Alliance for Aging Application for Funds

##### **APPENDIX V**

**ALLIANCE FOR AGING, INC.**

**REQUSET FOR PROPSAL**

**SERVICE PROVIDER APPLICATION**

**OAA APPLICATION FOR FUNDS**

##### OAA APPLICATION FOR FUNDS

**(Please include page numbers below as they appear in the application)**

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###### Applicant’s Summary Information Page

|  |  |
| --- | --- |
| 1. PROVIDER INFORMATION:Executive Director:{Name/Address/Phone}Legal Name of Agency: Mailing Address:Telephone Number:] | 1. GOVERNING BOARD CHAIR:

{Name/Address/Phone}Name of Grantee Agency:1. ADVISORY COUNCIL CHAIR (if applicable):

{Name/Address/Phone} |
| 4. TYPE OF AGENCY/ORGANIZATION:[ ]  NOT FOR PROFIT[ ]  FOR PROFIT [ ]  PUBLIC OR LOCAL GOVERNMENT |  1. Miami-Dade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monroe\_\_\_\_\_\_\_

 [ ]  Region A [ ]  Region B [ ]  Region A [ ]  Region C [ ]  Region D [ ]  Region B [ ]  Region E [ ]  Region F  |
| 1. FUNDS REQUESTED IN THIS PARTICULAR PROPOSAL: [ ]  Title III-B [ ]  Title III-C1 [ ]  Title III-C2 [ ]  Title III-D

 [ ]  Title III-E [ ]  Title III-ES [ ]  Title III-EG |
| 7. SERVICE(S) OFFERED: Indicate which Couty(s), Title(s), Service(s) and Region(s) you are applying for on the next two pages.  |
| 1. ADDRESS TO MAIL CHECK(S) FOR PAYMENT OF SERVICES:
 |
| 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:  |

ORIG ]

**MIAMI-DADE**

 **Title IIIB by Region**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** | **REGION C** | **REGION D** | **REGION E** | **REGION F** |
| Adult Day Care |  |  |  |  |  |  |
| In-Home Bundle |  |  |  |  |  |  |
| Recreation |  |  |  |  |  |  |
| Technology |  |  |  |  |  |  |
| Transportation |  |  |  |  |  |  |

 **Title IIIB County Wide**

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Chore Bundle |  |
| Education/Training |  |
| Gerontological Counseling |  |
| Mental Health Counseling |  |
| Emergency Alert Response Bundle |  |
| Material Aid / Housing Improvement Bundle |  |
| Specialized Medical Equipment, Services, & Supplies |  |

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Kosher Congregate Meals Bundle |  |

 **Title IIIC1 County Wide**



 **Title IIIC1 by Region**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** | **REGION C** | **REGION D** | **REGION E** | **REGION F** |
| Congregate Meals Bundle |  |  |  |  |  |  |

 **Title IIIC2 by Region**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** | **REGION C** | **REGION D** | **REGION E** | **REGION F** |
| Home Delivered Meals Bundle - Hot |  |  |  |  |  |  |
| Home Delivered Meals Bundle - Frozen |  |  |  |  |  |  |

 **Title IIID by Regional Area**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGIONAL AREA** **A,B,D** | **REGIONAL AREA****C,E,F** |
| A Matter of Balance |  |  |
| Un Asunto de Equiilibrio |  |  |
| Bingosize (English & Spanish) |  |  |
| Enhanced Fitness (English) |  |  |
| Enhanced Fitness (Spanish) |  |  |
| Arthritis Foundation Tai Chi (English & Spanish |  |  |
| Tai Chi / Tai Ji Quan Moving for Better Balance (English & Spanish) |  |  |
| Diabetes Self-Management |  |  |
| Programa de Manejo Personal de la Diabetes |  |  |
| Chronic Disease Self-Management |  |  |
| Tomando Control de su Salud |  |  |
| Walk Waith Ease (English and Spanish) |  |  |
| Fir & Strong (English & Spanish) |  |  |
| Savvy Caregiver (English) |  |  |
| Savvy Caregiver (Spanish) |  |  |

 **Title IIIE by Region**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** | **REGION C** | **REGION D** | **REGION E** | **REGION F** |
| Adult Day Care |  |  |  |  |  |  |
| Respite Services – In Home |  |  |  |  |  |  |
| Respite Services - Facility  |  |  |  |  |  |  |

2

**MIAMI DADE CONTINUED**

**Title IIIES County Wide Title IIIEG County Wide**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| **Service** | **County Wide** |
|  Chore Bundle |  |
|  Material Aid / Housing Improvement Bundle |  |
| Specialized Medical Equipment, Services, & Supplies |  |

 |

|  |  |
| --- | --- |
| **Service** | **County Wide** |
| **Grandparents Bundle** |  |

 |

**===========================================================================================================**

**MONROE**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** |
| In-Home Bundle |  |  |
| Recreation |  |  |
| Technology |  |  |

 **Title IIIB by Region Title IIIB County Wide**

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Chore Bundle |  |
| Mental Health Counseling |  |
| Specialized Medical Equipment, Services, & Supplies |  |

 **Title IIIC1 by Region Title IIIC2 by Region**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** |
| Home Delivered Meals Bundle - Frozen |  |  |

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** |
| Congregate Meals Bundle |  |  |

 **Title IIID County Wide Title IIIE by Region**

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| A Matter of Balance / Un Asunto de Equilibrio |  |
| Bingosize |  |
| Enhanced Fitness |  |
| Chronic Disease Self-Management / Tomando Control de su Salud |  |
| Savvy Caregiver |  |

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** |
| Adult Day Care |  |  |
| Respite Services – In Home |  |  |
| Respite Services – In Facility |  |  |

 **Title IIIES County Wide Title IIIEG County Wide**

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Chore Bundle |  |
| Material Aide / Housing Improvement Bundle |  |
| Specialized Medical Equipment, Services, & Supplies |  |

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Grandparent Bundle |  |

**===========================================================================================================**

**COMBINED MIAMI-DADE & MONROE COUNTIES**

 **IIIB Title IIIES**

|  |  |
| --- | --- |
| **SERVICE** | **Both Counties** |
| Legal Assistance |  |

|  |  |
| --- | --- |
| **SERVICE** | **Both Counties** |
| Legal Assistance |  |

###### **II.A. General Requirements**

* + 1. Consumer Projections, Profile and Targeting

In keeping with the intent of the Older Americans Act, which mandates that services be targeted to those 60 years of age and older in greatest social and economic need, especially low-income minority individuals or individuals socially or geographically isolated the Alliance has established the below projections for service.



