dependents. This policy gap is especially troubling given that caregiving responsibilities often make it impossible to meet traditional work requirements, despite the fact that these caregivers are providing services that directly reduce the burden on Georgia's long-term care infrastructure.

Ms. Griggs also noted the growing challenges in the individual insurance market, where some caregivers who lack access to employer or public insurance purchase coverage through Georgia Access, the state's Affordable Care Act marketplace. While some caregivers were satisfied with this coverage, there is growing concern about premium hikes. Georgia's marketplace premiums are projected to increase by 22 percent in 2025, the fourth highest increase in the nation. This rise is due in part to the scheduled expiration of enhanced federal premium tax credits, which will double premium costs for many low-income families. Ms. Griggs noted that caregivers earning just above the poverty line, especially those working part-time, are particularly vulnerable to these changes. Many find themselves choosing between paying for health insurance, food, or utilities. Even those with coverage often feel "functionally uninsured" due to high deductibles, which can exceed \$10,000 before benefits are activated, making it difficult to afford routine care or prescriptions.

5. DBHDD (Commissioner Kevin Tanner)

Commissioner Kevin Tanner presented on DBHDD's role. The agency is both Georgia's mental health and IDD's authority. It operates five state psychiatric hospitals and six field offices with regional directors and assistant commissioners positioned across North and South Georgia to maximize access. He provided a brief history of the program's design being grounded in the 1999 *Olmstead v. L.C. Supreme Court* decision, which requires services for people with disabilities to be delivered in the most integrated, least-restrictive settings—an Americans with Disabilities Act mandate that underpins Georgia's use of Medicaid HCBS waivers rather than institutional care.

Commissioner Tanner distinguished the two waivers administered by DBHDD. The NOW supports people who can live at home (alone or with family) with targeted in-home services. As of May 2025, 455 Georgians were actively receiving NOW. The COMP funds higher-intensity services—often in four-person community group homes. It has 9,789 active recipients. Eligibility centers on an intellectual disability⁴³ or a closely related condition (*e.g.*, autism, cerebral palsy, Down syndrome), with onset before age 18 for intellectual disability or before 22 for related conditions. Beyond diagnosis, applicants must demonstrate substantial functional limitations in areas such as self-care, communication, mobility, decision-making, or the ability to live independently.

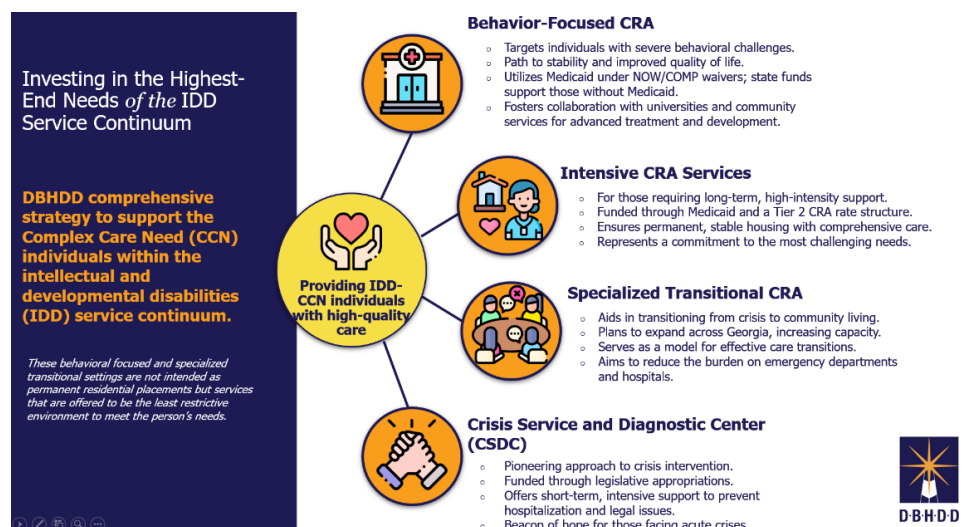
He explained DBHDD's "planning list," which the agency uses to forecast need and budget. Approximately 7,900 people are on the list statewide, including about 3,200 under age 21 (who can be queued for future need even though most children are served through other programs). Importantly, the list is prioritized by acuity rather than first-come, first-served. A person's position can move up rapidly after major life events (*e.g.*, the sudden loss of a primary caregiver). Commissioner Tanner reported that DBHDD is building a new, stakeholder-informed planning tool that will segment the list into "immediate," "intermediate (2–5 years)," and "forecast" need bands, giving appropriators clearer, decision-ready numbers for funding NOW/COMP slots and aiming, over time, to eliminate the backlog.

The Commissioner detailed the scope of services funded through NOW and COMP including (1) clinical supports (behavioral services; adult nursing by LPNs/RNs; nutrition oversight with attention to choking risks and bowel obstruction management; and speech, occupational, and physical therapy), (2) community integration (including supported employment), and (3) daily-life supports delivered either in family homes or in provider-operated community residences. He emphasized person-centered planning via support coordinators (case managers) who tailor plans to each individual's goals.

To reduce ER boarding and better serve people with very high needs, DBHDD launched three new CMS-approved residential models with distinct reimbursement: (1) Behavioral-Focused CRA for severe behavioral presentations; (2) Intensive CRA for long-term, high-intensity support needs in non-institutional homes; and (3) Specialized Transitional placements that step people down from crisis beds back into community living. (*See chart on the right*).

He noted the new Crisis Service and Diagnostic Center in Monroe. It is a 36,000-square-foot, 16-bed inpatient facility combining inpatient operations (by River Edge) with comprehensive outpatient clinics run by Mercer's medical/dental schools and partnerships with Augusta University's dental residency. The first admission was discharged to a transitional home on September 25th. Seven admissions were expected by week's end with a methodical ramp-up to the full 16-bed census over the next few months.

Commissioner Tanner closed by urging legislators to connect with DBHDD's six regional offices and to treat the department as a navigation hub even



⁴³ An individual with an intellectual disability is one that has an IQ of 70 or below (with flexibility up to 70–75, if adaptive-functioning deficits are significant).

when services fall outside NOW/COMP (e.g., the Early and Periodic Screening, Diagnostic, and Treatment program for children administered by DCH).

6. GDVS (Mr. Edwin Berry and Ms. Belinda Boldoe)

Mr. Edwin Berry presented on GDVS' two primary functions: (1) benefits and (2) healthcare. He explained that caregiver supports only flow when requirements on both are met. GDVS supports all veterans statewide—often by obtaining VA Form 21-22 to gain real-time file access, submit claims, and manage appeals when PCAFC applications are denied. At the federal level (administered in Georgia), the General Caregiver Support Program is the less stringent track, while the PCAFC has tighter thresholds. There are two baseline conditions for any caregiver services, the veteran must: (1) be enrolled in VA healthcare and (2) have a documented need for help with ADLs such as transferring from bed, bathing, feeding, medication management, and supervision for safety.

Mr. Berry provided an overview of the PCAFC's key quantitative thresholds. Historically, veterans generally needed to hold at least a 70 percent service-connected disability rating on the VA Benefits side before healthcare can evaluate them for PCAFC. In addition, the veteran must require in-person personal care services for a minimum of six continuous months based on functional limitations (e.g., inability to perform ADLs) or safety risks warranting instruction and supervision. Mr. Berry stressed that a 70 percent rating alone is not sufficient. It is a screening threshold that triggers deeper functional assessments and caregiver evaluations. He also noted that eligibility can be denied at any step in the pathway, reflecting a multi-gate review process.

