Area Agency on Aging
of Pasco - Pinellas, Inc.

Appendix III

Service Provider Application Formats

July 1, 2023 – June 30, 2024

A. PROGRAM MODULE FORMATS

RESPONSE TO REQUEST FOR PROPOSAL SPECIFICATIONS

B. CONTRACT MODULE FORMATS

ATTACHMENTS

I.A. SERVICE PROVIDER
SUMMARY INFORMATION PAGE

PSA:__

ORIGINAL SUBMISSION [ ]
REVISION [ ]

1. PROVIDER INFORMATION: Executive Director: {Name/Address/Phone} Legal Name of Agency: Mailing Address Telephone Number: [ ]	2. GOVERNING BOARD CHAIR: {Name/Address/Phone Name of Grantee Agency: 3. ADVISORY COUNCIL CHAIR: (if applicable) {Name/Address/Phone}
4. TYPE OF AGENCY/ORGANIZATION: NOT FOR PROFIT: __ PRIVATE ___ PUBLIC PRIVATE FOR PROFIT ___	5. PROPOSED FUNDING PERIOD: A. New Applicant B. Continuation

6. FUNDS REQUESTED:

[X] ADI
[X] CCE
[X] HCE
[ ] OTHER (SPECIFY)

7. SERVICE AREA: [X] Single County
[ ] Multi county: List:
Selected Communities of a County. Specify

8. ADDRESS FOR PAYMENT OF CHECKS ITEM #: [ ] #1 [ ] #2

9. CERTIFICATION BY AUTHORIZED AGENCY OFFICER:

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.

Name:_____ Signature:

Title:_____ Date:

RESPONSE TO REQUEST FOR PROPOSAL SPECIFICATIONS

II.A. Corporate Qualifications and Capability:
Narrative

II.A.1. Narrative Synopsis:
Narrative

II.A.2. Organizational Charts:
Proposer Format

II.A.3. Names/Addresses/Telephone Numbers and Term Expiration Dates of Members of the Board of Directors or Corporate Officers:
Proposer Format

II.A.4. Audited Financial Statements
Attachment

II.A.5. Certification (signed) of Availability of 60 days Operating Funds
Proposer Format

II.A.6. Corporate Bylaws
Attachment

II.A.7. IRS Determination
Attachment

II.A.8. Statement of No Involvement and Contract Terms and Conditions:

STATEMENT OF NO INVOLVEMENT

I, _____, as an authorized representative of

_____, certify that no member of this firm nor any person having interest in this firm has

been awarded a contract by the Department of Elder Affairs 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

II.A.9. Contract Terms and Conditions

CONTRACT TERMS AND CONDITIONS

I, _____, as an authorized representative of

_____, certify that this firm agrees to all the terms and conditions of the contract as

set forth in this Request For Proposal.

_____ _____

Authorized Representative Date

II.A.10. Assurance of Sufficient Insurance Coverage:
Attachment

II.A.11. Administrative Assessment Checklist
Attachment utilizing the checklist found in **Appendix IV**

II.A.12. Explanation and/or Outline of Proposed Staffing Plan:
Narrative

II.A.12.a. Current and Proposed Job Descriptions/Pay Rates/Position Qualifications
Attachment

II.A.13. Cost Efficiency and Program Effectiveness Plan:
Narrative

II.A.14. Statement Assuring No CCE Funds Used in Development of RFP.
Attachment utilizing the statement found in **Appendix VII.**

III.A. DESCRIPTION OF SERVICE DELIVERY AND COORDINATION

Narrative

III.A.1. Service Delivery and Coordination Plan:

(Provide one for each of the following, as appropriate)

- Case Management (Address separately for CCE/HCE/ADI)

A description of how Case Management will be delivered for clients in common with other programs, i.e., CCE, ADI, HCE, or OAA must be included on the Case Management Description of Service Delivery form.