Table 1. Projected Consumer Profile Summary Under OAA



Older Americans Act Service Delivery System:

Discuss each of the following—to guide your discussion, review the list of objectives listed in section III of this application and DOEA Program and Services Handbook. Please follow the same numbering system provided below.

Any supporting documentation or evidence should be included in the applicant-created “Exhibit File” which shall have its own labeling and table of contents unless stated otherwise.

* + - 1. **Service access, delivery and reporting process.**
				1. Explain how your program will:

Target eligible individuals in the respective region(s);

Prioritize services to individuals in greatest economic and social need; low-income older individuals; including low-income minority older individuals; older individuals with limited English proficiency; and elder individuals residing in identified region(s); and

Serve eligible OAA Consumers in the identified region(s).

* + - * 1. Describe how you will ensure the following processes will comply with the **DOEA Program and Services Handbook and Alliance for Aging Area Plan including annual updates** to:

Assess for program and service eligibility;

prioritize service delivery during the screening process to serve most in need;

coordinate needed services, to include services not provided by your agency; and

deliver OAA services to targeted Consumers (older persons in greatest economic and social need; low-income older individuals; including low-income minority older individuals; older individuals with limited English proficiency; and elder individuals residing in rural areas).

* + - * 1. Detail and explain how your agency’s systems will successfully:

determine if a consumer should be referred to the ADRC for other Long-Term Care programs;

ensure comprehensive and accurate wait list management for registered services in the Enterprise Client Information Registration and Tracking System (eCIRTS);

provide accurate and timely billing and service reports to the Alliance for Aging ;

ensure that you do not surplus any funding at the end of each contract period for the proposed region(s).

allow for timely response to all routine and/or special requests for information and reports. This explanation shall include how the applicant will establish due dates for any subcontractors and vendors to ensure compliance with the Alliance’s reporting periods.

* + - * 1. Acknowledge your requirement to and discuss how you will:
1. Ensure sufficient trained and skilled workers are available to provide services to clients in English, Spanish, and Creole;
2. Cooperatively respond to requests for assistance for referrals from the Adult Protective System (APS); and
3. Coordinate with other Alliance funded agencies to ensure there are no overlapping services.
	* + 1. **Ability to increase provider capacity by supplementing OAA funds under this RFP.**
				1. Detail other sources of funding or resources such as local government, philanthropic grants or in-kind contributions that you presently have available and will seek during the contract periods associated with this RFP. Describe recruitment and use of volunteers to supplement/match the funding under this RFP. For each source estimate the dollar amount, including the in-kind value of volunteer time and donations.
				2. Describe plans to further develop your agency’s financial capacity.
			2. **New approaches/models of service delivery**
				1. Discuss how you will strengthen and streamline the aging network’s capacity, inspiring innovation, integrating best practices, and building efficiencies to respond to the growing and diversifying aging population**.**

2. If your plan is to use technology, Explain how you intend to address social isolation and enhance participants’ quality of life through the use of Technology. The explanation must describe the specific technological device that you want to implement, how it will address social isolation and enhance their quality of life. The response must also explain how you will designate staff to be responsible for overseeing the program, including the monitoring of Usage Reports, developing quality assurance processes, tracking client satisfaction, assisting participants, and ensuring vendor(s) are abiding by all contract guidelines and requirements.);

* + - 1. **Staff Development**
				1. Detail your plans to ensure you have a pool of staff qualified by experience, education and training with sensitivity to culture, religious and language differences and with proper and sufficient program and fiscal accountability. Also include how these activities are funded. Detail plans for:

staff recruitment, including steps that will be taken to ensure a complete and consistent workforce to perform services under the Older Americans Act, and

staff pre-service and in-service training. Your plan should include the minimum standards/topics as outlined in Appendix A and Chapter 5 (if applicable) of the DOEA Programs and Services Handbook. Note: Copies of staff training procedures must be maintained and available upon request by the Alliance.

Employee performance evaluation.

* + - 1. **Leadership and Advocacy**
				1. Discuss your leadership and advocacy role for elder issues within the area that you intend to serve.
		1. Quality Assurance
			1. **External Quality Assurance**. Each provider is required to annually survey a sample of older persons being served annually for each service in order to objectively determine the level of client satisfaction. The information obtained is to be used to improve services and must be made available to the Alliance monitoring staff. Copies of the Consumer Satisfaction policies and procedures must be maintained on file for Alliance review.
				1. Consumer Satisfaction --Describe the process and methods that will be followed to:

Determine annual consumer satisfaction,

Address consumer concerns and

Implement needed changes.

* + - * 1. Describe the tools you will use to:

Assess the level of consumer participation and

Satisfaction with services delivered.

* + - 1. **Internal Quality Assurance**
				1. Internal evaluation processes—With regard to the services that you propose to provide, describe the internal methods and management controls to assure:

The quality of the services,

The quantity and economy of the services,

The appropriateness of the services.

Grant budget management.

* + - * 1. Unusual Incidents--Describe your written policies and procedures:

Investigate unusual incidents.

Document and maintain files of unusual incidents.

Timely report unusual incidents

Implement corrective measures if warranted.

* + 1. Title Specific
			1. **Title III-B Offered Services**: The selected services must be consistent with the previously submitted Notice of Intent to Apply submitted by Applicant. Place a check in the box of each supportive service and region that you intend to offer under this RFP.

**If the applicant is NOT proposing to provide any of these Title III-B services,** then write “N/A” in the following box and skip the rest of this section.

 OAA Title III-B Services

 **MIAMI-DADE COUNTY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** | **REGION C** | **REGION D** | **REGION E** | **REGION F** |
| Adult Day Care |  |  |  |  |  |  |
| In-Home Bundle |  |  |  |  |  |  |
| Recreation |  |  |  |  |  |  |
| Technology |  |  |  |  |  |  |
| Transportation |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Chore Bundle |  |
| Education/Training |  |
| Gerontological Counseling |  |
| Mental Health Counseling |  |
| Emergency Alert Response Bundle |  |
| Material Aid / Housing Improvement Bundle |  |
| Specialized Medical Equipment, Services, & Supplies |  |

 OAA Title III-B Services

 **MONROE COUNTY**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** |
| In-Home Bundle |  |  |
| Recreation |  |  |
| Technology |  |  |

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Chore Bundle |  |
| Material Aid / Housing Improvement Bundle |  |
| Specialized Medical Equipment, Services, & Supplies |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 OAA Title IIIB Services

 **COMBINED MIAMI-DADE AND MONROE COUNTY**

|  |  |
| --- | --- |
| **SERVICE** | **Both Counties** |
| Legal Services |  |

**INTENTION TO SUBCONTRACT FOR SERVICES**

Any subcontracts for services under this application must be identified on this form. (attach additional pages if needed):

|  |  |  |
| --- | --- | --- |
| **Service to be Subcontracted** | **Subcontractor Name** | **License # (if applicable)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Subcontracting requirements are listed in the DOEA Program and Services Handbook**. By submitting this form, the applicant attests that it has read and understands these requirements.** Execution of any contracts that result from this application is contingent upon satisfactory fulfillment of all subcontracting requirements listed in the Handbook.

