



Area Agency on Aging
of Pasco - Pinellas, Inc.

**2012
OLDER AMERICANS ACT
CONTINUING SERVICE PROVIDER APPLICATION**

**IIIEG Grandparent Program (NFCSP)
IIIB Emergency Alert Response Services
IIIB Transportation Services
IIIDI & IIIDII Disease Prevention and Health Promotion Services**

TABLE OF CONTENTS

Table of Contents		1
General Instructions		2
A. PROGRAM MODULE		
I.A	Service Provider Summary Information	2-3
II.A.1.	Needs Assessment	4
II.A.2.	Provider Qualifications	4
II.A.3.	Provider Capability	4
II.A.4.	Targeting	4
II.A.5.	Identifying and Prioritizing Clients	4
II.A.6.	Process for Reducing or Terminating Services	4
II.A.7.	Eligibility and Assessment/Reassessment Process	4
III.A	Description of Service Delivery	5
III.A.1.	Site Location	5
III.A.2.	Specific Activities	5
III.A.3.	Explanation of Proposed Staffing	5
B. CONTRACT MODULE		
I.B.1.	Audited Financial Statement	6
I.B.2.	Certification of Operating Funds	6
I.B.3.	Statement of No Involvement	6
I.B.4.	Insurance Coverage	6
*II.B.1.	Personnel Cost Flow Worksheet	7
*II.B.2.	Supporting Budget Worksheet	7
II.B.3.	Supporting Budget Schedule by Program Activity	7
II.B.4	Match Commitment Forms	7-13
II.B.5	Availability of Documents	14

*These sections are not required when completed by a for-profit company.

GENERAL INSTRUCTIONS

- ▶ The service provider application must include the following:
 - A. Program Module - contains general information about the provider and the service for which the continuing application is being made. (See Table of Contents A.I.A through A.III.A.3)
 - B. Contract Module - contains specific funding and service cost information. (See Table of Contents B.I.B.1. through B.II.B.5)

- ▶ Prescribed formats are contained in boxes within the document and must be used. If formats do not allow sufficient space, additional pages may be attached as needed.

- ▶ Where no format is prescribed, the applicant may use plain paper with a heading on each page to identify the application section

- ▶ Dollar amounts should be rounded to the nearest whole dollar.

- ▶ Applications must include all information requested and each page must be numbered sequentially.

Table of Contents: To be included in every application and must have corresponding page numbers identified.

I.A. Service Provider Summary Information: To be completed by every applicant Format follows.

<p>1. PROVIDER INFORMATION: Executive Director: {Name/Address/Phone}</p> <p>Legal Name of Agency:</p> <p>Mailing Address:</p> <p>Telephone Number: []</p>	<p>2. GOVERNING BOARD CHAIR: {Name/Address/Phone}</p> <p>Name of Grantee Agency:</p> <p>3. ADVISORY COUNCIL CHAIR: (if applicable) {Name/Address/Phone}</p>
<p>4. TYPE OF AGENCY/ORGANIZATION:</p> <p>NOT FOR PROFIT: <input type="checkbox"/> PRIVATE <input type="checkbox"/> PUBLIC</p> <p>PRIVATE FOR PROFIT</p>	<p>5. PROPOSED FUNDING PERIOD: January 1, 2012 – December 31, 2012</p> <p>A. New Applicant</p> <p>B. Continuation <input checked="" type="checkbox"/></p>
<p>6. FUNDS REQUESTED:</p> <p><input type="checkbox"/> OAA Title IIIB <input type="checkbox"/> OAA Title III-C1 <input type="checkbox"/> OTHER (SPECIFY) <input type="checkbox"/> OAA Title III-C2 <input type="checkbox"/> OAA Title IIID <input type="checkbox"/> LSP <input type="checkbox"/> OAA Title IIIEG <input type="checkbox"/> OAA Title VII <input type="checkbox"/> USDA</p>	
<p>7. SERVICE AREA: <input type="checkbox"/> Single County _____ <input type="checkbox"/> Multi county: List:</p> <p>Selected Communities of a County. Specify:</p>	
<p>8. ADDRESS FOR PAYMENT OF CHECKS ITEM #: <input type="checkbox"/> #1 <input type="checkbox"/> #2</p>	
<p>9. CERTIFICATION BY AUTHORIZED AGENCY OFFICER:</p> <p>I hereby certify that the contents of this document are true, accurate and complete statements. I acknowledge that intentional misrepresentation or falsification may result in the termination of financial assistance.</p> <p>Name: _____ Signature: _____</p> <p>Title: _____ Date: _____</p>	

A. PROGRAM MODULE

Responses to this section should be in narrative format.

II.A.1. NEEDS ASSESSMENT: Update information provided in original application only if necessary.