Process detail was a major focus, and Mr. Berry described a 10-step PCAFC application pathway.⁴⁴ He noted a recurrent failure point in the initial assessment call: veterans' pride can lead them to understate limitations to a VA clinician they do not know, which prevents advancement to subsequent steps and forces restarts. He also explained that the VA issues approval/denial notices on the healthcare side with privacy/HIPAA constraints. As a result, denial letters often cite broad criteria rather than specific, itemized reasons. Mr. Berry recommended more explicit, first-page denial rationales (e.g., listing precisely which criteria were not met), mirroring the clearer format used by the VA Benefits side.

SFC Program

During the committee's study of family caregiving, the committee had an in-depth study of Georgia's SFC program. This subsection provides the information learned from various SFC providers working in Georgia.

7. Primecare Homecare Services (Mr. Faris Flournoy)

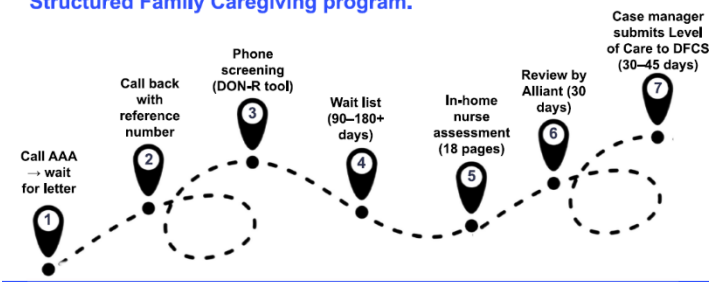
Mr. Ferris Flournoy, CEO of Primecare Homecare Services, presented on the importance and implementation of Georgia's SFC program. He shared the story of his own grandmother's Alzheimer's diagnosis and his family's journey in caring for her without formal resources, illustrating how common it is for Georgia families to assume caregiving roles without access to state-supported services. He noted that the US is currently experiencing a "silver tsunami," with 9,000 to 10,000 Baby Boomers turning 65 each day, resulting in mounting pressure on families and the healthcare systems. He noted that Georgia ranks low nationally in access to care, particularly in rural areas, which face critical shortages of healthcare professionals and infrastructure.

Mr. Flournoy described the financial and emotional burdens placed on family caregivers, using an example of Ms. Claire and her daughter Myra. He illustrated how family caregivers face emotional isolation, role strain, low confidence in clinical tasks, and financial instability. These are compounded by structural confusion between Medicare and Medicaid, leading many to wrongly believe Medicare covers long-term home care. Mr. Flournoy clarified that access to SFC in Georgia is restricted to individuals who: (1) are Medicaid recipients, (2) are 65 plus or disabled, (3) meet nursing home level of care via the DAWN-R tool, and (4) are enrolled in waiver programs like SOURCE or CCSP. This restrictive eligibility pipeline, while medically appropriate, is accompanied by severe delays and procedural obstacles.

⁴⁴ The process is as follows: application submission → application intake → veteran assessment → veteran functional assessment → caregiver assessment → initial application review → caregiver training → home-care assessment → final application review → notification.

THE JOURNEY ALONE: THE REALITY TODAY

Families in Georgia are waiting 6+ months just to enroll in Structured Family Caregiving program.



nurse visits, paperwork processing, and final authorization, often while caregiving unassisted and without compensation.

8. Careforth (Dr. Carla Pennington and Mr. Mike Adams)

Careforth opened its presentation by emphasizing that family caregivers form the backbone of Georgia’s long-term care system. Mr. Mike Adams, Director of Government Relations for Careforth, explained that SFC is designed to recognize and strengthen the role family caregiver play. Careforth has refined the SFC model for more than 25 years and now operates in 10 states, supporting over 10,000 Medicaid members and 15,000 family caregivers. Careforth’s clinical model has held National Committee on Quality Assurance accreditation for more than a decade. Mr. Adams noted this as evidence of standardized high-quality care delivery.

In Georgia, Careforth currently supports families across 117 of the state’s 159 counties. It extends its services into both rural and urban areas. The average Georgia SFC member is 69 years old and nearly one in four lives with Alzheimer’s disease or another dementia, which is more than twice the statewide prevalence. Dr. Pennington explained that this underscores the program’s role in serving individuals with high-acuity needs. She highlighted that participating SFC members across Careforth’s 10-state footprint experience significantly improved health outcomes when compared to similar populations. Specifically, SFC participants have 28 percent fewer injurious falls and 21 percent fewer ER visits. They also remain safely at home for more than three additional years. This generates an estimated \$60,000 per person per year in Medicaid savings due to delayed institutionalization and reduced reliance on paid personal care services. Careforth paired these clinical outcomes with caregiver-reported data: 98 percent of family caregivers state that Careforth helped them meet their care goals; and 95 percent report reduced caregiver burden due to coaching and support.

Mr. Adams provided a comparative review of Georgia’s SFC policies against those of North Carolina, Louisiana, and Ohio. (See chart below). He explained that Georgia’s access criteria are significantly more restrictive compared to other

Comparison of Select State Policies

Category	Georgia	North Carolina	Louisiana	Ohio
Member Eligibility for SFC	Member must meet Waiver eligibility criteria - financial and clinical – nursing facility level of care + must need 5 hours personal care/day Cost share	Member must Waiver eligibility criteria - financial and clinical – nursing facility level of care No cost share	Member must Waiver eligibility criteria - financial and clinical – nursing facility level of care No cost share	Member must Waiver eligibility criteria - financial and clinical – nursing facility level of care Limited cost share
Caregiver Qualifications for SFC	Must be related by blood or adoption or identified as an in-law Restrictions on caregivers working inside or outside the home, or also caring for minors (limitation in rule)	May be friends and family, including spouse If caregiver can meet member’s needs and work, working is permitted (individualized assessment)	May be friends and family, including spouse If caregiver can meet member’s needs and work, working is permitted (individualized assessment)	May be friends and family, including spouse If caregiver can meet member’s needs and work, working is permitted (individualized assessment)
Additional Safeguards for Service Integrity	Background Checks, including Fingerprinting Higher number of disqualification rules	Background Checks	Background Checks	Background Checks Include fingerprinting and tiered exclusions based on offenses and years since conviction

compliance. Instead, they have expanded the pool of eligible caregivers.

Chairman Jones asked how families typically learn about Careforth’s SFC services, noting that a previous state presenter had described using advertising to raise public awareness. In response, Dr. Pennington explained that families are primarily connected to the program through Georgia’s waiver case management agencies. The agencies inform individuals about all services for which they are eligible and direct them to appropriate providers. She emphasized that these case management entities serve as the central referral pathway rather than public advertising.

Chairman Jones then asked whether all providers must meet the same qualifications. Dr. Pennington confirmed that all participating providers follow uniform qualification standards to ensure consistency across the system.

9. FreedomCare (Mr. Andrew Luu)

Mr. Andrew Luu of FreedomCare presented a data-driven overview of how SFC functions as a Medicaid-funded HCBS that compensates and trains family members to care for loved ones who would otherwise need institutional care. He explained that the SFC model rests on three pillars: (1) financial support; (2) clinical coaching; and (3) emotional well-being. He emphasized that SFC offers predictable, capped costs per day, unlike fluctuating hourly home-care models, which makes SFC a scalable and sustainable long-term budget strategy for states with rapidly aging populations.