- Case Aide

Service:

Site Location:

Days and Hours of Operation:

Specific Activities Your Agency Will Provide Under This Service:

Coordination Methodology:

III.A.2. Provider Work Plan

This format is applicable only to agencies not currently serving as a Lead Agency. Such agencies are considered new applicant agencies or previous providers offering a new service. This format must address the "phase in" process. Attach continuation sheets as needed.

SERVICE:_____ ESTIMATED # OF CLIENTS:
ANTICIPATED START DATE OF SERVICE:

MAJOR WORK TASKS TO ACHIEVE SERVICE OBJECTIVE

START-UP ACTIVITIES (Briefly describe tasks and estimated completion dates):
TASK:

ESTIMATED COMPLETION DATE:
TASK:

ESTIMATED COMPLETION DATE:
TASK:

ESTIMATED COMPLETION DATE:
TASK:

ESTIMATED COMPLETION DATE:

For applicants currently serving as Lead Agency, a narrative will be submitted addressing how their agency will coordinate with vendors. Both counties must discuss coordination with the Area Agency on Aging on all service delivery components.

III.A.3. **Client Identification Methodology:**
Narrative

III.A.4. **Client Prioritization/Termination Plan:**
(Address High Risk, Moderate Risk and Low Risk. Include procedure explaining how clients receiving a low-risk score at the time of the initial assessment could be returned to the Assessed Priority Consumer List.

III.A.5. **Emergency Service /Referral Response Methodology:**
Narrative

III.A.6. **Client Adverse Incident, Complaint and Grievance Procedures.**
Narrative

III.A.7. **Client Confidentiality and Security:**
Narrative

III.A.8. **HIPAA**
Narrative

III.A.9. **E-Verify Requirements**
Narrative

III.A.10. **Social Security Disclosures**
Narrative

III.A.11. **Background Screening**
Narrative

III.A.12. **Conflict of Interest**
Narrative

III.A.13. **Plan to Maintain Quality Control of Services and Monitor Client Satisfaction:**
Narrative

III.A.14. **Continuation Bidder Documentation of Effective Management / Service Quality:**
Attach monitoring reports and letter of reference.

III.A.15. **New Bidder Documentation of Effective Management / Service Quality:**
Attach monitoring reports and letter of reference.

III.A.16. **Documentation of Bidder Experience:**
Narrative

III.A.17. **Plan to achieve Outcome/Output measures:**
Narrative

III.A.18. **Volunteers**
Narrative

III.A.19. **Disaster Preparedness**
Narrative

III.A.20. **Co-Payments**
Narrative, refer to the Notice of Instruction attached.

Department of
ELDER AFFAIRS
STATE OF FLORIDA

Ron DeSantis
Governor

Michelle Branham
Secretary

MEMORANDUM

TO: AAA Executive Directors

FROM: Michelle Branham, Secretary

DATE: January 4, 2023

SUBJECT: Notice of Instruction: ADI/CCE Co-payment Information, Effective 2/1/2023

The purpose of this notice is to disseminate updated co-payment assessment policy information and forms for clients receiving Community Care for the Elderly (CCE) and Alzheimer's Disease Initiative (ADI) services.

Pursuant to 430.204(8), the dollar amount for co-payments associated with CCE and ADI must be calculated by applying the current federal poverty guidelines published by the U.S. Department of Health and Human Services. The current guidelines are posted on their website at:

- https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Form Updates: Effective February 1, 2023

Responsive to policy changes and Financial Eligibility Standards, the monthly income range found on the co-payment schedules for both couples and individuals have changed from the previous year.

The following attachments are included with this notice:

- Co-Payment Financial Worksheet and Assessed Co-Payment form (Attachment 1);
- Community Care for the Elderly and Alzheimer's Disease Initiative Co-Payment Schedule for an Individual (Attachment 2);
- Community Care for the Elderly and Alzheimer's Disease Initiative Co-Payment Schedule for a Couple (Attachment 3); and
- Co-Payment Financial Worksheet Instructions (Attachment 4).

