

WESTERN RESERVE AREA AGENCY ON AGING

**REQUEST FOR PROPOSAL**

INSTRUCTIONS AND Application FORMS

Alzheimer’s Respite Funds SFY 2024-2027

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**`****INTRODUCTION**

To apply to Alzheimer’s Respite funds, Applicant’s must return a complete Alzheimer’s Respite Request for Proposal Application to WRAAA by the due date. All required components of a complete application are listed on the following page, The Document Checklist Form.

However, before beginning to fill out the forms, the Applicant should review the following documents, which are available from the WRAAA website [www.areaagingsolutions.org](http://www.areaagingsolutions.org).

1. The **Overview** describes the Alzheimer’s Respite program and WRAAA’s expectations of the Applicants, provides a timetable that notes significant dates in the competitive proposal process, and is incorporated by reference into and is a part of this Request For Proposal (RFP). In the event of any conflict between the Overview.pdf and this RFP, this RFP shall control.
2. The **Contract Sample** contains the terms of the Agreement that will be signed by successful Applicants and WRAAA, and its requirements are incorporated by reference into and are a part of this RFP.
3. The Ohio Department of Aging (ODA) **Rules** are posted here: <https://codes.ohio.gov/ohio-administrative-code/173>. Applicants must comply with the applicable Rules which are part of the Ohio Administrative Code. The requirements of the Administrative Rules are incorporated by reference into and are a part of this RFP.
4. **Ohio Department of Aging Policy 316.00 –** Alzheimer’s Respite posted on the WRAAA website. The requirements of such policy are incorporated by reference into and are a part of this RFP.

The Application Proposal includes some WRAAA-specified forms that must be filled in and signed by the applicant. The instructions and many of these forms are incorporated into this document, referred to as **Instructions and Forms**. This document should be downloaded from the WRAAA website: [www.areaagingsolutions.org](http://www.areaagingsolutions.org). Applicants should fill in the shaded text boxes. When complete, the forms should be printed and signed by an authorized representative of the organization.

Other documents that should be downloaded from the WRAAA website include the **Contract Workbook** and **Form W9.**

All forms should then be compiled in order and double-checked for completion and appropriate, original signatures. A copy of the entire application should be made. The original and copy of the application should be submitted in a single packet to WRAAA by the due date.

# APPLICANT PROPOSAL DOCUMENT CHECKLIST

**Please use this checklist to organize all application documents in your Application Proposal**

**Applicant Name:**      

This application proposal includes all materials needed to apply for Alzheimer’s Respite funding, including appropriate original signatures, plus one complete copy of the application.

This application will be received by the Western Reserve Area Agency on Aging (WRAAA), 1700 E. 13th St., Suite 114, Attn: Connie Benedum, Cleveland, OH 44114

before**.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Document Name** | **Application Order** | **Applicant Provides** | **Forms in This Word Document** | **Forms in Excel Workbook** | **Your Checklist** |
| Applicant Proposal Document Checklist | 1 |  | This Page |  |  |
| Applicant Information Sheet | 2 |  |  | **×** |  |
| Applicant Authorization to Submit Certification | 3 |  | **×** |  |  |
| General Assurance | 4 |  | **×** |  |  |
| Department Of Health And Human Services Assurances Of Compliance With Section 504 Of The Rehabilitation Act Of 1973, As Amended | 5 |  | **×** |  |  |
| Certification Regarding Debarment, Suspension, and Other Responsibility Matters | 6 |  | **×** |  |  |
| Applicant Overview Questions | 7 |  | **×** |  |  |
| Conditions of Participation Questions | 8 |  | **×** |  |  |
| Organizational Chart | 9 | **×** |  |  |  |
| Service Application Questions (1 per service proposed) | 10 |  | **×** |  |  |
| Contract Service Page and supporting worksheets (1 set per service) | 11 |  |  | **×** |  |
| Proof of registration with the Ohio Secretary of State as a non-profit organization or as a for-profit business | 12 | **×** |  |  |  |
| Evidence of at least One Million Dollars of commercial liability insurance coverage aggregate and per occurrence. | 13 | **×** |  |  |  |
| Evidence of insurance coverage of at least $50,000.00 for consumer loss due to theft or property damage. | 14 | **×** |  |  |  |
| A copy of the written procedure describing the step-by-step instructions a consumer may follow to file an insurance claim | 15 | **×** |  |  |  |
| Form IRS W-9 - Print and submit with original signature. | 16 |  | Form W9.pdf |  |  |
| Mission Statement | 17 | **×** |  |  |  |

# APPLICANT AUTHORIZATION TO SUBMIT CERTIFICATION

On behalf of APPLICANT,      , a prospective “Provider” within the meaning of O.A.C. 173-3-01(B)(17), ( I / We) the undersigned, certify(ies) that all information (including funding levels) is true to the best of my / our knowledge.