**Any Subcontracted services requiring a valid permit, license or certificate of use should be inserted as part of the applicant’s Exhibit folder.**

If this application is requesting funding for Center Based Services, please provide the following information for each proposed site (attach additional pages if needed):

**Center Based Services Facility Site Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Site Address (Street, number, City, Zip Code) | Region | Capacity | AHCA License # | License Expiration Date | Facility Type |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| 5. |  |  |  |  |  |
| 6. |  |  |  |  |  |

* + - 1. **Title III-B Outcome Measures and Standards**

The next pages list outcome measures and standards that the Alliance has identified for Title III-B funding under this RFP. Using the format provided in the next pages, please describe in sufficient detail the implementation strategies/action steps, outcomes, and outputs/inputs that your agency will follow to achieve or exceed the standards listed.

If you are applying for a registered service in this title, this section must be completed.

 (attach additional pages if needed)

|  |  |
| --- | --- |
| **Outcome Measure 1:** | Percentage of new service recipients whose ADL assessment scores has been maintained or improved. |
| **Standard:** | 65 percent (refers to percent of Consumers whose ADL assessment score in DOEA 701A assessment forms, improved or stayed the same from one fiscal year to the next.). |
| **Strategy/Action Steps**: Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

|  |  |
| --- | --- |
| **Outcome Measure 2:** | Percentage of new service recipients whose IADL assessment scores has been maintained or improved. |
| **Standard:** | 62.3 percent (refers to percent of Consumers whose IADL assessment score in DOEA 701A assessment forms, improved or stayed the same from one fiscal year to the next.) |
| **Strategy/Action Steps:** Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

|  |  |
| --- | --- |
| **Outcome Measure 3:** | Percent of caregivers whose ability to provide care is maintained or improved after one year of service intervention (as determined by the caregiver and the assessor |
| **Standard:** | 90 percent (Percent of caregivers whose ability to provide care is maintained or improved after one year of service intervention (as determined by the caregiver and the assessor in the DOEA 701A assessment forms from one fiscal year to the next.) |
| **Strategy/Action Steps:** Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

* + - 1. **Title III-C1 Offered Services**: The selected services must be consistent with the previously submitted Notice of Intent to Apply submitted by Applicant. Place a check in the box of each service and region that you intend to offer under this RFP.

**If the applicant is NOT proposing to provide any of these Title III-C1 services,** then write “N/A” in the following box and skip the rest of this section.

**OAA Title III-C1 Services**

**MIAMI-DADE COUNTY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** | **REGION C** | **REGION D** | **REGION E** | **REGION F** |
| Congregate Meals Bundle |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Kosher Congregate Meals Bundle |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OAA Title III-C1 Services**

**MONROE COUNTY**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** |
| –Congregate Meals Bundle |  |  |

**INTENTION TO SUBCONTRACT FOR SERVICES**

Any subcontracts for services under this application must be identified on this form. Describe the subcontracts below (attach additional pages if needed):

|  |  |  |
| --- | --- | --- |
| **Service to be Subcontracted** | **Subcontractor Name** | **License # (if applicable)** |
|  |  |  |
|  |  |  |
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Nutrition Provider shall obtain the services of a licensed dietician in planning and providing nutrition services. The dietician paid by the project’s food service vendor cannot provide these services. Responsibilities and functions of the Qualified Dietician are identified in the DOEA Programs and Services Handbook.

**The Nutrition Provider will include copies of the dietician’s license with this application and inserted as part of the applicant’s created Exhibit folder.**

With the application, applicants must submit a copy of the food vendor license and a valid permit, license or certificate of use issued by the appropriate regulatory authority for the premises from which food will be prepared. Contracts for the provision of food may be executed only with those vendors who supply meals from premises that have a valid permit, license, or certificate issued by the appropriate regulatory authority.

**The** **food vendor license and a valid permit, license or certificate of use should be inserted as part of the applicant’s Exhibit folder.**

Nutrition Providers are required to have at least three (3) days’ worth of shelf stable meals for emergency meals with reserved funds set aside to purchase the food items; AND at least one back-up caterer (for the same meal type) who can provide meals immediately in the event of an emergency**. Applicants must attest that this requirement has been met with the submission of the Application and attestation shall be included in the Exhibit File.**

Please provide the following information for each proposed site (attach additional pages if needed):

**Meal Site/ Senior Center Information**

|  |  |  |
| --- | --- | --- |
| **Site Address (Street, number, City, Zip Code)** | **Region** | **# of OAA participants you are applying to serve at this facility** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
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| 16. |  |  |
| 17. |  |  |
| 18. |  |  |

* + - 1. **Title III-C1 Outcome Measures and Standards**

The next table lists outcome measures and standards that the Alliance has identified for Title III-C1 funding under this RFP. Using the format provided in the table below, please describe in sufficient detail the implementation strategies/action steps, outcomes, and outputs/inputs that your agency will follow to achieve or exceed the standards listed.

(attach additional pages if needed)

|  |  |
| --- | --- |
| **Outcome Measure 1:** | Percent of new service recipients with high-risk nutrition scores whose nutritional status improved. |
| **Standard:** | 66 percent (Percent of new consumers with a “high risk” nutritional score in the DOEA 701C assessment form that improved at their next assessment.) |
| **Strategy/Action Steps**: Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

* + - 1. **Title III-C2 Offered Services.** The selected services must be consistent with the previously submitted Notice of Intent to Apply submitted by Applicant. Place a check in the box of each service and region that you intend to offer under this RFP.

**If the applicant is NOT proposing to provide any of these Title III-C2 services,** then write “N/A” in the following box and skip the rest of this section.