II.A.2. PROVIDER QUALIFICATIONS:

- Provide current organizational chart of department and agency involved with the proposal, including any proposed changes.
- Provide list of current Board of Directors or Corporate Officers with term dates and contact information.

II.A.3. PROVIDER CAPABILITY: Update original application as necessary.

1. Provider meets the minimum qualifications to provide the service being bid on. See Service Definitions in Appendix A of the DOEA Program and Services Handbook, issued in August 2010.
2. Provider has the capacity (staff and technology) for utilizing CIRTS to record client information and/or to report units of service.
3. Provider is aware of and willing to partner with the Aging and Disability Resource Center (ADRC).

II.A.4. TARGETING: Update targeting methods and goals from original application. Numbers of clients to be served must be identical and supported by the Supporting Budget Schedule located in the Contract Section.

II.A.5. IDENTIFYING AND PRIORITIZING CLIENTS: Update the Agency's process for receiving and processing requests for service. The Supporting Budget Schedule, located in the Contract Section should support the number of clients to be served.

II.A.6. PROCESS FOR REDUCING OR TERMINATING SERVICES:

Provide an update describing process and criteria to be used when reducing services, terminating a client from the program, or placing an individual on "Hold" Status.

II.A.7. ELIGIBILITY AND ASSESSMENT/REASSESSMENT PROCESS: Update original proposal describing the intake process, eligibility determination and documentation procedures. Provide assurance that active clients and clients waiting for services are to be reassessed yearly.

III.A. DESCRIPTION OF SERVICE DELIVERY: Update “Description of Service Delivery” from original application.

SERVICE: _____

PROGRAM(S): Older Americans Act

III.A.1. SITE LOCATION: Provider must include a list of addresses and contact information for administrative and service delivery sites, with corresponding days and hours of operation.

III.A.2. SPECIFIC SERVICE ACTIVITIES

Provide an update to original application as necessary.

III.A.3. EXPLANATION/OUTLINE OF PROPOSED STAFFING

Provide an update as to how your agency proposes to meet staffing requirements for the services proposed, as well as for the financial and CIRTTS reporting requirements and responsibilities of an Older Americans Act provider.

Subcontractors: If applicable, provide information on how sub contractors are going to be used in the implementation of the service being performed and how sub contractors will be selected. Service providers are responsible for exercising independent judgment in the selection of the subcontractor that can best meet the service needs of the older persons within the service area. For each subcontractor to be used in the provision of service during the 2012 contract year, the following information will be required by the AAA:

1. The scope of service being performed by the subcontractor.
2. Amount of funds expected to be paid to the subcontractor. Include detail on unit rate and units to be provided by subcontractor.
3. Provide detailed explanation how the following will be assured to the AAA:
 - a. Non-federal financial participation;
 - b. Methodology for contributions;
 - c. Methodology for reporting the number of unduplicated persons and units of service;
 - d. Methodology for CIRTTS reporting; and
 - e. Audit trail for financial transactions.
4. The detail including the frequency by which you will be monitoring the sub-contractor for contractual requirements.

If the service provider intends to subcontract with a profit-making organization, prior approval must be obtained from the AAA before contract execution. Copies of all executed subcontract agreements will be required.

B. CONTRACT MODULE

Providers are expected to maximize funding by appropriately budgeting funds to ensure services are available throughout the duration of the contract period. Any deviation from this must be approved by the Area Agency on Aging.

I. B.1. AUDITED FINANCIAL STATEMENTS attesting to the reliability of the applicant’s financial and administrative system should be provided. Should be an attachment to the proposal

I.B.2. CERTIFICATION OF AVAILABILITY OF 30 DAYS OPERATING FUNDS must be provided in a signed statement.

I.B.3. STATEMENT OF NO INVOLVEMENT AND REQUEST FOR PROPOSAL TERMS AND CONDITIONS must be completed and signed by an authorized representative of the applicant agency. If this is not either a Board Member or Corporate Officer with signatory authority, please also include a signed authorization by the agency’s Board of Directors indicating that the individual signing documents for this Proposal has the authorization of the Board to do so. Statement format follows:

STATEMENT OF NO INVOLVEMENT	
I, _____, as an authorized representative of _____,	
_certify that no member of firm nor any person having interest in this firm has	
been awarded a contract by the Department of Elder Affairs or Area Agency on Aging on a	
noncompetitive basis to:	
(1)	develop this Request for Proposals;
(2)	perform a feasibility study concerning the scope of work contained in this RFP; or
(3)	develop a program similar to what is contained in this RFP.
Authorized Representative	Date
REQUEST FOR PROPOSAL AND CONTRACT TERMS AND CONDITIONS	
I, _____, as an authorized representative of _____,	
certify that, if selected as the successful applicant, this agency/firm agrees to all the terms and	
conditions set forth in the Request for Proposal and contract.	
Authorized Representative	Date

I.B.4. Assurance of Insurance Coverage must include a list of insurance coverage detailing Insurance Company, type of insurance, amount of insurance and limits. If the applicant chooses to do so, a statement of insurance coverage may be included. Minimum coverage shall include liability, worker’s compensation, employee bonding, and director’s and officer’s liability insurance. (Please note that all applicants are required to present documentation of actual insurance coverage.)