This application was approved and authorized for submission to the WRAAA, in accordance with O.A.C. 173-3-01(B)(17), by      , (Name of “Consumer-directed individual provider”, “Applicant Provider” or “Self-Employed Provider” ) during a meeting (if applicable) held       (Date of Meeting).

Should I / Applicant receive the grant(s) applied for, I / We will fulfill the intent of the application. I / We further understand that additional documentation will be required after grants are awarded and agree to comply with WRAAA requirements regarding it.

IF AN ENTITY:

Legal Name of Applicant (Please type legal name of Applicant on line below)

President, Governing Board (if applicable) (Please type name of President on line below)

Signature of President (if applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director of Applicant (if applicable) (Please type name of Director on line below)

Signature of Director (if applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF AN INDIVIDUAL:

Please type name and role of individual on line below:

Signature of Individual:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary business telephone number or toll-free telephone number of Applicant:

(     )       -

Facsimile number of Applicant:

(     )       -

**GENERAL ASSURANCE**

**General Assurance of Compliance with Conditions of Participation and Service Specifications (Page 1 of 2)**

The Applicant hereby assures and certifies that it is in good standing with the Western Reserve Area Agency on Aging and will comply with the ODA and WRAAA Conditions of Participation, Administrative Rules, procedures, service specifications, guidelines and requirements, as they relate to the application, acceptance and use of Alzheimer Respite funds for the Applicant's proposed aging services program. Also the Applicant assures and certifies that:

1. It recognizes that although quality assurance practices and procedures are mandated and monitored by the ODA and WRAAA, it is the Applicant that must retain ultimate responsibility for the quality assurance function. It further recognizes that the overall responsibility for ensuring quality rests within the provider's organization.

2. It shall comply with the ODA/WRAAA Conditions of Participation in the Administrative Rules, which focus on agency operations and consumer care, including: Rule 173-39-02 regarding ODA provider certification clauses, Rule 173-3-04 general requirements for AAA-provider agreements, Rule 173-3-06 requirements to include in every AAA provider agreement Rule173-9 regarding criminal records check, and Rule 173-3-07 regarding consumer cost share, and with WRAAA Policies and Procedures.

3. It shall comply with ODA Administrative Rules for the following services: Rule 173-3-06.1 for Adult day care services, ODA Policy 316.00 and WRAAA specifications for other services. The applicant acknowledges responsibility as to compliance and awareness that failure on its part to comply may constitute sufficient basis for (1) a finding by WRAAA of lack of administrative capability, and (2) imposition by WRAAA of appropriate sanctions.

1. Funds awarded as a result of this proposed request shall be expended for the purposes set forth herein and in accordance with all applicable laws, regulations, policies and procedures of the Western Reserve Area Agency on Aging and the Ohio Department of Aging.
2. The Applicant's employment practices (including recruitment and employment), provision of services, and purchasing or subcontracting of goods and services shall be non-discriminatory in accord with all applicable laws and regulations. The Applicant further assures that no portion of its program(s) for which WRAAA funding is sought will in any way discriminate against, deny benefits to, deny employment to, or exclude from participation any persons on the grounds of race, color, national origin, religion, age, sex, handicap, political affiliation or belief, or any other legally protected classification. Effort shall be made by Applicant to make programs and facilities accessible to eligible qualified handicapped and disabled persons.
3. The Applicant assures that it complies with all federal wage and hour laws, and all workers’ compensation laws.
4. Any proposed changes in the proposal as approved shall be submitted in writing by the Applicant and upon written notification of approval by the WRAAA shall be deemed incorporated into and become part of this Agreement.
5. The Applicant agrees to comply with all provisions of the contract and requirement of Federal and State law.
6. The Applicant understands that funds awarded may be increased or decreased at any time due to changes in Federal or State funding
7. Funds awarded by the Western Reserve Area Agency on Aging [WRAAA] may be terminated at any time for violation of any terms, conditions and/or requirements of this RFP or an Agreement between Applicant and WRAAA.
8. Contractor affirms that it has read and understands Executive Order 2019-12D and Executive Order 2022-02D and shall abide by those requirements in performance of this Agreement. Contractor shall perform no Services required under this Agreement outside the United States, shall not locate State of Ohio data offshore in any way and shall not make purchases from Russian institutions or companies and shall immediately notify ODA of any change or shift in the location(s) of Services performed by Contractor or its sub-recipients under this Agreement. No Service shall be changed or shifted to a location(s) outside the United States.
9. The Assurance obligates the Applicant for the period of their service contract to proceed in good faith and in cooperative effort to bring those services subject to quality assurance which are contracted for into compliance with all applicable quality assurance standards and requirements.
10. The Applicant affirms, understands and will abide by the requirements of Executive Order 2019-12D banning the expenditure of public funds on offshore services issued by Ohio Governor Mike DeWine. The Executive Order is available at the following website: <https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/2019-12d>.