OAA Subtitle III-C2 Services

**MIAMI-DADE COUNTY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** | **REGION C** | **REGION D** | **REGION E** | **REGION F** |
| Home Delivered Meals Bundle – Hot |  |  |  |  |  |  |
| Home Delivered Meals Bundle - Frozen |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Kosher Home Delivered Meals Bundle |  |

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OAA Subtitle III-C2 Services

**MONROE COUNTY**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** |
| Home Delivered Meals Bundle - Frozen |  |  |

**INTENTION TO SUBCONTRACT FOR SERVICES**

Any subcontracts for services under this application must be identified on this form. Describe the subcontracts below (attach additional pages if needed):

|  |  |  |
| --- | --- | --- |
| **Service to be Subcontracted** | **Subcontractor Name** | **License # (if applicable)** |
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Nutrition Provider shall obtain the services of a licensed dietician in planning and providing nutrition services. The dietician paid by the project’s food service vendor cannot provide these services. Responsibilities and functions of the Qualified Dietician are identified in the DOEA Programs and Services Handbook.

**The Nutrition Provider will include copies of the dietician’s license with this application and submit in the applicant’s created Exhibit folder.**

With this application, applicants must submit a copy of the food vendor license and a valid permit, license or certificate of use issued by the appropriate regulatory authority for the premises from which food will be prepared. Contracts for the provision of food may be executed only with those vendors who supply meals from premises that have a valid permit, license, or certificate issued by the appropriate regulatory authority.

**The licenses, permits and certificate of use documents should be submitted in the applicant’s Exhibit folder.**

Nutrition Providers are required to have at least three (3) days’ worth of shelf stable meals; or a pre-approved three-day menu for emergency meals with reserved funds set aside to purchase the food items; AND at least one back-up caterer (for the same meal type) who can provide meals immediately in the event of an emergency**. Applicants must attest that this requirement has been met with the submission of the Application and the attestation must be submitted in the Exhibit folder.**

As part of the C2 bundle, a rate must be submitted for Screening and Assessment, Emergency Shelf Stable Meals, Nutrition Counseling, and Nutrition Education.

* + - 1. **Title III-C2 Outcome Measures and Standards**

The next table lists outcome measures and standards that the Alliance has identified for Title III-C2 funding under this RFP. Using the format provided in the table below, please describe in sufficient detail the implementation strategies/action steps, outcomes, and outputs/inputs that your agency will follow to achieve or exceed the standards listed.

(attach additional pages if needed)

|  |  |
| --- | --- |
| **Outcome Measure 1:** | Percentage of new service recipients whose ADL assessment scores has been maintained or improved. |
| **Standard:** | 65 percent (refers to percent of Consumers whose ADL assessment score in DOEA 701A assessment forms, improved or stayed the same from one fiscal year to the next.). |
| **Strategy/Action Steps**: Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |
| **Outcome Measure 2:** | Percentage of new service recipients whose IADL assessment scores has been maintained or improved. |
| **Standard:** | 62.3 percent (refers to percent of Consumers whose IADL assessment score in DOEA 701A assessment forms, improved or stayed the same from one fiscal year to the next.) |
| **Strategy/Action Steps:** Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

|  |  |
| --- | --- |
| **Outcome Measure 3:** | Percent of caregivers whose ability to provide care is maintained or improved after one year of service intervention (as determined by the caregiver and the assessor |
| **Standard:** | 90 percent (Percent of caregivers whose ability to provide care is maintained or improved after one year of service intervention (as determined by the caregiver and the assessor in the DOEA 701A assessment forms from one fiscal year to the next.) |
| **Strategy/Action Steps:** Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

|  |  |
| --- | --- |
| **Outcome Measure 4:** | Percent of new service recipients with high-risk nutrition scores whose nutritional status improved. |
| **Standard:** | 66 percent (Percent of new consumers with a “high risk” nutritional score in the DOEA 701C assessment form that improved at their next assessment.) |
| **Strategy/Action Steps**: Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

* + - 1. **Title III-D Offered Services.** The selected services must be consistent with the previously submitted Notice of Intent to Apply submitted by Applicant. Place a check in the box of each service and Regional Area that you intend to offer under this RFP.

**If the applicant is NOT proposing to provide any of these Title III-D services,** then write “N/A” in the following box and skip the rest of this section.

OAA Subtitle III-D Services

**MIAMI-DADE COUNTY**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGIONAL AREA** **A,B,D** | **REGIONAL AREA****C,E,F** |
| A Matter of Balance |  |  |
| Un Asunto de Equiilibrio |  |  |
| Bingosize (English & Spanish) |  |  |
| Enhanced Fitness (English) |  |  |
| Enhanced Fitness (Spanish) |  |  |
| Arthritis Foundation Tai Chi (English & Spanish |  |  |
| Tai Chi / Tai Ji Quan Moving for Better Balance (English & Spanish) |  |  |
| Diabetes Self-Management |  |  |
| Programa de Manejo Personal de la Diabetes |  |  |
| Chronic Disease Self-Management |  |  |
| Tomando Control de su Salud |  |  |
| Walk Waith Ease (English and Spanish) |  |  |
| Fir & Strong (English & Spanish) |  |  |
| Savvy Caregiver (English) |  |  |
| Savvy Caregiver (Spanish) |  |  |

OAA Subtitle III-D Services

**MONROE COUNTY**

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| A Matter of Balance / Un Asunto de Euilibrio |  |
| Bingosize |  |
| Enhanced Fitness |  |
| Chronic Disease Self-Management / Tomando Control de su Salud |  |
| Savvy Caregiver |  |

**INTENTION TO SUBCONTRACT FOR SERVICES**

Any subcontracts for services under this application must be identified on this form. Describe the subcontracts below (attach additional pages if needed):

|  |  |  |
| --- | --- | --- |
| **Service to be Subcontracted** | **Subcontractor Name** | **License # (if applicable)** |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |  |

**Evidence Based Program Facility Site Information**

(attach additional pages as necessary)

|  |  |  |
| --- | --- | --- |
| Site Address (Street, number, City, Zip Code) | Room Capacity | **Name of Evidence Based Program to be delivered** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

* + - 1. **Title III-E, III-ES, III-EG Offered Services.** The selected services must be consistent with the previously submitted Notice of Intent to Apply submitted by Applicant. Place a check in the box of each service and Regional Area that you intend to offer under this RFP.

**If the applicant is NOT proposing to provide any of these Title III-E services,** then write “N/A” in the following box and skip the rest of this section.