Comparison of Georgia Medicaid Long-Term Care Options

Feature	SFC	CCSP	Source	Nursing Home
Setting	Home-based	Home/community	Home/community + PCP	Institutional
Caregiver	Family (non-spouse)	Professional/self-directed	Professional + PCP	Facility staff
Payment	Yes - stipend	Yes - if self-directed	Yes - if self-directed	No
Oversight	Health coach	Case management	Case + PCP	24/7 staff
Flexibility	High	Moderate	Moderate	Low
Cost to State	Low	Low	Low	High
Waitlist	Yes	Yes	Yes	No
Eligibility	Medicaid + CCSP/ SOURCE	Medicaid	Medicaid + medical need	Medicaid + NF level

Turning to cost savings, Mr. Luu compared the annual Medicaid expenditures for three care settings: (1) nursing homes; (2) traditional home health aide care; and (3) SFC. (See chart on the left). Nursing home care costs approximately \$7,000 per month. Traditional home health aide care costs about \$4,000 per month. SFC costs roughly \$2,000 per month. He noted that states save an average of \$61,000 per participant per year when individuals receive SFC instead of entering

institutional care. Because the typical SFC duration is three years, the cumulative Medicaid savings average \$190,000 per enrollee. Mr. Luu also described population-level projections using Georgia as the example: if just 10 percent of Georgia’s 40,000 nursing-home residents (three-quarters of whom are Medicaid-funded) shifted to SFC—the projected annual state savings is between \$200–\$260 million. Using home-care users as another example, the transitioning of 10 percent of traditional attendant-care members to SFC could generate \$48–\$96 million annually (based on a per-member savings of \$24,000).

Mr. Luu then presented demographic data that illustrated why SFC is particularly important for Georgia. He noted that counties such as Quitman, Towns, and Union already have populations where 40 percent of residents are age 60 or older. He explained that these demographic pressures increasingly strain the HCBS system. The strain is evidenced with waitlists, provider shortages, and severe direct-care workforce gaps in rural areas. He stated that the rising age-60 plus and age-65 plus population curves (with the steepest growth occurring in non-metro counties) reinforces the need for scalable family-centered models like SFC. Mr. Luu stated that families are already filling these gaps informally often without pay or training. SFC formalizes the care they are already providing through stipends, coaching, respite, and evidence-based support.

Finally, Mr. Luu highlighted outcome improvements using clinical data trends which showed that SFC participants experience 45 percent fewer falls and 21 percent fewer ER visits compared to similar populations in traditional care settings. He also discussed FreedomCare’s innovative use of mobile apps to track early indicators of health decline (such as urine odor and frequency) to help prevent hospitalizations from conditions (like UTIs—which are a leading cause of ER visits among older women). Mr. Luu concluded by noting SFC’s benefits such better outcomes, lower costs, and stronger families.

Chairman Jones asked how FreedomCare determined that falls decrease under SFC. Mr. Luu explained that they compare SFC participants to individuals served through traditional agency-model home care using standardized tools including the CMS STEADI fall-risk assessment. They also track all critical incidents through their mobile app. This data consistently shows fewer falls among SFC recipients. When asked why SFC produces better outcomes, he noted that SFC offers greater flexibility to build enhanced and customized assessments beyond minimum state requirements. Unlike traditional models that rely on rigid duty codes. He added that some states, such as Massachusetts, mandate biannual fall-risk assessments. In states without such rules, SFC providers can innovate additional assessments which collectively contribute to lower fall rates among SFC participants.

PROGRAMS AND SERVICES OFFERED IN OTHER STATES

The fourth theme studied the programs and services offered in other states. The purpose of this theme was to analyze other states' family caregiving landscapes to search for possible solutions to address the issues facing Georgia's caregivers. The committee studied programs and services that are not available in Georgia and those that are but are different from Georgia's—to determine if modifying current programs or instilling new programs could improve family caregiver services here in Georgia.

1. NCSL (Ms. Kathryn Costanza, Mr. Joe Livingston, and Ms. Glenn Jacoby)

The presentation, delivered by Ms. Katherine Costanza, Mr. Joe Livingston, and Ms. Glenn Jacoby from NCSL, opened with an overview of the scale and characteristics of unpaid caregiving in the United States. According to Ms. Costanza, one in five Americans provides unpaid care, and half of all caregivers for older adults are caring for someone with Alzheimer's disease or another dementia. She noted that one in four unpaid caregivers report negative physical, emotional, or financial effects. This baseline data framed why states are increasingly developing paid caregiving programs, tax credits, and other supports.

In reviewing Medicaid-based paid family caregiving, Ms. Costanza described a three-part framework used by states: (1) program authority, (2) benefit definition, and (3) provider eligibility rules. The major Medicaid authorities—state plan options versus §1915(c) HCBS waivers—showing that waivers allow targeting of specific populations (*e.g.*, older adults, individuals with I/DD medically complex children), while state plan options apply statewide. She noted that Community First Choice carries a six percent enhanced federal match. The range of benefits states may reimburse include personal care services, consumer-directed services, and SFC. Ms. Costanza noted that:

- 10 states, including Georgia, have adopted a SFC model;
- 22 states use a Medicaid state plan option to reimburse legally responsible individuals and other relatives;
- 49 states and Washington, D.C., reimburse family caregivers through waivers; and
- 46 states plus Washington, D.C., allow consumer direction enabling beneficiaries to hire legally responsible relatives.

Ms. Costanza also noted that the vast majority of states permit paid caregiving for individuals with I/DD, physical disabilities, or older adults. State examples of recent statutory changes included North Dakota's 2023 pilot program, later amended in 2025 to prevent duplicative payments across Medicaid benefits, and New Mexico's new three-year kinship caregiver pilot, visualized in timeline graphics showing the year of enactment and program duration.

The presentation then shifted to family support programs outside direct Medicaid reimbursement. Ms. Costanza's outlined categories of supports—such as respite, adult day services, home modifications, assistive technology, caregiver counseling, training, and health-insurance access adjustments. Several state-specific examples were highlighted:

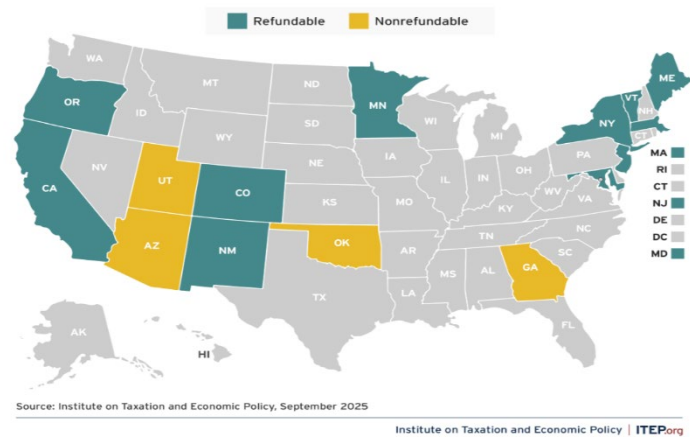
- Arizona's 2020 program offered 50 percent reimbursement (up to \$1,000) for home modifications and assistive technology, funded by a one-time \$1.5 million appropriation before sunseting in 2024;
- Maryland's program reimburses caregivers for 30 percent of qualified expenses above \$2,000, with an annual \$5 million state appropriation;
- Pennsylvania permits reimbursement of up to \$600 per month and \$5,000 lifetime for home modifications and assistive devices; and
- Tennessee's Katie Beckett Part B program offers up to \$10,000 annually for respite, modifications, assistive technology, and training to families of children at risk of institutionalization.