**IF AN ENTITY:**

LEGAL NAME OF APPLICANT AGENCY (TYPE)

SIGNATORY NAME (TYPE)

TITLE OF SIGNATORY (TYPE)

SIGNATURE OF AUTHORIZED OFFICIAL DATE

**IF AN INDIVIDUAL:**

TYPED NAME OF INDIVIDUAL

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

SIGNATURE OF INDIVIDUAL DATE

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# Department Of Health And Human Services Assurances Of Compliance With Section 504 Of THE REHABILITATION Act Of 1973, As Amended

The undersigned (hereinafter called the "Recipient") HEREBY AGREES THAT recipient will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to 84.5(a) of the regulation {45 C.F.R. 84.5 (a)}, the Recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance, including payments or other assistance made after such date on application for federal financial assistance that were approved before such date. The Recipient recognizes and agrees that such federal financial assistance will be extended in reliance on the representation and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the Recipient, Recipient’s successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of and/or as the Recipient.

This Assurance obligates the Recipient for the period during which federal financial assistance is extended to Recipient by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in 84.5(b) of the regulation {45 C.F.R. 84.5(b)}.

The Recipient: {Check (a) or (b)}

a. employs fewer than fifteen persons;

b. employs fifteen or more persons and, pursuant to §84.7(a) of the regulation [45 C.F.R 84.7(a)], has designated the following person(s) to coordinate its efforts to comply with the Health and Human Services regulations:

Name of Designee (Type or Print)

Name of Recipient (Type or Print)

Street Address or P.O. Box

City, State Zip

(IRS) Employer Identification Number

Area Code ‑ Telephone Number

I certify that the above information is complete and correct to the best of my knowledge.

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

Date Signature and Title of Authorized Official

# Certification Regarding Debarment, Suspension and Other Responsibility Matters

**By signing this proposal**, Applicant certifies to the best of its knowledge and belief that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. If Applicant is unable to certify to any of the above, it shall attach an explanation to this agreement. Applicant further agrees that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions" without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

**Certification Regarding Lobbying**

**By signing this proposal**, Applicant certifies, to best of its knowledge and belief, that: (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the subcontract, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the Applicant shall complete and submit Standard Form‑LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. (3) The Applicant shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

**Note**: If Disclosure Forms are required, please contact: Mr. William Sexton, Deputy Director, Grants and Contracts Management Division, Room 341F, HHH Building, 200 Independence Avenue, SW, Washington, D.C. 20201-0001.

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

Date Signature and Title of Authorized Official

# APPLICANT OVERVIEW QUESTIONS

In the space provided below, or on a separate attached sheet, please answer the listed questions. When finished please print all of the pages that include your answers. The space for your response will expand to the length of your response. Applicant shall respond to all questions with information encompassing Applicant’s entire business enterprise.

Please **do not** attach brochures, newspaper clippings or other materials. Points will be deducted for unanswered questions and indirect answers.

| **APPLICANT OVERVIEW QUESTIONS**  **1 - 11** | |
| --- | --- |
|  | Please provide a short description of Applicant, your certifications, and identify new or changing service trends. |
|  | Describe Applicant’s mission and state how the services fit within the Applicant’s mission. Include a copy of the mission statement as an attachment. |
|  | Please describe why Applicant is applying for Alzheimer’s Respite funding. |
|  | Please describe Applicant’s experience serving people with Alzheimer’s Disease and related dementia and their caregivers. |
|  | Please describe the geographic area Applicant will offer the proposed services. Include a list of zip codes that define the service area. |
|  | Please accurately describe the services for which Applicant is seeking funding provide, and describe how you plan to provide them. |
|  | Please state how Applicant’s total budget reflects the itemized costs for the services Applicant is applying to provide. |
|  | Describe the Applicant’s community outreach efforts to caregivers and consumers with the greatest economic and social needs. Explain how the success of this outreach is measured |
|  | Describe the Applicant’s experience in measuring feedback from caregivers on their satisfaction with the service. |
|  | Please affirmatively state whether Applicant is debarred or listed on the non-procurement portion of the General Services Administration’s “Excluded Parties List System” (EPLS); access to the EPLS is readily available on <https://sam.gov/SAM/> |
|  | Please affirmatively state whether Applicant has the ability to perform and will perform according to the requirements contained in the Contract Sample.pdf, should Applicant receive the funding/grant(s) for which application is made. |

**ORGANIZATIONAL CHART ATTACHMENT**

Please submit an organizational chart that identifies staff members involved in the delivery of Alzheimer’s Respite services. The format is not specified but the chart should include:

* Names
* Titles
* Indication of full, part-time or volunteer status
* Clear lines of authority

The chart(s) should include at least all those who are licensed or work in a supervisory or coordinating role. If it is not practical to list the names of all staff members (for example, due to the large number of aides who could potentially perform the services), describe the number of aides and summarize their credentials.