OAA Subtitle III-E Services

**MIAMI-DADE COUNTY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** | **REGION C** | **REGION D** | **REGION E** | **REGION F** |
| Adult Day Care |  |  |  |  |  |  |
| Respite Services – In Home |  |  |  |  |  |  |
| Respite Services - Facility  |  |  |  |  |  |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

OAA Subtitle III-E Services

**MONROE COUNTY**

|  |  |  |
| --- | --- | --- |
| **SERVICE** | **REGION A** | **REGION B** |
| Adult Day Care |  |  |
| Respite Services – In Home |  |  |
| Respite Services – In Facility |  |  |

**INTENTION TO SUBCONTRACT FOR SERVICES**

Any subcontracts for services under this application must be identified on this form. Describe the subcontracts below (attach additional pages if needed):

|  |  |  |
| --- | --- | --- |
| **Service to be Subcontracted** | **Subcontractor Name** | **License # (if applicable)** |
|  |  |  |
|  |  |  |
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**Center Based Facility Site Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Site Address (Street, number, City, Zip Code) | Region | Capacity | **AHCA License #** | **License Expiration Date** | FacilityType |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| 5. |  |  |  |  |  |
| 6. |  |  |  |  |  |

**========================================================================================================================================================================**

OAA Subtitle III-ES Services

**MIAMI-DADE COUNTY**

|  |  |
| --- | --- |
| **Service** | **County Wide** |
|  Chore Bundle |  |
|  Material Aid / Housing Improvement Bundle |  |
| Specialized Medical Equipment, Services, & Supplies |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

OAA Subtitle III-ES Services

**MONROE COUNTY**

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Chore Bundle |  |
| Material Aid / Housing Improvement Bundle |  |
| Specialized Medical Equipment, Services, & Supplies |  |

**INTENTION TO SUBCONTRACT FOR SERVICES**

Any subcontracts for services under this application must be identified on this form. Describe the subcontracts below (attach additional pages if needed):

|  |  |  |
| --- | --- | --- |
| **Service to be Subcontracted** | **Subcontractor Name** | **License # (if applicable)** |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |

**======================================================================================================================================================**

OAA Subtitle III-EG Services

**MIAMI-DADE COUNTY**

|  |  |
| --- | --- |
| **Service** | **County Wide** |
| Grandparents Bundle |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

OAA Subtitle III-EG Services

**MONROE COUNTY**

|  |  |
| --- | --- |
| **SERVICE** | **County Wide** |
| Grandparent Bundle |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

OAA Subtitle III-EG Services

**COMBINED MIAMI-DADE & MONROE COUNTIES**

|  |  |
| --- | --- |
| **SERVICE** | **Both Counties** |
| Legal Assistance |  |

**INTENTION TO SUBCONTRACT FOR SERVICES**

Any subcontracts for services under this application must be identified on this form. Describe the subcontracts below (attach additional pages if needed):

|  |  |  |
| --- | --- | --- |
| **Service to be Subcontracted** | **Subcontractor Name** | **License # (if applicable)** |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |  |

Program Facility Site Information (attach additional pages as necessary)

|  |  |  |
| --- | --- | --- |
| Site Address (Street, number, City, Zip Code) | Room Capacity | **Name of Evidence Based Program to be delivered** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

**Title III-E Outcome Measures and Standards**

If you are applying for a registered service in this title, this section must be completed.

|  |  |
| --- | --- |
| **Outcome Measure 1:** | Percentage of new service recipients whose ADL assessment scores has been maintained or improved. |
| **Standard:** | 65 percent (refers to percent of Consumers whose ADL assessment score in DOEA 701A assessment forms, improved or stayed the same from one fiscal year to the next.). |
| **Strategy/Action Steps**: Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

|  |  |
| --- | --- |
| **Outcome Measure 2:** | Percentage of new service recipients whose IADL assessment scores has been maintained or improved. |
| **Standard:** | 62.3 percent (refers to percent of Consumers whose IADL assessment score in DOEA 701A assessment forms, improved or stayed the same from one fiscal year to the next.) |
| **Strategy/Action Steps:** Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

|  |  |
| --- | --- |
| **Outcome Measure 3:** | Percentage of caregivers who self-report being very confident about their ability to continue to provide care. |
| **Standard:** | 89 percent (refers to percent of caregivers who self-report being very confident about their ability to continue to provide care in the DOEA 701A assessment forms from one fiscal year to the next.) |
| **Strategy/Action Steps:** Describe your strategies for meeting this outcome measure with the services you are proposing. If you plan to exceed the standard describe how this will be accomplished. |
| **Outcomes:** Describe the result or impact of program activities on the client/consumer. |
| **Outputs/Inputs:** Describe the services that will be delivered to clients/consumer (units of service) to meet the objective and the resources used to provide those services (dollars, staff, etc.). |

**IIIA Outreach**

OAA, Title III providers must provide targeted community outreach efforts that will assist in identifying individuals who have the greatest economic or social need, particularly low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.

Outreach is defined as a face-to-face, one-to-one intervention with clients initiated by the agency for the purpose of identifying potential clients or caregivers and encouraging their use of existing and available resources. Outreach efforts shall take place in highly visible public locations or in neighborhoods identified for visiting or canvassing.

A Designated Provider will be required to semi-annually report to the Alliance the type of outreach events or activities conducted, the date and location of the outreach events or activities, the total number of participants at each event or activity, the individuals service needs identified at each event or activity, and the referral sources or information provided at each outreach event or activity.

The Applicant must:

Provide a detailed description, in narrative form, of how it plans to conduct outreach events or activities in the community to identify individuals who have the greatest economic or social need, particularly low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. The description must include the specific number of outreach events or activities it plans to conduct at a minimum each year.

The description of the above shall not exceed two (2) double spaced pages using a font size of at least 11 pt.

###### **IVA. Applicant’s Qualifications and Prior Experience**

**The applicant shall indicate its experience and performance record in the following responses.**

**1a**. How many years of experience does the applicant have in providing services that are being applied for (specify for each specific service), including funding source?

**1b.** Provide at least 1 letter of reference from a funding entity, excluding the Alliance for Aging. The letter of reference must reflect the size and scope of the program, any form of disciplinary action taken, and a reflection of programmatic surplus (including total dollar amount of surplus) to demonstrate proper use of the funding allocation. **The letter of reference must be submitted in the applicant’s Exhibit folder.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**. Has the applicant been placed on any form of corrective action by any funding source(s) (including the Alliance) for any reason since January 2020?