ALLOCATION METHODS: *FOR PROFIT COMPANIES ARE EXEMPT FROM RESPONDING TO ITEMS PRECEDED BY AN ASTERISK (*) PERTAINING TO UNIT COST DETERMINATION. THE MATCH REQUIREMNT OF 10% IS APPLICABLE TO ALL PROPOSALS.*

***II.B.1. PERSONNEL COST FLOW WORKSHEET:**

DOEA unit cost methodology spreadsheet is available from the Area Agency on Aging.

***II B.2. SUPPORTING BUDGET WORKSHEET:**

DOEA unit cost methodology spreadsheet is available from the Area Agency on Aging.

II.B.3. SUPPORTING BUDGET SCHEDULE BY PROGRAM ACTIVITY:

DOEA unit cost methodology spreadsheet must be utilized to determine the unit rate for the service. The unit rate is subject to approval by the AAAPP.

Separate Supporting Budget Schedules must be included for LSP and for OAA.
Unduplicated clients are to reflect each specific program and need to coincide with the narrative section of the application

III.B.4. MATCHING COMMITMENT DOCUMENTATION

MATCH COMMITMENT OF CASH DONATION

SFY: _____ FFY: _____

Original, dated
 Revision, dated

Contract Amendment #

Agency Name: Program:			
Donor Identification:			
Name:			
Street:			
City: _____		State: _____	Zip: _____
Phone:			
Authorized Representative:			
Total Amount	# Payments	Amount/Payment	Contribution Period
\$		\$	
Special Conditions:			
Donor Certification:			
<p>I hereby certify intent to make the cash donation set forth above for use in the specified program during the program's upcoming funding period. This cash is not included as contribution for any other State or Federally assisted program or any Federal contract and is not borne by the Federal government directly or indirectly under any federal grant or contract.</p>			
X _____		Date:	
Signature of Donor or Representative			

MATCH COMMITMENT FOR DONATION OF BUILDING SPACE

SFY:____ FFY:____

Original, dated
 Revision, dated
Contract Amendment #

Agency Name:	Program:
Donor Identification: Name: Street: City: _____ State: _____ Zip: Phone: Authorized Representative:	
Description of Space: <input type="checkbox"/> Office <input type="checkbox"/> Site <input type="checkbox"/> Other	
Provider Owned Space: 1. Number of square feet used by project _____ sq.ft. 2. Appraised rental value per square foot \$_____/sq.ft. 3. Total value of space used by project (1x2) \$ _____	
Donor Owned Space: 1. Established monthly rental value \$ _____ 2. Number of months rent to be paid by donor _____ mos 3. Value of donated space (1x2) \$ _____	
Special Conditions:	
Donor Certification: I hereby certify intent to donate use of the space set forth above for the program specified above during the program's upcoming funding period. This space is not being used as match for any other State or Federal program or contract. X _____ Date: Signature of Donor or Representative	

MATCH COMMITMENT OF SUPPLIES

SFY: _____ FFY: _____

Original, dated
 Revision, dated
 Contract Amendment #

Agency Name:	Program:
Donor Identification:	
Name: _____	
Street: _____	
City: _____ State: _____ Zip: _____	
Phone: _____	
Authorized Representative: _____	
Description of Supplies:	
The below described supplies are committed for use by the project for the period of: _____	
Computation of Value:	
Value to be claimed by project: _____ \$	
Special Conditions:	
Donor Certification:	
I hereby certify intent to donate these supplies for the program specified above during the program's upcoming funding period. These supplies are not being used as match for any other State or Federally assisted program or contract.	
X _____	Date: _____
Signature of Donor or Representative	