Mr. Joe Livingston then presented on state and federal tax credits affecting families with caregiving responsibilities. He explained that 20 states currently offer child tax credits, with benefit values ranging from \$100 per child in Arizona to \$1,750 in Minnesota. (*See chart below*). The income phase-out structures for these credits vary with thresholds starting as low as \$29,000 in Minnesota and extending to \$400,000 in Maine which demonstrate the broad variation in policy targeting. Mr. Livingston further detailed child and dependent care credits, available in 26 states plus Washington D.C. He provided comparative examples such as New York's refundable credit up to 110 percent of the federal credit, Alabama's 50 percent child-care cost credit, and Colorado's 50 percent match to the federal credit. He also noted Nebraska's 2023 Caregiver Tax Credit, offering a non-refundable 50 percent credit, capped at \$2,000—

\$3,000, for caregiving expenses—particularly higher for veterans and dementia care—within a \$1.5 million annual program cap.

Mr. Livingston also reviewed new federal tax changes under House Resolution 1. Key changes include increasing the Child Tax Credit to \$2,200 and indexing it to inflation, expanding the Child and Dependent Care Tax Credit to up to 50 percent for low-income families, and increasing the Dependent Care FSA limit from \$5,000 to \$7,500. He also explained how these federal provisions interact with state-level credits, particularly in states conforming to federal AGI, where tax-advantaged FSA dollars also reduce state tax liability.

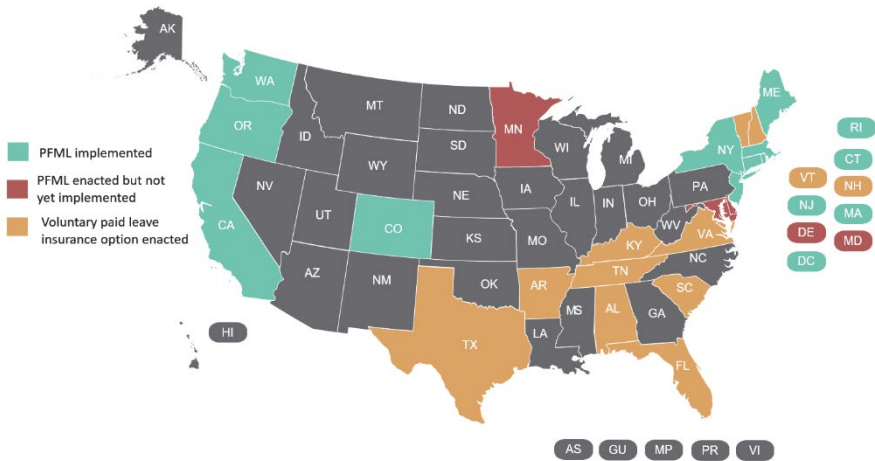
State Child Tax Credits in 2026



The final portion of the presentation, led by Ms. Glenn Jacoby, focused on PFML policies. Ms. Jacoby began by contrasting federal FMLA requirements with state PFML programs. She noted that 44 percent of US workers lack access even to unpaid FMLA leave, primarily due to the federal threshold requiring employers to have 50 or more employees. In contrast, 13 states and Washington, D.C. now operate publicly funded PFML programs, typically providing approximately 12 weeks of paid leave for personal medical conditions, bonding with a new child, and caring for a family member, with many states adopting broader family definitions than FMLA.

Ms. Jacoby concluded by outlining the rapidly growing trend of voluntary paid family leave insurance (including several states neighboring Georgia) were noted as adopters of voluntary models (*i.e.*, SC, AL, FL, TN, KY, VA, AR, and TX). (See chart below). These programs, introduced first in New Hampshire and Vermont, modify state insurance codes so private insurers may offer paid leave products directly to employers. She compared mandatory PFML programs with voluntary private models, noting differences in coverage, financing mechanisms, and employer participation. Ms. Jacoby emphasized that these programs remain new and evolving, and she encouraged legislators to consult NCSL for state-specific implementation data and comparative analyses.

The State of Paid Leave



Chairman Jones asked whether caregiving policy—particularly tax credits and related supports—was still an area where states were actively trying to determine the best approach. He wanted to understand whether policymaking around caregiving services remained a fluid landscape in which states were experimenting with different tools and adjustments.

Mr. Livingston responded that states make continual changes to caregiving-related tax policies, adjusting income thresholds, credit amounts, and refundability structures. The recent passage of House Resolution 1 also requires states to reevaluate how federal benefits interact with state-level supports. He emphasized that many states are grappling with how to better target lower-income families through refundable or hybrid tax-credit models. Ms. Costanza added that the COVID-19 pandemic highlighted significant unmet needs in long-term services and supports and that states are facing increasing strain on the direct-care workforce. These pressures prompted many states to examine family caregiving more deliberately, often through study committees, task forces, or advisory groups designed to evaluate how family caregiving fits within broader health and social policy frameworks.

2. Minnesota DHS’ CFSS Program (Ms. Erin Huldeen and Ms. Jeanine Wilson)

The Minnesota DHS presenters, Ms. Erin Huldeen and Ms. Janine Wilson from the Disability Services Division, described the state's new CFSS program. CFSS is a self-directed Medicaid service for people with disabilities and complex needs. CFSS is designed to help individuals remain in their homes and communities while giving them more choice and control over how services are delivered. Minnesota launched CFSS on October 1, 2024, and is using it to replace its traditional PCA program and Community Support Grant. The transition period spans from October 1, 2024, through September 30, 2026, indicating that Minnesota expects it will take about two full years to transition all eligible participants to CFSS. The program is built using multiple federal authorities—1915(k), 1915(i), 1115, 1915(c), and 1915(b)—which were all activated together to support the shift.

Ms. Huldeen traced CFSS back to a bipartisan reform enacted by the 2011 Minnesota Legislature, which sought to reform long-term services and supports for seniors, people with disabilities, and others with complex needs. The legislative goals for this program include: achieving better health outcomes; increasing independence and community integration; reducing reliance on institutional care; and ensuring quality, consistency, and long-term fiscal sustainability in the Minnesota Medicaid system. She emphasized that, at that time, the cost trajectory of long-term services and supports in Minnesota were “unsustainable” without structural change. CFSS is explicitly designed to keep as many people as possible in their own homes, avoid one-size-fits-all benefits, and reduce the need for more expensive facility-based care.

Ms. Huldeen noted several advantages of CFSS over the previous PCA model, focusing on expansion of who can be paid workers and the flexibility of services. Under CFSS, more eligible workers are allowed. Specifically, parents of minors can be paid to provide care, spouses can be workers, and individuals receiving CFSS themselves can also serve as workers for another CFSS participant. New covered services that can be purchased with CFSS funds include: paid worker training, PERS, and goods and services that are tied to the person's assessed needs and that substitute for personal care (for example, assistive equipment that reduces hands-on care needs). Another key program feature is flexibility in using the authorized units or dollars—that is, participants can allocate them across the month or across the year depending on fluctuations in their needs rather than being locked into a rigid schedule.

She then detailed Minnesota's service infrastructure supporting CFSS, showing four main groups—(1) lead agencies (county agencies, managed care organizations, and tribal nations) oversee and coordinate service delivery; (2) consultation service providers, a new Minnesota-specific provider type, who educate participants about CFSS, helps them develop their service delivery plan, and provides ongoing support throughout the plan year (this consultation step must occur before an individual can move into the direct personal care portion of CFSS); (3) FMS providers assist people using the budget model with employing workers and making payments for approved goods and services; and (4) CFSS provider agencies (which transitioned from PCA provider status) hire, train, and supervise workers for those using the agency model. In CFSS, an individual can choose between two service models: (1) the agency model (units authorized in 15-minute increments, with an agency employing all workers); and (2) the budget model (authorized units converted into a dollar budget that can be used for workers, goods, services, and PERS). Participants can choose either model at assessment and may switch between models during the year.