If “Yes,” please attach an additional document specifying the funding source and the circumstances. If the corrective action has been resolved, indicate when and how. PLEASE PROVIDE DOCUMENTATION FROM FUNDING SOURCE VERIFYING THAT THE REASON(S) FOR THE CORRECTIVE ACTION STATUS HAVE BEEN RESOLVED, AND THAT THE AGENCY IS IN GOOD STANDING. **The supporting documentation for Corrective Action reason and current status and must be submitted in the applicant’s Exhibit folder.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3**. Has the applicant or any person associated with the applicant in the capacity of owner, partner, director, officer, principal, investigator, project director, manager, auditor, or position involving the administration of funds been terminated by any funding source(s) for cause.

If “Yes,” please attach an additional document specifying the funding source and the circumstances. **COPY OF ANY TERMINATION LETTER MUST BE ATTACHED IN THE EXHIBIT FILE**.

**NOTE: ANY PROVIDER WHOSE CONTRACT FROM ANY FUNDING SOURCE, INCLUDING ALLIANCE FOR AGING, WAS TERMINATED FOR CAUSE AS A RESULT OF FINANCIAL IRREGULARITIES OR CONTRACTUAL VIOLATION WITHIN THE PRECEDING SIX YEAR PERIOD PRIOR TO THE SUBMISSION DATE OF THIS RFP IS NOT ELIGIBLE TO APPLY FOR OAA FUNDING DURING THIS RFP CYCLE.**

For purposes of these questions, the term “applicant” includes: (1) any affiliates that are wholly owned by the applicant; (2) any parent company that owns all interest in the applicant; and (3) any predecessor in interest to the applicant.

###### **VA. Organizational Capability Package**

The applicant must provide the listed items in the order specified below:

1. A copy of the most recent organizational chart certified as accurate by an officer of the applicant and illustrating the structure and relationship of all paid staff positions related to the program in question.
2. Copies of job descriptions for all key staff involved in the performance of this contract, including management.
3. A copy of the two (2) most recent consecutive audited financial statements and compliance reporting package. With respect to such audited financial statements, include any letters to management submitted by the independent auditor under separate cover as well as any response stating management's position and plan of action.
4. A full roster of all current members of the applicant’s Board of Directors, Officers, or equivalent hierarchical leadership structure (for each member include contact information independent of applicant’s corporate address).
5. A copy of the applicant’s corporate bylaws, if applicable.
6. A certificate of insurance from applicant’s agent detailing the types of coverage currently held, the maximum dollar amount for each, and the dates when coverage became effective and is scheduled to terminate. The applicant is required to demonstrate liability and worker’s compensation insurance coverage, as required by law.
7. The completed and signed Certifications and Assurances forms (Attachment II).

**Note: None of the items listed above are scored, but they are required to be submitted.**

**Failure of an applicant to submit any of these items shall automatically be deemed a material deviation that adversely affects that interest of the Alliance and shall result in rejection of the application by the Alliance.**

# CONTRACT MODULE

**Instructions:**

In order for the Contract Module to be reviewed and scored, the applicant must:

* + - * 1. Complete Section I.B (Unit Cost Grids) for each service (within the appropriate Title and County) that is being applied to serve according to those directions.
				2. Complete Form II.B (Match Commitment)

###### **I.B. Unit Cost Grids**

Complete the rows for each service that you are applying for.

Enter the current unduplicated number of OAA funded clients for each service, if any.

Enter the annual projected new (unduplicated) clients anticipated in the OAA funded service.

For the “Proposed OAA Funded” column (B), include the total funds requested by OAA Title III-B by service. (Do NOT include match.)

For the “OAA Match Funds” column (C), include the amount of Match. The minimum is $1 of match for every $9 of grant funds.

For the “Anticipated All Other Sources” column (D), include other funding resources for these services, for example, CCE, Medicaid, United Way, etc. These funds will provide the Alliance with a measure of provider capacity and OAA funding leverage. A separate table is provided to enumerate these “Anticipated All Other Sources” funds.

Enter the number of units you are applying for in the “Proposed OAA Units” column (E).

Enter the adjusted unit rate in the “Proposed OAA Adjusted Unit Rate” column (F). See Paragraph C.

1. f. of the RFP for details.

The value in column (F) should not be higher than the amount in the “Maximum Allowed Adjusted Rate” column (G).

The value in column (B) should equal the number in column (E) times the rate in column (F).

Make sure that each service with a value in the “Proposed OAA Funded” column is checked in Table 4.

Due to the heterogeneity of their units of service, services with an asterisk in column (G) do not have a maximum unit rate.

**Note: The Unit Cost Grid provides information about service funding from non-OAA sources and the proposed adjusted unit rate per service. The proposed unit rate per service must be supported by a Unit Cost Methodology which will be reviewed after the intent to award but prior to contract execution.**

**MIAMI-DADE COUNTY TITLE III-B**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current****Unduplicated OAA Clients** | **Projected Annual New OAA Clients (Unduplicated)** | (A)Service Offered  | (B)Proposed OAAFunded (Total $) | (C) OAAMatchFunds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E)Proposed OAAUnits | (F)Proposed OAAAdjusted Unit Rate | (G)Maximum Allowed Rate1 |
|  |  | In Home Services/Supportive Services: |
|  |  | Chore |  |  |  |  |  |  113.33 |
|  |  | Chore (enhanced) |  |  |  |  |  | 113.33 |
|  |  | Education/Training (Individual and/or Group) |  |  |  |  |  | 45.05 |
|  |  | Emergency Alert Response (Install/Maintenance) |  |  |  |  |  | 75.572.42 |
|  |  | Counseling (Gerontological) |  |  |  |  |  | Grp 159.50Ind 164.22 |
|  |  | Emergency Alert Response |  |  |  |  |  | Instal 75.57Maint 2.42 |
|  |  | Escort (Registered) |  |  |  |  |  | 25.85 |
|  |  | Homemaker |  |  |  |  |  | 47.86 |
|  |  | Personal Care |  |  |  |  |  | 52.01 |
|  |  | Companionship |  |  |  |  |  | 50.71 |
|  |  | Legal Assistance |  |  |  |  |  | 206.80 |
|  |  | Housing Improvements |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  | Material Aid |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  | Mental Health Counseling (Individual and Group) |  |  |  |  |  | Grp 159.50Ind 225.43 |
|  |  | Recreation |  |  |  |  |  | 131.60 |
|  |  | Screening and Assessment |  |  |  |  |  | 141.76 |
|  |  | Specialized Medical Equipment and Supplies |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  | Technology (Equipment, Install, Staff Support |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  | Transportation |  |  |  |  |  | 66.67 |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