**CONDITIONS OF PARTICIPATION QUESTIONS**

**(Questions 1 – 32)**

Answers to these questions must reflect Applicant’s **current practices**.

Points will be deducted for unanswered questions and indirect answers.

| **CONDITIONS OF PARTICIPATION QUESTIONS**  **Questions 1 - 32** | | | | |
| --- | --- | --- | --- | --- |
| **Organizational Structure** | | **Yes** | **No** | |
|  | Is Applicant a formally organized:  501c3 service agency providing the services applied for?  or a  Formally organized business, providing the services applied for,  and disclosing all entities with five-percent or more ownership? |  |  | |
|  | Does Applicant have written statements defining the purpose of business or service agency, and its policies and directives, bylaws, or articles of incorporation? |  |  | |
|  | Does Applicant have a written table of organization that clearly identifies managers, supervisors, staff and lines of authority? |  |  | |
|  | Does Applicant operate in compliance with all applicable federal, state, and local laws, and have a written statement supporting compliance with: non-discrimination laws, federal wage and hour laws, and workers compensation laws in the recruitment and employment of individuals; non-discrimination laws in the provision of services? |  |  | |
|  | Does Applicant have a written affirmative action plan that is used when posting open positions and making hiring decisions? |  |  | |
| **Personnel** | | **Yes** | **No** | |
|  | Does Applicant have written job descriptions including qualifications for each position involved in the delivery of services? |  |  | |
|  | Does Applicant provide performance appraisals or a development plan for all employed, contract workers, and volunteers involved in providing services? |  |  | |
|  | Does Applicant have a signed and dated document indicating completion of employee orientation including: employee position description and expectations, personnel policies, reporting procedures and policies, an organizational table, and a code of ethics? |  |  | |
| **Policies and Procedures** | | **Yes** | **No** | |
|  | Does Applicant have written procedures regarding business operations and provisions of service? |  |  | |
|  | Does Applicant have written procedures supporting a system to document services delivered, billed, and reimbursed that complies with service specifications described in these application materials? |  |  | |
|  | Does Applicant have a written procedure for reporting and documenting all participant incidents including significant changes that affect service delivery or imminent health or safety risks? |  |  | |
|  | Can you provide evidence detailing financial responsibility in the coverage of consumer loss due to theft, property damage or personal injury? |  |  | |
| **Policies and Procedures (Continued)** | | **Yes** | **No** | |
|  | Does Applicant have written procedures which identify the steps a consumer must take to file a liability claim, including a phone number for the Long Term Care Ombudsman (LTCO)? |  |  | |
|  | Does Applicant have a separate grievance policy and procedure in place for all consumers regarding Alzheimers Respite Services seeking a resolution from their grievance from WRAAA and LTCO? |  |  | |
|  | Does Applicant have a written procedure for follow-up and investigation of consumer complaints and grievances? |  |  | |
|  | Does Applicant maintain a file for each consumer and caregiver which includes: name, address, telephone number, DOB, gender, emergency contact person or caregiver information, functional abilities and limitations relevant to authorized services, demographic data as requested by WRAAA? |  |  | |
|  | Does Applicant maintain documentation of each consumer contact and each service delivered? |  |  | |
|  | Does Applicant obtain written approval from the consumer to release relevant participant information to WRAAA? |  |  | |
|  | Does Applicant utilize a designated locked storage space for consumer records? |  |  | |
|  | Does Applicant have a policy to ensure that the confidentiality of information about older persons is protected? |  |  | |
|  | Does Applicant retain all consumer records for at least three years or until an audit is completed? |  |  | |
|  | Does Applicant provide the opportunity for consumer to make voluntary contributions for services? |  |  | |
|  | Does Applicant have a procedure to administer cost-sharing with consumers? |  |  | |
|  | Does Applicant conduct consumer/caregiver satisfaction surveys? |  |  | |
| **Compliance** | | **Yes** | **No** |
|  | Is Applicant willing to deliver services in compliance with service provisions for providers? |  |  |
|  | Is Applicant willing to maintain documentation demonstrating that all service provisions have been met when delivered either directly or by sub-contract? |  |  |
|  | Is Applicant willing to allow access to ODA, AAA, and other representatives with a need to access the Applicant’s facility, policies, procedures, records, and other documents related to the provision of Alzheimer’s Respite services? |  |  |
|  | Does Applicant comply with Rule 173-9regarding background checks and database reviews of direct service workers? |  |  |
|  | Is Applicant willing to allow ODA and/or AAA monitors to access the criminal background reports of staff members? |  |  |
| **Additional Terms** | | **Yes** | **No** |
|  | Is Applicant willing to cooperate with the AAA and ODA to assess the extent of a disaster impact upon persons aged sixty years and over, and to coordinate with public and private resources in the field of aging in order to assist older disaster victims, whenever the President of the United States declares that the service area is a disaster area? |  |  |
|  | Does Applicant immediately notify the appropriate authorities once Applicant has reasonable cause to believe that a Consumer is the victim of abuse, neglect or exploitation? |  |  |
| **Applicant Comments** | | | |
|  | Please provide a brief written explanation regarding each question for which a “NO” response was given: | | |