MATCH COMMITMENT OF EQUIPMENT

SFY: _____ FFY: _____

Original, dated
 Revision, dated
Contract Amendment #

Agency Name:	Program:		
Donor Identification:			
Name: _____			
Street: _____			
City: _____ State: _____ Zip: _____			
Phone: _____			
Authorized Representative: _____			
Description of Equipment:			
The below described equipment is committed for use by the project for the period of: (From) (To)			
	Acquisition		
<u>Description of Item</u>	<u>Number</u>	<u>Cost</u>	<u>Value to Project*</u>
1. _____	_____	_____	
2. _____	_____	_____	
3. _____	_____	_____	
4. _____	_____	_____	
5. _____	_____	_____	
	Total Value Claimed:		
*Items that are currently owned by the Grantee or are loaned or donated to the project are valued at an annual rate of 6-2/3 percent of the acquisition value.			
Donor Certification:			
This equipment is not included as a contribution for any other State or Federally Assisted program or contract and costs are not borne by the Federal Government directly or indirectly under any Federal grant or contract except as provided for under:			
_____ (cite the authorizing Federal regulation or law if applicable).			
X _____	Date: _____		
Signature of Donor or Representative			

**MATCH COMMITMENT OF IN-KIND CONTRIBUTION OF SERVICES
BY STAFF OF SERVICE PROVIDER OR STAFF OF OTHER ORGANIZATIONS**

SFY: _____ FFY: _____

Original, dated
 Revision, dated
 Contract Amendment #

Agency Name:		Program:			
Donor Identification:					
Name: _____					
Street: _____					
City: _____ State: _____ Zip: _____					
Phone: _____					
Authorized Representative: _____					
Descriptions of Positions:					
	<u>Position</u> <u>Title</u>	<u>Service</u>	<u>Hourly Rate or</u> <u>Annual Salary</u>	<u># Hours</u> <u>Worked</u>	<u>Value to</u> <u>Project*</u>
1.	_____	_____	\$ _____	_____	\$ _____
2.	_____	_____	\$ _____	_____	\$ _____
3.	_____	_____	\$ _____	_____	\$ _____
Total -					\$ _____
*Value to project = (# of hours worked) x (Hourly rate) or (Annual Salary ÷ 2080 hrs) x (# of hours worked)					
Donor Certification:					
<p>These services are not included as match for any other State or Federally Assisted program or contract and costs are not borne by the Federal Government directly or indirectly under any Federal grant or contract except as provided for under:</p> <p>_____ (cite the authorizing Federal regulation or law if applicable). It is certified that the time devoted to the project will be performed during normal working hours.</p>					
X _____			Date:		
Signature of Donor or Representative					

MATCH COMMITMENT OF IN-KIND VOLUNTEER PERSONNEL AND TRAVEL

SFY: _____ FFY: _____

Original, dated
 Revision, dated
 Contract Amendment #

Agency Name:	Program:
---------------------	-----------------

Donor Identification:
 Name:
 Street:
 City: _____ State: _____ Zip:
 Phone:
 Authorized Representative:

The volunteer staff positions identified below will be filled by local volunteers who will be recruited, trained and supervised as an ongoing activity of our agency. We will maintain volunteer records to document individual volunteer activity.
Describe Volunteer Effort:

	Position Title	Equivalent Hourly Rate	# of Hours	Value to Project
1		\$		\$
2		\$		\$
3		\$		\$
TOTAL VALUE TO AGENCY				\$

Equivalent Hourly Rates were determined by:
 Rates for comparable positions within own agency.
 State Employment Service estimate of rates for type of work.
 Rates for comparable positions within other local agencies.

ESTIMATED MILEAGE	X	RATE PER MILE	=	VALUE
				\$

Donor Certification:
 I hereby certify that commitments have been received from individual volunteers or groups sufficient to provide the volunteer hours and travel identified above.

X _____ **Date:** _____
 Signature of Agency Official

Name: _____

AVAILABILITY OF DOCUMENTS

The undersigned hereby gives full assurance that the following documents are maintained in the administrative office of the provider and will be filed in such a manner as to ensure ready access for inspection by the AAA or its designee(s) at any time. The Provider will furnish copies of these documents to the AAA upon request.

1. Current Board Roster
2. Articles of Incorporation
3. Corporate By-Laws
4. Advisory Council By-Laws and Membership
5. Corporate Fee Documentation
6. Insurance Coverage Verification
7. Bonding Verification
8. Staffing Plan
 - a. Position Descriptions
 - b. Pay Plan
 - c. Organizational Chart
 - d. Executive Director's Resume
9. Personnel Policies Manual
10. Financial Procedures Manual
11. Operational Procedures Manual
12. Interagency Agreements
13. Affirmative Action Plan
14. Outreach Plan, if applicable
15. Americans With Disabilities Act Assurance and Supporting Documentation
16. Unusual Incident File
17. Contribution System
18. Inventory List

CERTIFICATION BY AUTHORIZED AGENCY OFFICIAL:

I hereby certify that the documents identified above currently exist and are properly maintained in the administrative office of the Provider. Assurance is given that the AAA or its designee(s) will be given immediate access to these documents, upon request.

Signature

Date

Name of Authorized Individual

Title of Authorized Individual