**MONROE COUNTY TITLE III-B**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current****Unduplicated OAA Clients** | **Projected Annual New OAA Clients (Unduplicated)** | (A)Service Offered  | (B)Proposed OAAFunded (Total $) | (C) OAAMatchFunds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E)Proposed OAAUnits | (F)Proposed OAAAdjusted Unit Rate | (G)Maximum Allowed Rate1 |
|  |  | In Home Services/Supportive Services: |
|  |  | Chore |  |  |  |  |  | 113.33 |
|  |  | Chore (enhanced) |  |  |  |  |  | 45.05 |
|  |  | Escort (Registered) |  |  |  |  |  | 25.85 |
|  |  | Homemaker |  |  |  |  |  | 47.87 |
|  |  | Personal Care |  |  |  |  |  | 52.01 |
|  |  | Companionship |  |  |  |  |  | 50.71 |
|  |  | Mental Health Counseling (Individual and Group) |  |  |  |  |  | Grp 159.50Ind 225.43 |
|  |  | Recreation |  |  |  |  |  | 131.60 |
|  |  | Screening and Assessment |  |  |  |  |  | 141.76 |
|  |  | Specialized Medical Equipment & Supplies |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  | Technology (Equipment, Install, Staff Support |  |  |  |  | Cost Reimb | Cost Reimb |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

**Anticipated Other Funding Sources Detail for TITLE III-B services**

|  |  |  |
| --- | --- | --- |
| **Service** | **Other Funding Sources** | **Amount** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Note 1: Sum of Other Funding Sources for each service must equal column (D) for that service in Unit Cost Grid above.**

**MIAMI-DADE COUNTY TITLE III-C1**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Unduplicated OAA Clients** | **Projected Annual New OAA Clients (Unduplicated)** | (A)Service Offered  | (B)Proposed OAAFunded (Total $) | (C) OAAMatchFunds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E)Proposed OAAUnits | (F)Proposed OAA Unit Adjusted Rate | (G)Maximum Allowed Rate1 |
|  |  | Congregate Meal Services: |
|  |  | Congregate meals— traditional |  |  |  |  |  | 20.90 |
|  |  | Congregate Meals Kosher |  |  |  |  |  | 20.90 |
|  |  | Emergency Shelf Stable Meals\* |  |  |  |  |  | 20.90 |
|  |  | Nutrition Education\* |  |  |  |  |  | 17.19 |
|  |  | Nutrition Counseling\* |  |  |  |  |  | 101.20 |
|  |  | Congregate Meals Screening\* |  |  |  |  |  | 69.83 |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

**MONROE COUNTY TITLE III-C1**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Unduplicated OAA Clients** | **Projected Annual New OAA Clients (Unduplicated)** | (A)Service Offered | (B)Proposed OAAFunded (Total $) | (C) OAAMatchFunds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E)Proposed OAAUnits | (F)Proposed OAA Unit Adjusted Rate | (G)Maximum Allowed Rate1 |
|  |  | Congregate Meal Services: |
|  |  | Congregate meals— traditional |  |  |  |  |  | 20.90 |
|  |  | Emergency Shelf Stable Meals\* |  |  |  |  |  | 20.90 |
|  |  | Nutrition Education\* |  |  |  |  |  | 17.79 |
|  |  | Nutrition Counseling\* |  |  |  |  |  | 101.20 |
|  |  | Congregate Meals Screening\* |  |  |  |  |  | 69.83 |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

Anticipated Other Funding Sources Detail for Title III-C1

|  |  |  |
| --- | --- | --- |
| Service | Other Funding Source | $$(Note 1) |
|  |  PART  |  |
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**Note 1: Sum of Other Funding Sources for each service must equal column (D) for that service in Unit Cost Grid above.**

**MIAMI-DADE COUNTY TITLE III-C2**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Unduplicated OAA Clients** | **Projected Annual New OAA Clients (Unduplicated)** | **MIAMI-DADE COUNTY**(A)Service Offered | (B)Proposed OAAFunded (Total $) | (C) OAAMatchFunds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E))Proposed OAAUnits | (F)Proposed OAA Unit Adjusted Rate | (G)Maximum Allowed Rate1 |
|  |  | Home delivered meal services: |
|  |  | Home delivered meals— Hot |  |  |  |  |  | 8.61 |
|  |  | Home delivered meals— Frozen |  |  |  |  |  | 10.23 |
|  |  | Home delivered meals— Kosher |  |  |  |  |  | 21.69 |
|  |  | Emergency Shelf Stable Meals |  |  |  |  |  | 21.69 |
|  |  | Nutrition Education\* |  |  |  |  |  | 17.79 |
|  |  | Nutrition Counseling\* |  |  |  |  |  | 110.23 |
|  |  | Screening and Assessment\* |  |  |  |  |  | 99.00 |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

**MONROE COUNTY TITLE III-C2**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Unduplicated OAA Clients** | **Projected Annual New OAA Clients (Unduplicated)** | **MONROE COUNTY**(A)Service Offered | (B)Proposed OAAFunded (Total $) | (C) OAAMatchFunds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E))Proposed OAAUnits | (F)Proposed OAA Unit Adjusted Rate | (G)Maximum Allowed Rate1 |
|  |  | Home delivered meal services: |
|  |  | Home delivered meals— Frozen |  |  |  |  |  | 10.23 |
|  |  | Emergency Shelf Stable Meals |  |  |  |  |  | 21.69 |
|  |  | Nutrition Education\* |  |  |  |  |  | 17.79 |
|  |  | Nutrition Counseling\* |  |  |  |  |  | 110.23 |
|  |  | Screening and Assessment\* |  |  |  |  |  | 99.00 |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

**Anticipated Other Funding Sources Detail**:

|  |  |  |
| --- | --- | --- |
| Service | Other Funding Source | $$(Note 1) |
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**Note 1: Sum of Other Funding Sources for each service must equal column (D) for that service in Unit Cost Grid above.**