**ADULT DAY SERVICE QUESTIONS**

**(Questions 1 to 48)**

The following questions are required for those Applicants applying for ***Alzheimer’s Respite* *Adult Day******Services***. Please read Rule 173-3-06.1 for Adult Day Service Specifications.

Adult Day Service (ADS) means a regularly-scheduled service delivered at an ADS center, which is a non-institutional, community-based setting. ADS includes recreational and education programming to support an individual’s health and independence goals; at least one meal, but no more than two meals per day; and sometimes, health status monitoring, skilled therapy services, and transportation to and from the ADS center..

Alzheimer’s Respite eligibility criteria:

* Caregiver of an individual of any age with Alzheimer’s disease or a related disorder
* For Alzheimer’s Respite, the caregiver must be relieved from providing care i.e. caregiver must provide care to the individual with Alzheimer’s or a related dementia to be eligible. The assessment should include the type and frequency of care provided.
* For the purpose of Alzheimer’s Respite, the term “frail” means a person who is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual. In this context, “frail” has the same meaning as “at risk of institutionalization.”

The ADS must provide respite to a family caregiver of a consumer with a diagnosis of Alzheimer’s or related dementia.

A unit of ADS is a four to eight hour day. A unit of ADS does not include the transportation service, even if the consumer is transported to or from the ADS facility by the ADS provider.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