Minnesota kept the eligibility criteria largely the same as the prior PCA benefit. To qualify for CFSS, a person must be: enrolled in one of Minnesota's health care programs; not live in a hospital, nursing facility, or intermediate care facility; and not live-in housing owned or controlled by the provider agency delivering services. The individual must be able to direct their own care and must undergo a CFSS assessment. Minnesota uses a statewide, universal assessment tool called Min Choices, which incorporates age-based developmental milestones and functional needs to determine both eligibility and the number of units a person qualifies for. She noted that Min Choices is a key Minnesota-specific feature that allows consistent assessment across age groups and disability types.

Ms. Huldeen then moved to current transition data. As of September 30, 2024, Minnesota identified about 56,000 people who need to move from PCA to CFSS. Of these, there is limited data for roughly 12,000 individuals who receive services through managed care organizations, so DHS is still working to refine those counts. She noted that about 9,000–10,000 people have fully transitioned to CFSS; about 25,000 people are “in process”, meaning they have authorizations and are working toward CFSS but are still using PCA; and approximately 11,000 people who had not yet made any progress toward transition. Ms. Wilson clarified that many in the “in process” group are currently working with consultation service providers to build plans before they can be fully enrolled in CFSS.

She also summarized projected enrollment and costs. For 2024, DHS estimates an annual caseload of roughly 50,000 individuals receiving services, with an average monthly caseload of about 49,000. By fiscal year 2029, Minnesota

projects that monthly caseload will modestly decline to about 47,000. However, total spending is expected to increase significantly: in 2024, CFSS-related spending is estimated at \$1.4 billion, and by 2029 it is projected to reach around \$2.4 billion. The average monthly cost per person is approximately \$2,986 (just under \$3,000), and Minnesota currently has about 900 provider agencies delivering these services and around 60,000 workers (PCAs) providing in-home support statewide.

Ms. Huldeen identified capacity constraints as the primary challenge in Minnesota's transition to CFSS. There are 17 consultation service provider agencies currently enrolled to serve the entire population of approximately 56,000 people needing to transition. Ms. Wilson noted that some of these 17 agencies are small BIPOC-owned providers with only one or two staff members, meaning actual worker capacity is far lower than the agency count suggests. At the same time, all 900 PCA agencies had to re-enroll as CFSS provider agencies, a process that took several months and slowed implementation. DHS has limited staff capacity and has taken on tasks typically done by lead agencies (counties, MCOs, and tribes), such as educating providers and completing actions for state plan (non-waiver) recipients. To address these issues, Minnesota issued RFPs for additional consultation service providers and received 130 applications, which Ms. Huldeen noted demonstrates evidence of strong interest in expanding capacity.

Finally, the presenters described Minnesota's implementation and feedback infrastructure and shared lessons learned. DHS holds monthly meetings with sponsors and partners to hear what is happening in the field. DHS also offers monthly "office hours" separately for each provider group (consultation providers, lead agencies, CFSS provider agencies, and FMS providers), and convenes a quarterly Implementation Council that includes managed care organizations, consultation providers, FMS, CFSS provider agencies, tribal nations, case managers, and—most importantly—a majority of people receiving services and their family members. DHS provides virtual information sessions to beneficiaries and deployed a navigation team that calls or emails every eligible person to explain the transition from PCA to CFSS. Originally, Minnesota aimed to complete the transition by September 30, 2025, but due to the scale—nearly 60,000 people—and multiple bottlenecks in consultation and provider enrollment, DHS extended the deadline to September 30, 2026. In closing, Ms. Wilson stressed that attempting to move an entire statewide population under multiple authorities (1915(k), 1915(i), 1115, 1915(c), 1915(b)) all at once was "monstrous" and difficult to manage. In retrospect, Minnesota would recommend phasing transitions by population or authority, rather than converting all authorities and all beneficiaries at the same time, especially when the goal is to ensure no one loses services during the transition.

Chairman Jones asked about the qualifications required to become a consultation service provider. Ms. Wilson explained that the requirements are intentionally rigorous and typically include a bachelor's degree or a licensed professional background such as nursing, physician assistant work, or related experience serving older adults or people with disabilities. She noted that the qualifications mirror those expected of assessors and case managers in county agencies, managed care organizations, and tribal nations. Agencies must also meet organizational standards related to insurance and financial stability, making the approval process extensive. She also noted that despite the high bar, interest has been strong: in the most recent application round, approximately 130 organizations submitted proposals to become consultation service providers, and the department hopes to bring additional providers online soon.

3. Washington DSHS' MAC and TSOA (Ms. Aime Fink, Ms. Dana Allard-Webb, and Ms. Mandy Weeks-Greene)

The Washington DSHS began its presentation by outlining the demographic pressures shaping its long-term services and supports system. Ms. Aime Fink, Office Chief of the State Unit on Aging with DSHS, explained that adults over age 60 now account for approximately 23 percent of Washington residents, while adults age 65 and older make up just under 18 percent. She further explained that population group age 85 and older will dramatically increase over the next 30 years, indicating rapid growth in the oldest-old population. She emphasized that although many older adults remain healthy and active, the 85 plus cohort typically has far higher rates of chronic illness, dementia, and mobility needs, which creates disproportionate demand for long-term services and supports. Washington's demographic trajectory over the past two decades, she noted, has driven the need for new policies and innovative caregiving programs.

Ms. Dana Allard-Webb, the Family and Caregiver Support Program manager with DSHS, discussed updated AARP statistics, which showed a substantial increase in the number of unpaid family caregivers in Washington State. According to the most recent AARP analysis, Washington's population of unpaid caregivers rose from 820,000 during the previous reporting period to 1,330,000, representing a significant surge in the number of residents providing

informal care. She highlighted this as further evidence of the accelerating need for state-level supports, explaining that Washington's aging population is directly tied to the rising number of unpaid caregivers.

To explain how Washington's programs evolved in response to these trends, Ms. Fink walked the committee through a detailed timeline summarizing more than 30 years of legislative action. Between 1989 and 2000, the state legislature first prioritized unpaid family caregivers, identifying them as essential to sustaining the LTSS system. During that period, the state offered only one primary service—respite care. By 2000–2001, Washington expanded service options and then adopted the federal OAA Title III-E, which funded a broader benefit package for caregivers. The timeline illustrated Washington's increasing commitment to structured caregiver support as demographic pressures intensified.

A major turning point came in 2007–2008, which marked a shift in state policy. The legislature determined that Washington needed an evidence-based caregiver assessment tool to produce actionable insights and measurable data about caregiver strain. This decision led to the adoption of TCARE, an evidence-based assessment model designed to identify caregiver burden and tailor supports accordingly. The statewide rollout occurred in 2009. This expansion coincided with new legislative funding. Ms. Fink stated that increased investment allowed the state to reach more caregivers with a “modest but meaningful” package of supports.

After several years of TCARE implementation, Washington conducted a statewide data analysis to determine whether evidence-based interventions were producing measurable outcomes. The analysis demonstrated both cost savings and delayed entry into higher-cost long-term care services such as Medicaid LTSS and nursing facility care. These findings convinced the legislature to allocate additional funding for caregiver programs. Ms. Fink emphasized that this empirical validation set the stage for the state's next major innovation: the creation of two new Medicaid-funded caregiver programs.