4040 Esplanade Way, Tallahassee, FL 32399-7000
Phone: (850) 414-2000 | Fax: (850) 414-2004 | TDD: (850) 414-2001
visit us at: elderaffairs.org

B. CONTRACT MODULE FORMATS

II.B.1. Personnel Cost Flow Worksheet
Included with the “2023-2024 Contract Module Worksheets.xls”

II.B.2. Supporting Budget Worksheet
Included with the “2023-2024 Contract Module Worksheets.xls”

II.B.3. Supporting Budget by Program Activity
Included with the “2023-2024 Contract Module Worksheets.xls”

III.B.1. MATCH COMMITMENT OF CASH DONATION

[ ] Original, dated

SFY: _____FFY:_____[ ] 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:

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.

X_____ Date:

Signature of Donor or Representative

III.B.2. MATCH COMMITMENT FOR DONATION OF BUILDING SPACE

[ ] Original, dated
SFY:____FFY:____[ ] Revision, dated
Contract Amendment #

Agency Name: **Program:**

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

Description of Space: [ ] Office [ ] Site [ ] 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

III.B.3. MATCH COMMITMENT OF SUPPLIES

[ ] Original, dated

SFY:_____FFY:_____[ ] 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:

(From)
(To)

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

III.B.4 MATCH COMMITMENT OF EQUIPMENT

[ ] Original, dated
SFY:_____FFY:_____[ ] 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)

	Description of Item	Acquisition Number	Cost	Value to Project*
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

III.B.5. MATCH COMMITMENT OF IN-KIND CONTRIBUTION OF SERVICES BY STAFF OF SERVICE PROVIDER OR STAFF OF OTHER ORGANIZATIONS

[ ] Original, dated

SFY:_____FFY:_____[ ] Revision, dated

Contract Amendment #

Agency Name: **Program:**

Donor Identification:

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

Descriptions of Positions:

	Position Title	Service	Hourly Rate or Annual Salary	# Hours Worked	Value to Project*
1.	_____	_____	$_____	____	$
2.	_____	_____	$_____	____	$
3.	_____	_____	$_____	____	$
				Total -	**$**

*Value to project = (# of hours worked) x (Hourly rate) or (Annual Salary) 2080 hrs) x (# of hours worked)

Donor Certification:

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:
(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.**

X_____ Date:
Signature of Donor or Representative

III.B.6. MATCH COMMITMENT OF IN-KIND VOLUNTEER PERSONNEL AND TRAVEL

[ ] Original, dated
SFY:_____FFY:_____[ ] 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:

IV.B. 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

V.B. EQUIPMENT PROPERTY INVENTORY:

Proposer format

VI.B. CERTIFICATION REGARDING DEBARMENT, SUSPENSION:

Debarment and Suspension Certification (29 CFR Part 95 and 45 CFR Part 74)

The undersigned Contractor certifies to the best of its knowledge and belief, that it and its principals:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by a Federal Department or agency;
2. Have not within a three-year period preceding this Contract been convicted or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
3. Are not presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph A.2. of this certification; and/or
4. Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause of default.

Signature_____
Date_____
Name and Title of Authorized Individual _____
Name of Organization _____

ATTACHMENT I: STAFF DEVELOPMENT AND TRAINING PLAN
Narrative

ATTACHMENT II: SITE LIST

Provider:_____ **[ ] Original, Dated**
Federal/State Fiscal Year: _____ **[ ] Revision, Dated**
Contract Amendment #

Site No.

Contact: Name:
Address:

Phone No:

INSPECTION DATES:
Fire:
Safety:
Other:

Site No.

Contact: Name:
Address:

Phone No:

INSPECTION DATES:
Fire:
Safety:
Other:

Site No.

Contact: **Name:**
Address:

Phone No:

INSPECTION DATES:
Fire:
Safety:
Other:

Attachment III.

FIVE YEAR SERVICE UNIT RATE QUOTE

Proposed Service	Year 2	Year3	Year 4	Year 5	Year 6
Case Management Total Unit cost	$____	$____	$_____	$_____	$_____
Case Aide Total Unit cost	$____	$____	$_____	$_____	$_____

_____ _____

Signature Date