|  | **ADULT DAY SERVICE QUESTIONS**  **Questions 1 to 48** | | | | | **Yes** | **No** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Level of Adult Day Services (Rule 173-3-06.1)** | | | | | | |
|  |  | Is Applicant applying to provide: | | | |  |  |
|  |  | Basic ADS only? | | | |  |  |
|  |  | Enhanced and Basic ADS only? | | | |  |  |
|  |  | Intensive, Enhanced and Basic ADS? | | | |  |  |
|  | **Purpose of Alzheimer’s Respite Adult Day Services** | | | | | | |
|  |  | Is the Adult Day Program provided by Applicant designed to meet the needs of consumers with Alzheimer’s or related dementia? | | | |  |  |
|  |  | Describe how: | | | | | |
|  |  | Does your Adult Day Program encourage optimal capacity for self-care or maximize the functional abilities of consumers. | | | |  |  |
|  |  | Describe how. | | | |  |  |
|  |  | Is the Adult Day Program designed to provide respite for the consumer’s caregiver? | | | |  |  |
|  |  | Describe how and what activities caregivers are able to participate in as a result: | | | | | |
|  |  | **Does the Applicant track outcomes of the Adult Day Program, and the satisfaction of each consumer and his/her caregiver?** | | | | | |
|  |  | Describe the outcomes you measure: | | | | | |
|  |  | Are the Adult Day Program staff members trained to understand the unique needs of consumers with Alzheimer’s or other related dementia? | | | |  |  |
|  |  | Describe your training course and/or methods: | | | | | |
|  |  | Describe how effective your outreach has been in the past (for example, how many new consumers were enrolled in the past 12 month? If you have a waiting list, how many individuals are on it?) | | | | | |
|  | **Facility** | | | | | | |
|  |  | What is/are the address(es) of the Adult Day site(s)? | | | | | |
|  |  | | |  |  | | |
|  |  | What is the *maximum* number of consumers to be present at one time at this Adult Day site: | | | | | |
|  |  | | |  |  | | |
|  |  | Does your facility maintain a staff to consumer ratio of at least one (1) staff member to every six (6) consumers at all times? | | | |  |  |
|  |  | Does your facility have a separate, identifiable space available for ADS activities, with at least sixty square feet (excluding hallways, offices, rest rooms and storage areas) per consumer? | | | |  |  |
|  |  | What is the total square footage available for Adult Day programming at each site? | | | | | |
|  |  | Does your facility comply with the American with Disabilities Act (ADA) Accessibility Guidelines for Buildings and Facilities? | | | |  |  |
|  |  | Does your facility have at least one (1) working toilet for every ten (10) consumers, and at least one (1) wheelchair-accessible toilet? | | | |  |  |
|  |  | What is the number of working toilets? | | | | | |
|  |  | What is the number of wheel-chair accessible toilets? | | | | | |
|  |  | Does your facility have a locked area in which consumers’ medications are kept at the appropriate temperature that meets the storage requirements of the medications? | | | |  |  |
|  |  | Are toxic substances stored in an area that is inaccessible to the consumers? | | | |  |  |
|  |  | **If requesting funding for intensive ADS**: Does your facility have bathing facilities suitable to the needs of individual consumers? | | | |  |  |
|  |  | Does Applicant develop and annually review a fire inspection and emergency safety plan? | | | |  |  |
|  |  | Does Applicant post evacuation procedures in prominent locations throughout the facility? | | | |  |  |
|  |  | Does Applicant conduct evacuation drills at least quarterly when consumers are present and retain records which include the date and time of the drills? | | | |  |  |
|  |  | What were the dates of your last three (3) evacuation drills? | | | | | |
|  |  | Does your facility retain records of routine maintenance and annual inspections of each fire extinguisher and smoke alarm in the facility? | | | |  |  |
|  |  | Who provides maintenance? | | | | | |
|  |  | Who performs the inspections? | | | | | |
|  |  | What was the date of the last inspection? | | | | | |
|  | **Adult Day Service Consumer Management** | | | | | | |
|  |  | Does Applicant conduct an initial assessment of each consumer which includes the functional and cognitive profiles that identify the ADL’s and IADL’s that require attention or assistance of the ADS center staff and the social profile (Major life events, caregiver data, behavior patterns, etc.)? | | | |  |  |
|  |  | When is the initial assessment completed? | | | | | |
|  |  | Does Applicant perform an initial health assessment which identifies the psychosocial needs, risk factors, diet and medications? | | | |  |  |
|  |  | Describe the qualifications of the individual who performs these assessments for Applicant. | | | | | |
|  |  | When is the health assessment completed? | | | | | |
|  |  | Does Applicant create an Activity Plan that addresses the consumer’s strengths, needs, problems or difficulties, goals, objectives and a plan to achieve them? | | | |  |  |
|  |  | What are the title and qualifications of the individual who develops Applicant’s Activity Plans: | | | | | |
|  |  | When is the Activity Plan completed? | | | | | |
|  |  | Does Applicant conduct interdisciplinary care conferences for each consumer at least once every six months and create a plan as a result of the conference? | | | |  |  |
|  |  | Describe the titles and credentials of the individuals who routinely participate in the interdisciplinary care conferences: | | | | | |
|  |  | Are the consumer and his/her caregiver invited to attend the care conference? Please estimate the percentage of the care conferences in which the caregiver attended or phoned in during the past year. | | | | | |