In 2017, Washington launched its 1115 Medicaid demonstration. It created two new programs: MAC and TSOA. Ms. Fink described how this shift enabled the state to use Medicaid dollars in new ways to support both unpaid caregivers and care receivers, particularly those aged 55 and older. She noted that this was the first-time state workers could enter a home and say, “We can help both of you,” because both the caregiver and care recipient could now qualify for services under MAC or TSOA. The programs were designed to delay or divert entry into costly residential or intensive Medicaid LTSS services.

Ms. Allard-Webb described how Washington uses the TCARE model to target resources. She described a three-step service and funding structure built around TCARE screening and assessment. Step one provides limited one-time assistance. Step two offers up to \$500 per year tied to semiannual screening. Step three provides the full suite of supports based on an annual assessment and evidence-based recommendations. She noted that Washington's TCARE algorithm yields quantifiable data—such as caregiver stress scores and burden indicators—that directly influence service planning. It allows the state to focus resources where evidence indicates they have the greatest impact.

Ms. Fink concluded by describing a study that Washington participated in to understand the differences in outcomes. The study implementation analyzed Washington's outcome data before and after the evidence-based model. The study found that its evidence-based model produces measurable improvements for caregivers. Drawing on the data analysis, the study found that 84 percent of caregivers show improved outcomes within six months of receiving TCARE-guided services including reductions in stress, burden, and depressive symptoms. The study noted a statistically significant reduction in “intention to place” among spousal caregivers—meaning fewer spouses felt compelled to consider nursing facility placement. Many caregivers reported that the TCARE screening and consultation was the first time anyone had asked, “How are you doing?” Ms. Fink emphasized that these insights highlight how direct caregiver supports improve quality of life for both caregivers and care recipients while simultaneously reducing long-term care costs for the state.

Senator Wicks asked how Washington State is addressing the caregiver shortages to ensure adequate access in both rural and urban areas. Ms. Fink explained that Washington, historically, relied solely on home care agencies to provide respite and related services. She further explained that this created long waitlists and limited capacity—especially in rural regions. To expand the available workforce, the state recently introduced individual providers which allow care recipients to hire family members or friends as paid caregivers. This shift has significantly strengthened Washington's MAC and TSOA programs by reducing wait times and increasing flexibility. She noted that workforce shortages continue to persist but that programs have made progress. She emphasized that the individual provider model has

not yet been incorporated into the traditional Family Caregiver Support Program. Washington also operates a training unit that works to attract and prepare direct care workers. It promotes career ladders (from entry-level positions to CNA, LPN, and RN roles) and partners with high schools to provide early training so students can begin caregiving work at age 18. According to the most recent AARP analysis, Washington offers the highest direct care worker wages in the nation. Ms. Allard-Webb explained that even with the higher wages, shortages remain which indicates that wages alone cannot solve the problem.

When asked about typical respite schedules, Ms. Fink explained that household and personal support services (such as cooking and shopping) are usually provided once weekly for five to seven hours. However, some caregivers opt for two shorter visits which Ms. Fink noted are harder to staff.

In response to a question about how Washington measures improvement in caregiver burden, Ms. Allard-Webb stated that the state uses standardized TCARE assessment data to compare the initial screening results with six- and twelve-month follow-up scores to measure changes in stress, burden, and other indicators of caregiver well-being.

Paid Family and Medical Leave Programs

During the committee's study of family caregiving, the committee conducted an in-depth analysis of other states' paid family and medical leave programs. This subsection provides the information learned from various governmental and non-governmental entities who provided information on these programs.

4. A Better Balance (Ms. Feroza Freeland)

Ms. Feroza Freeland, Policy Director for the Southern Office at A Better Balance, explained that the universal and predictable need for paid family and medical leave across the lifespan. She stated that every worker will eventually experience a major medical or caregiving event requiring extended time away from work. Examples include: caring for an aging parent or spouse with cancer, recovering from a serious illness, or welcoming a new child. Ms. Freeland noted that the US remains one of the only countries without a national paid leave program.

Ms. Freeland provided Georgia-specific workforce data showing that over 70 percent of workers in Georgia lack access to paid family leave. She explained that approximately 11 percent of lower-income workers have any form of paid leave coverage through an employer. She also noted that the federal Family and Medical Leave Act is inadequate because over 40 percent of US workers are not eligible for FMLA protections. She emphasized that unpaid leave is typically not financially feasible, even for those eligible for FMLA protection.

To illustrate the growing national momentum for state action, Ms. Freeland stated that 13 states and the District of Columbia have enacted comprehensive paid family and medical leave programs. These programs cover nearly all workers in those jurisdictions. She also noted that there has been a rapid expansion of interest in the South for these programs. She noted that Virginia became the first Southern state to pass a statewide paid family and medical leave law (although the governor later vetoed it). She explained that the policy activity demonstrates clear and increasing momentum.

Ms. Freeland explained how states paid leave programs function. These programs use payroll contribution models which are typically shared between employers and employees. These contributions fund both program benefits and administrative costs. This practically renders these programs self-sustaining following implementation. She noted that pooled contributions reduce burdens on businesses (particularly, small businesses that lack the infrastructure to manage private paid-leave benefits). Some states, she noted, allow the smallest employers to participate at no cost by exempting them from paying the employer portion of payroll contributions.

The following are key structural elements of paid leave policies: covered reasons for leave, benefit duration, wage replacement, and job protection. Under these programs, qualifying events include: parental leave; care for a seriously ill family member; one's own medical condition; military deployment needs; and (increasingly) safe leave for survivors of domestic violence. She emphasized that strong job and health insurance protections are essential to ensuring that workers can return to their jobs and cannot be fired for taking leave.

The Bipartisan Policy Center survey data provides that over 70 percent of adults who have left the labor force cite personal health or caregiving responsibilities as the primary reason. Additional existing state programs show improved retention, higher productivity, and reduced turnover costs for employers. A cost-savings model compared the expense of replacing an employee to the cost of providing 12 weeks of paid leave. It showed that turnover costs far

exceed paid-leave benefit costs. Ms. Freeland closed by highlighting that Georgia has already taken an important first step by enacting paid parental leave for public employees.

5. Colorado's Paid FAMLI Program (Ms. Tracy Marshall and Mr. David Gallivan)

Mr. David Gallivan, the branch manager for policy and appeals for Colorado's Paid Family and Medical Leave Insurance (FAMLI) program, began by outlining the history of the FAMLI program. He noted that Colorado is the only state in the nation to enact FAMLI through a ballot measure, rather than legislation. He provided key milestones—beginning with 2019, when a legislative task force produced recommendations that were not adopted by the legislature. Proposition 118 passed with 57 percent voter support which enacted this program. The program formally launched in 2021. Premium collections began in January 2023. Benefit payments started on January 1, 2024. He noted that by the end of quarter two, Colorado had surpassed 175,000 claims. It had also paid out over \$1 billion in benefits which signaled a rapid uptake and integration into workers' lives.

Mr. Gallivan explained that this program's worker eligibility is intentionally broad. FAMLI applies to all public and private employees including nonprofits, religious organizations, seasonal and temporary workers, part-time workers, domestic workers, and visa-holding employees. Only two categories of workers are excluded: (1) federal employees and (2) railroad workers. Additionally, self-employed Coloradans may elect coverage which enables sole proprietors and gig workers to buy into this state-run safety net which traditionally has not been available to them.