**MIAMI-DADE COUNTY TITLE III-D**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Minimum Number of Sessions (Units) to be Provided** | (A)Service Offered | (B)Proposed OAAFunded (Total $) | (C)OAA Match Funds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E)Proposed OAAUnits | (F)Proposed OAAAdjusted Unit Rate | (G)Maximum Allowed Rate1 |
|  | Evidence Based Disease Prevention and Health Promotion Services: |
|  | A Matter of Balance/Un Asunto Equilibrio | $ |  |  |  |  | 2,750.00 |
|  | Bingocize | $ |  |  |  |  | 5,530.00 |
|  | Enhance Fitness | $ |  |  |  |  | 150.00 |
|  | Arthritis Foundation Tai Chi Program | $ |  |  |  |  | 5,500.00 |
|  | Tai Chi/Tai Ji Quan Moving for Better Balance | $ |  |  |  |  | 12,000.00 |
|  | Diabetes Self- Management Program/Programa de Manejo Personal de la Diabetes | $ |  |  |  |  | 2,710.00 |
|  | Chronic Disease Self- Management Program/Tomando Control su Salud | $ |  |  |  |  | 2,710.00 |
|  | Walk with Ease | $ |  |  |  |  | 2,750.00 |
|  | Fit and Strong! | $ |  |  |  |  | 4,500.00 |
|  | Savvy Caregiver | $ |  |  |  |  | 2,700.00 |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

**MONROE COUNTY TITLE III-D**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Minimum Number of Sessions (Units) to be Provided** | (A)Service Offered | (B)Proposed OAAFunded (Total $) | (C)OAA Match Funds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E)Proposed OAAUnits | (F)Proposed OAAAdjusted Unit Rate | (G)Maximum Allowed Rate1 |
|  | Evidence Based Disease Prevention and Health Promotion Services: |
|  | A Matter of Balance/Un Asunto Equilibrio | $ |  |  |  |  | 2,750.00 |
|  | Bingocize | $ |  |  |  |  | 5,530.00 |
|  | Enhance Fitness | $ |  |  |  |  | 150.00 |
|  | Chronic Disease Self- Management Program/Tomando Control su Salud | $ |  |  |  |  | 2,710.00 |
|  | Savvy Caregiver | $ |  |  |  |  | 2,700.00 |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

**Anticipated Other Funding Sources Detail**:

|  |  |  |
| --- | --- | --- |
| Service | Other Funding Source | $$(Note 1) |
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**Note 1: Sum of Other Funding Sources for each service must equal column (D) for that service in Unit Cost Grid above.**

**MIAMI-DADE COUNTY TITLE III-E**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Unduplicated OAA Clients** | **Projected Annual New OAA Clients (Unduplicated)** | (A)Service Offered | (B)Proposed OAA Funded (Total $) | (C) OAAMatchFunds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E))Proposed OAAUnits | (F)Proposed OAA Unit Adjusted Rate | (G)Maximum Allowed Rate1 |
|  |  | Program III-E: Support Services |
|  |  | Adult Day Care  |  |  |  |  |  | 187.00 |
|  |  | Respite In-Home  |  |  |  |  |  | 52.34 |
|  |  | Respite in Facility |  |  |  |  |  | 89.12 |
|  |  | Screening & Assessment |  |  |  |  |  | 110.25 |
|  |  |  | Program III-ES: Supplemental Services |
|  |  | Chore |  |  |  |  |  | 165.00 |
|  |  | Chore - Enhanced |  |  |  |  |  | 76.08 |
|  |  | Legal Assistance |  |  |  |  |  | 206.80 |
|  |  | Material Aid |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  | Housing Improvement |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  | Specialized Medical Equipment & Supplies |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  |  | Program III-EG: Grandparent Services |
|  |  | Home Delivered Meals – Frozen |  |  |  |  |  | 10.23 |
|  |  | Homemaker |  |  |  |  |  | 47.86 |
|  |  | Sitter |  |  |  |  |  | 50.00 |
|  |  | Screening and Assessment |  |  |  |  |  | 99.00 |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

**MONROE COUNTY TITLE III-E**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Current Unduplicated OAA Clients** | **Projected Annual New OAA Clients (Unduplicated)** | (A)Service Offered | (B)Proposed OAA Funded (Total $) | (C) OAAMatchFunds (Total $) | (D)Anticipated All Other Sources (Total $) List Detail Below | (E))Proposed OAAUnits | (F)Proposed OAA Unit Adjusted Rate | (G)Maximum Allowed Rate1 |
|  |  | Program III-E: Support Services |
|  |  | Adult Day Care  |  |  |  |  |  | 187.00 |
|  |  | Respite In Home  |  |  |  |  |  | 52.34 |
|  |  | Respite in Facility |  |  |  |  |  | 89.12 |
|  |  | Screening & Assessment |  |  |  |  |  | 110.25 |
|  |  |  | Program III-ES: Supplemental Services |
|  |  | Chore |  |  |  |  |  | 165.00 |
|  |  | Chore - Enhanced |  |  |  |  |  | 76.08 |
|  |  | Material Aide |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  | Housing Improvement |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  | Specialized Medical Equipment & Supplies |  |  |  |  | Cost Reimb | Cost Reimb |
|  |  |  | Program III-EG: Grandparent Services |
|  |  | Home Delivered Meals Frozen |  |  |  |  |  | 10.23 |
|  |  | Homemaker |  |  |  |  |  | 47.86 |
|  |  | Sitter |  |  |  |  |  | 50.00 |
|  |  | Screening and Assessment |  |  |  |  |  | 99.00 |

* The proposed reimbursement rate cannot exceed the maximum allowed rate.

**Anticipated Other Funding Sources Detail:**

|  |  |  |
| --- | --- | --- |
| **Service** | **Other Funding Source** | **$$(Note 1)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Note 1: Sum of Other Funding Sources for each service must equal column (D) for that service in Unit Cost Grid above**

**II.B**  **MATCH COMMITMENT**

2024 OAA RFP

**Applicant Organizational Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place an “X” next to the means for which you have identified as your ability to meet the 10% match requirement for Titles III-B, III-C1, III-C2, and III-E.

1. Match can be met using more than one means
2. Match, whether Cash or In-Kind, must be related to the program or service you are matching.
3. Federal Funds cannot be used as Match to any OAA awards.

|  |  |
| --- | --- |
|  | **Means to Meet Match** |
|   | Cash  |
|   | In-Kind Donated Space |
|   | In-Kind Donated Supplies |
|   | In-Kind Donated Equipment |
|   | In-Kind Professional Services |
|   | In-Kind Volunteer Hours & Milage |

For each means you have selected above, provide the original source of the match.

|  |  |  |
| --- | --- | --- |
| **Means** | **Source** | **Value** |
| ***Examples:*** |  |  |
| ***Cash*** | ***ABC Foundation for Meals*** | ***$ 150,000.00***  |
| ***Donated Office Space*** | ***City of XXX*** | ***$ 625,000.00***  |
| ***Pro Bono Legal Services*** | ***Joh Doe, Esquire*** |  ***$ 20,000.00***  |
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Note: Value determination should be in accordance the 2CFR 200.306

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**Signature of Applicant Official Date**