|  |  | Does Applicant maintain of authorization from a licensed healthcare professional whose scope of practice includes making plans of treatment prior to administering medications or meals with a therapeutic diet, nursing services, nutrition counseling, physical therapy or speech therapy? | | | |  |  |
|  | **Adult Day Service Programming** | | | | | | |
|  |  | If Applicant provides the transportation service, does it comply with Rule 173-3-06.6? | | | | | |
|  |  | Describe the means of transportation that consumers use to travel to and from your facility. | | | |  |  |
|  |  | Are consumer activities planned and supervised by an Activity Director who is employed by Applicant? | | | |  |  |
|  |  | Does Applicant post the daily and monthly planned activities in prominent locations throughout the facility? | | | |  |  |
|  |  | Does Applicant ensure that at least two (2) staff members are present in the ADS activity area whenever more than one (1) consumer is present? | | | |  |  |
|  |  | Does Applicant ensure that at least one (1) of the two (2) staff members is a paid personal care staff member? | | | |  |  |
|  |  | Does Applicant ensure that at least one (1) of the two (2) staff members is certified  in CPR? | | | |  |  |
|  |  | Does Applicant provide lunch and snacks to each consumer who is present during serving times, and comply with Rule 173-4-05 of the Administrative Code? | | | |  |  |
|  |  | Does Applicant maintain a daily sign-in sheet that documents the date of service, the consumer’s name, arrival and departure times, mode of transportation, and the consumer’s signature? | | | |  |  |
|  |  | Is Applicant able to provide structured activity programming, health assessments, and supervision of one or more ADL? | | | |  |  |
|  |  | **If requesting funding for Enhanced ADS:** Is Applicant able to provide the components of Basic ADS plus hands-on assistance with one or more ADL (excluding bathing), supervision of medication administration, assistance with medication administration, comprehensive therapeutic activities, intermittent monitoring of health status, and hands-on assistance with personal hygiene activities (excluding bathing)? | | | |  |  |
|  |  | **If requesting funding for Intensive ADS:** Is Applicant also able to provide the components of Enhanced ADS plus provide hands-on assistance with two or more ADLs regular monitoring of health status, hands-on assistance with personal hygiene activities (including bathing, if needed), social work services, skilled nursing services (i.e. dressing changes), and rehabilitative services, including physical therapy, speech therapy, and occupational therapy? | | | |  |  |
|  | **Adult Day Services Staff Qualifications** | | | | | | |
|  |  | Does Applicant ensure that an RN or LPN (under RN supervision) is on-site whenever a consumer who receives enhanced ADS or intensive ADS requires services within the nurse’s scope of practice? | | | |  |  |
|  |  | Do all members of your Applicant’s ADS staff possess a current and valid license to practice their profession? | | | |  |  |
|  |  | Name the licensed individuals on the ADS staff, the type of license that they hold, and the expiration date of their current license to practice in their profession: | | | | | |
|  |  | Does the activity staff person who directsconsumer activities meet the requirements of 173-3-06.1B(5)(b)(ii)? | | | |  |  |
|  |  | Name the activity staff person who directs consumer activities, and describe their qualifications: | | | | | |
|  |  | Does the activity staff person(s) who leads or assists consumer activities meet the requirements of 173-3-06.1 B (5)(b)(ii)? | | | |  |  |
|  |  | Name all the activity staff persons who lead or assist consumer activities, and describe their qualifications: | | | | | |
|  |  | Do all other personal-care staff meet the requirements of 173-3-06.1 B(5)(b)(iv)? | | | |  |  |
|  |  | Name all the other personal-care staff persons and describe their qualifications: | | | | | |
|  | **Adult Day Services Staff Training** | | | | | | |
|  |  | Before each new personal care staff member provides ADS, does Applicant provide the following training and document the staff member’s completion of:  a. Orientation training including expectation of employees, Applicant’s ethical standards, an overview of personnel policies, incident reporting procedures, universal precautions for infection control, and description of organization and lines of communication?  b. Task-based instruction, which includes the instructor’s title, qualifications, and signature’ the date and time of instruction; the content of the instruction, and the name and signature of the personal care staff member completing the instruction? | | | |  |  |
|  |  | Does Applicant provide and document at least eight hours of in-service or continuing education on appropriate topics each calendar year? | | | |  |  |
|  |  | Describe your in-service or continuing education program: | | | | | |
|  |  | Does Applicant ensure that the caregiver meets the definition of caregiver? | | | | | |
|  |  | Does Applicant have a standard for assessing the caregiver’s needs? | | | | | |
|  |  | Does this assessment include the caregiver’s involvement and acceptance of the care plan? | | | | | |
|  |  | Does Applicant offer any specific programs for caregivers? | | | | | |
|  |  | How often are these programs offered to the caregiver? | | | | | |
|  |  | Describe the programs offered: | | | | | |
|  |  | If the caregiver was not involved, would the consumer be “at risk of institutionalization?” | | | | | |
|  | **Comments** | | | | | | |
|  |  | | Comments and explanations of any ‘No’ answers: *Please indicate question number with response* | | | | |