Colorado's five major leave categories are: parental bonding, medical leave, family caregiving leave, military exigency leave, and safe leave for survivors of domestic violence or sexual assault. He announced that Colorado will become the first state in the nation (January 2026) to offer a separate neonatal intensive care leave benefit. He explained that evidence shows that parental presence in the NICU dramatically increases positive health outcomes which justified the creation of this new benefit category. The program is designed not only for economic stability but also for improving medical outcomes for parents and infants.

Colorado workers may receive up to 12 weeks of FAMLI per year with an additional four weeks for birthing parents experiencing pregnancy complications. Once neonatal leave launches in 2026, parents with infant hospitalization needs may receive another 12 weeks. He explained that low-income workers receive up to 90 percent of their usual wages. However, replacement percentages decrease as income increases. Colorado's FAMLI includes job protection which guarantees workers the right to return to their position or an equivalent role which is an essential component for lower-income workers who may otherwise face job loss.

Ms. Tracy Marshall, division director for this program, then shifted the discussion to program usage. She noted that more than 255,000 claims have been filed since benefit payments began. Of those claims, 47 percent were for medical leave; about 33 percent for parental/bonding leave; and 13 percent for family caregiving leave. The remaining 17 percent were for safe leave and military leave combined. Also, 60 percent of claims were filed by women and 40 percent by men which she stated reflects both caregiving patterns and the gendered dynamics of parental leave. She highlighted these figures as strong evidence that the program has quickly become an essential tool for Colorado workers.

Next, she discussed caregiving leave usage across all regions of Colorado including urban, rural, suburban, and mountainous communities. She provided the top 10 zip codes for care leave by claim count which she stated demonstrated the wide socioeconomic reach of this program. She noted that caregiving leave is heavily used by adults in their 40s and 50s (the classic "sandwich generation"); while older workers primarily used leave to care for parents with dementia, Alzheimer's disease, knee replacement recovery, COPD, stroke, or cancer. Younger adults under 50 most often used caregiving leave to care for children with autism or post-surgical recovery such as after tonsil removal.

The economic impact of the FAMLI program is as follows: it has paid over \$1 billion to 187,000 individuals in 18 months. The maximum weekly benefit is approximately \$1,300. The median-benefit indicator showed that most Coloradans receive around \$797 per week while on leave. The Prenatal-to-3 Policy Impact Center recently ranked Colorado number one in the nation for resources supporting young children (naming, paid leave as a central factor). Additional research showed correlations between paid leave and reduced infant mortality, lower food insecurity, increased rates of developmental screenings, lower maternal mental-health distress, and reduced childhood poverty. One study from Denver University showed that paid leave already appears to reduce income-related stress among new parents specially during the perinatal period. Another study from the University of Colorado Health associated

the FAMLI program with reductions in domestic violence. It showed early evidence that financial stability and time away from work contribute to both safety and health.

6. Colorado Chapter of 9to5 (Ms. Kaitlin Alton)

Caitlyn Alton, Associate State Director of 9to5 Colorado, explained that Colorado's FAMLI program is a long and multi-year organizing and policy effort. She noted that Colorado pursued numerous unsuccessful legislative attempts before shifting strategy and securing passage through a statewide ballot measure. To illustrate this, she provided a timeline beginning with early legislative failures, the formation of a 2019 task force, and finally the 2020 ballot victory where the measure passed by a 15-percentage-point margin. She noted that support was geographically broad with "yes" votes documented across urban, suburban, and rural counties. She emphasized that the diversity of the votes showed a clear voter mandate for paid leave.

She detailed the structural pillars of an equitable paid family and medical leave system. The first pillar is "qualifying events" covered under Colorado's program. These events are: parental bonding; care for a seriously ill family member; one's own medical condition; safe leave; and military-related leave. The second pillar is "leave duration and frequency." The program provides 12 weeks of paid leave with additional weeks for complicated pregnancies and soon for parents of NICU infants. The third pillar is "wage replacement." The program's wage-replacement structure shows that low-wage earners can receive up to 90 percent wage replacement. The structure is a sliding scale for higher-income workers. She emphasized that this progressive wage-replacement design ensures low-income workers (who make up the majority of those needing leave) can realistically take time off. The final pillar is "job protection" which provides job security for employees who take time off by making sure the job is available to them upon their return.

Colorado intentionally crafted flexibility into its program. She compared continuous leave (weeks at a time), intermittent leave (episodic, unpredictable needs), and reduced schedule leave (such as part-time work combined with leave). She used examples like caregivers supporting dialysis treatments and workers recovering after surgery to show why flexibility is critical. She noted that Colorado's flexible approach improves accessibility, particularly for caregivers whose needs do not follow predictable schedules. She noted that prior to passage of this program many families faced "adverse outcomes" because available leave was insufficient in duration or completely unavailable through employers.

Next, she emphasized the importance of Colorado's expansive definition of "family." Its definition explicitly lists certain recognized relationships such as parents, spouses, domestic partners, children, siblings, grandparents, grandchildren. The definition also includes "anyone with whom the caregiver has an association equivalent to a family relationship." She explained that this inclusive definition ensures the policy reflects real caregiving networks, especially multigenerational, blended, or nontraditional household networks. She stated that over half of Colorado caregivers report providing care to someone outside a traditional nuclear family structure which underscores the need for an expanded definition.

She then described why Colorado opted for a state-run model. This model collects, pools, and distributes payroll premiums. Payroll contributions are split 50/50 between employers and workers. However, small businesses under 10 employees are exempt from the employer share. The program is self-funded, solvent, and structured so that premiums can be lowered over time if claims remain stable. She also noted that a state-run model keeps administrative costs low compared to private insurance models. It also allows workers to integrate paid leave across multiple jobs or gig work. She noted that this model was strongly supported by small businesses in the statewide coalition because it "leveled the playing field" for offering competitive benefits.

Finally, she concluded by explaining the broad coalition that carried the measure to victory. The coalition had fewer than 20 organizations early in the process but grew to approximately 90 organizations by 2020 including unions, community nonprofits, small business groups, and direct service organizations. She underscored that paid leave addressed longstanding inequities (particularly the disproportionate burden on women, women of color, and low-wage workers) and that these disparities were represented clearly in pre-program data. She ended by echoing the Colorado's data earlier in the hearing: FAMLI has proven to be an effective statewide tool that improves workforce attachment, reduces economic hardship, and meets caregiving needs across the lifespan.

7. Connecticut's Paid Leave Authority (Ms. Erin Choquette)

Ms. Erin Choquette, CEO of the Connecticut Paid Leave Authority, opened by explaining that Connecticut's program is administered through a quasi-public agency. The agency was given hiring and regulatory flexibility necessary to launch the program in under two years. She provided a timeline of this program. In 2019, the state legislature passed

Paid Leave law. Payroll deductions began in January 2021 and benefit payments in January 2022. The program is completely funded through employee payroll deductions. The deduction is 0.5 percent up to the Social Security wage cap. She emphasized that all contributions flow into the state-managed Paid Leave Trust Fund. The fund cannot be used for general state spending pursuant to its enacting statute. The fund must only be used to pay for program administration and benefit payments.

She discussed the fund's solvency which was a central legislative concern. Connecticut's fund balance exceeded \$585 million at the close of FY 2025. Its annual contributions total \$477 million. She explained that a seasonal pattern became visible where Q1 consistently shows the highest revenue—driven by employer bonus payments and high-earning workers reaching the Social Security cap later in the year. Additional data indicated that contribution revenue has risen each year since inception which was driven in part by Connecticut's minimum wage increases and overall economic growth. She noted that independent actuaries validate three solvency metrics annually and that the authority continues to “meet or exceed” all such benchmarks.

The presentation then shifted to coverage and eligibility, their data indicated that over 147,000 registered employers, 3,400 sole proprietors, and approximately 1.5 million workers are covered by the program. Work groups that are automatically included are private-sector workers, non-union state workers, certain school employees. Work groups may opt-in include municipal employees, unionized state workers, sole proprietors, and self-employed residents. She compared this program with private-plan participation which showed that there are 835 employers with approved private plans, of which 93 percent are fully insured. She explained that employers may only implement a private plan if a majority of workers vote in favor.

Eligibility is based on earnings rather than hours. A minimum-wage employee qualifies for benefits by working 11 hours per week in a quarter (earning \$2,325). She noted that there is an upward trend of benefit claims since January 2022 which have now surpassed 182,000 workers served with nearly \$1.4 billion benefits paid. The average leave duration is eight weeks overall with six weeks for caregiver leave. The average weekly benefit is \$759 (approximately \$100 per day). Also, lower-wage workers may receive up to 95 percent wage replacement which is capped at 60x the minimum wage (approximately \$942/week in 2025).

She stated that women account for 62 percent of benefit usage compared to men at 35 percent. A disparity she attributed to cultural caregiving patterns. She further explained usage by age group—with workers ages 29–44 comprising the largest share of total leave while caregivers ages 45–60 take nearly the same proportion of caregiver leave which she states reflects the “sandwich generation” balancing care for aging parents and dependent children. She explained that the most common caregiver leave is for caring for a parent followed by spouses and adult children. She also emphasized that the feared surge in maximum-length leave did not occur. She noted that most workers take “only the time they need” which is far below the statutory maximum of 12–14 weeks.

She concluded by providing some employer experience insights. She compared early fears (workers taking excessive leave, severe staffing disruptions, cost burdens) with actual outcomes which showed that the program resulted in high employer satisfaction, no evidence of leave abuse, and increased worker retention and productivity. Employers especially valued the zero-cost model because it relies entirely on employee contributions to fund the program. She added that some employers have shifted money previously used for short-term disability insurance into other employee benefits.

8. Washington's PFML Program (Ms. Rebecca Grady)

Ms. Rebecca Grady, Research and Data Manager for the Leave and Care Division within the Washington Employment Security Department, provided a comprehensive analysis of the outcomes, utilization trends, equity impacts, and employer responses associated with Washington's PFML program since benefit payments began in 2020. She explained the distribution of different types of leave applications during the most recent fiscal year. Earlier program years had been dominated by new-child bonding claims. However, as the program has matured, the data illustrates a clear and gradual shift from an increase in claims for one's own serious medical condition to claims for care of a family member's serious medical conditions. This trend aligned with broader national patterns showing that medical-related leave becomes the dominant driver of use once awareness stabilizes and the program becomes embedded in workforce culture.

She then highlighted Washington's continued year-over-year program growth—even five to six years after implementation. The total number of claims since 2020 illustrated a steep upward trajectory, signaling not only strong

demand but also increasing program familiarity among employers and workers. She emphasized that by the third year of implementation, evaluation data showed most new parents in Washington were using PFML (with nearly 50 percent of all new-child bonding claims filed by fathers). This paternal uptake was significant because it indicated a shift in caregiving norms and a broader acceptance of PFML across gender categories. The data further demonstrated that African American men and women were using PFML at relatively high rates. She noted that this was a promising finding given that national research consistently shows these workers are less likely to take needed leave due to economic and cultural barriers.

The presentation then turned to economic security impacts. She described a poverty impact graph developed by the Urban Institute and the US Department of Labor, depicting estimated reductions in family poverty if Washington's PFML program had existed in 2018. The graph showed that PFML would have lowered the poverty rate among eligible families by nearly nine percent and the poverty gap (with the additional resources required to lift families to the Supplemental Poverty Measure threshold) would have shrunk by 26 percent. These effects translated into an estimated \$47 million in reduced reliance on means-tested public assistance programs which demonstrate PFML's macro-level fiscal impact on state and federal safety-net expenditures.

She presented survey findings that captured the financial experiences of PFML customers. An overwhelming majority of respondents reported reduced financial stress and 70 percent stated they would have faced a financial crisis without PFML benefits. Most also said that both the duration of leave and benefit amounts were sufficient for their needs. To provide context, she explained that Washington workers may receive up to 12 weeks of medical leave or family leave individually; up to 16 weeks combined; and an additional two weeks for pregnancy-related complications such as C-sections. A progressive wage-replacement formula ensures that low-wage workers receive up to 90 percent wage replacement. A design feature strongly associated with equitable access.

A second survey focused specifically on caregivers taking leave to care for their own or a family member's serious medical condition. She referenced a bar chart showing respondents' likely actions in the absence of PFML. The majority indicated they would have struggled financially while many said they or their family member would not have received needed medical care which raise concerns about delayed treatment and poorer health outcomes. Approximately one-third reported they would have taken no time off at all. Also, about one-fifth said they would have left their job altogether which suggests substantial labor-force retention benefits attributable to PFML.

She supplemented these quantitative findings with customer testimonials. These included caregivers describing PFML as "life-saving," such as a parent whose child was experiencing a severe mental health crisis. Others spoke about postpartum recovery, breastfeeding success, and improvements in maternal and infant health, reinforcing extensive national research linking paid leave to healthier babies, reduced maternal morbidity, and stronger long-term outcomes for families.

Shifting to employer impacts, she highlighted a graph showing that 95 percent of workers were employed with the same employer one quarter after taking leave. She explained that this demonstrates exceptionally strong job retention. She also described a 2018 statewide employer survey that showed that 75 percent of employers supported PFML (even before the program launched). Employers across sectors cited improvements in employee morale, productivity, and turnover, as well as the ability to offer competitive benefits. She noted that small businesses initially expressed concern but PFML's structure ultimately relieved many burdens by establishing predictable statewide rules and by reducing the administrative complexity associated with employer-specific leave programs.

REPORT ADOPTION

The Senate Study Committee on Improving Family Caregiver Services held a final meeting on December 11, 2025 to discuss and adopt this report and the attached recommendations.

FINDINGS AND RECOMMENDATIONS

Based on the testimony and research presented, the Senate Study Committee on Improving Family Caregiver Services finds recommends:

1. Expand the types of caregiving services that qualify under Georgia's existing Paid Parental Leave Program to include other familial relationships;
2. Expand the Georgia Family Care Act's 5-Day Rule to include additional familial relationships with all other program aspects remaining the same;
3. Establish a pilot program to provide support for caregivers aged 65 or older who provide care to individuals with dementia;
4. Encourage the state to examine the feasibility of establishing a Childcare Facilities Program through targeted infrastructure grants for the construction of childcare facilities;
5. Encourage DAS to further study the difficulties or structural impediments that exist for African Americans and other minorities providing caregiver services; and
6. Encourage DAS to collaborate with GDVS to further study and determine how Veterans and their caregivers can better access caregiving services while having to navigate through the intersection of federal and state laws with regard to veterans' services.

Respectfully Submitted,

FINAL REPORT OF THE SENATE STUDY COMMITTEE ON IMPROVING FAMILY CAREGIVER SERVICES (SR 393)



**Senator Harold Jones II – Committee Chairman
District 22**