**INSTITUTIONAL CARE SERVICE QUESTIONS**

**(Question 1 to 25)**

The following questions are required for those Applicants applying for Alzheimer’s Respite Institutional Care Services.

Institutional Care means respite care for 24 hours or more in a hospital or other institutional setting.

The Institutional Care Service must provide respite to a family caregiver of a consumer with a diagnosis of Alzheimer’s or related dementia.

A unit of Institutional Care is a twenty-four hour day.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

|  | **INSITUTIONAL CARE SERVICE QUESTIONS**  **Questions 1 to 25** | | | | **Yes** | | **No** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Purpose of Alzheimer’s Respite Institutional Services** | | | | | | |
|  | |  | Is the Institutional Care Program provided by Applicant designed to meet the needs of consumers with Alzheimer’s or related dementia? | | |  |  | |
|  | |  | Describe how: | | | | | |
|  | |  | Is the Institutional Care Program designed to provide respite for the consumer’s caregiver? | | |  |  | |
|  | |  | Describe how and what activities caregivers are able to participate in as a result: | | | | | |
|  | |  | Are the Institutional Care Program staff members trained to understand the unique needs of consumers with Alzheimer’s or other related dementia? | | |  |  | |
|  | |  | Describe your training course and/or methods: | | | | | |
|  | |  | Describe how Applicant will continue the provision of this service in the event of an emergency. | | | | | |
|  | | **Facility** | | | | | | |
|  | |  | What is the address of the Institutional Care site? | | | | | |
|  | |  | What is the *maximum* number of consumers to be present at one time at this Institutional Care site: | | | | | |
|  | |  | Describe the staff to consumer ratio. | | |  |  | |
|  | |  | Does your facility have a separate, identifiable space available for activities, with at least sixty square feet (excluding hallways, offices, rest rooms and storage areas) per consumer? | | |  |  | |
|  | |  | Does your facility comply with the American with Disabilities Act (ADA) Accessibility Guidelines for Buildings and Facilities? | | |  |  | |
|  | |  | Does Applicant provide meals and snacks which are planned by a Licensed Dietician? | | |  |  | |
|  | |  | Does your facility have a locked area in which consumers’ medications are kept at the appropriate temperature that meets the storage requirements of the medications? | | |  |  | |
|  | |  | Are toxic substances stored in an area that is inaccessible to the consumers? | | |  |  | |
|  | |  | Does Applicant develop and annually review a fire inspection and emergency safety plan? | | |  |  | |
|  | |  | Does Applicant post evacuation procedures in prominent locations throughout the facility? | | |  |  | |
|  | |  | Does Applicant conduct evacuation drills at least quarterly and retain records which include the date and time of the drills? | | |  |  | |
|  | | a. | What were the dates of your last three (3) evacuation drills? | | | | | |
|  | |  | Does your facility retain records of routine maintenance and annual inspections of each fire extinguisher and smoke alarm in the facility? | | |  |  | |
|  | |  | Who provides maintenance? | | | | | |
|  | |  | Who performs the inspections? | | | | | |
|  | |  | What was the date of the last inspection? | | | | | |
|  | | **Institutional Care Consumer Management** | | | | | | |
|  | |  | Does Applicant conduct an initial assessment of each consumer which includes the functional and cognitive profiles that identify the ADL’s and IADL’s that require attention or assistance, a social profile, psychosocial needs, risk factors, diet and medication? | | |  |  | |
|  | |  | When is the initial assessment completed? | | | | | |
|  | |  | Does this assessment include the caregiver’s involvement? | |  | |  | |
|  | |  | Describe the qualifications of the individual who performs these assessments for Applicant. | | | | | |
|  | |  | Does Applicant maintain authorization from a licensed healthcare professional whose scope of practice includes making plans of treatment prior to administering medications or meals with a therapeutic diet, nursing services, nutrition counseling, physical therapy or speech therapy? | | |  |  | |
|  | |  | Does Applicant provide or arrange for transportation to the Alzheimer’s Respite Institutional Care Program? | | |  |  | |
|  | |  | Does Applicant post the daily and monthly planned activities in prominent locations throughout the facility? | | |  |  | |
|  | | **Institutional Care Services Staff Qualifications and Training** | | | | | | |
|  | |  | Do all members of your Applicant’s Institutional Care staff possess a current and valid license to practice their profession? | | |  |  | |
|  | |  | Name the licensed individuals, the type of license held, and the expiration date of their current license to practice in their profession: | | | | | |
|  | |  | Are consumer activities planned and supervised by an Activity Director who is employed by Applicant? | | |  |  | |
|  | |  | Name the activity staff person who directs consumer activities, and describe their qualifications: | | | | | |
|  | |  | Name all the activity staff persons who lead or assist consumer activities, and describe their qualifications: | | | | | |
|  | |  | Summarize which Institutional Care staff are certified in CPR. | | | | | |
|  | |  | Before each new personal care staff member provides care, does Applicant provide the following training and document the staff member’s completion of:  a. Orientation training including expectation of employees, Applicant’s ethical standards, an overview of personnel policies, incident reporting procedures, universal precautions for infection control, and description of organization and lines of communication?  b. Task-based instruction, which includes the instructor’s title, qualifications, and signature’ the date and time of instruction; the content of the instruction, and the name and signature of the personal care staff member completing the instruction? | | |  |  | |
|  | **Comments** | | | | | | |
|  |  | | | Comments and explanations of any ‘No’ answers: *Please indicate question number with response* | | | |

# ALZHEIMER’S RESPITE REIMBURSEMENT QUESTIONS

**(Questions 1 of 6)**

***Alzheimer’s Respite Reimbursement Questions***

In the space provided below please answer the listed questions.

Please **do not** attach Agency brochures, newspaper clippings or other materials. All questions must be answered as instructed.

|  |  |
| --- | --- |
|  | **Alzheimer’s Respite Reimbursement**  **Questions 1 to 6** |
| 1. 1 | Describe your Agency’s Respite Reimbursement Program. |
| 1. 2 | Describe your Agency’s outreach plan including the process for assisting consumers with the greatest economic and social needs with particular attention to consumers who are low-income, who are low-income minorities, who have limited proficiency in English language, who reside in rural areas, and who are at risk for institutional placement. |
| 1. 3 | Describe how your Agency determines service eligibility: |
| 1. 4 | Describe how your Agency allocates funds to clients; who gets what and how is that decision made? |
| 1. 5 | Describe the type of respite services provided through the respite funds. |
| 1. 6 | List all staff members (include credentials and/or relevant training) that will participate in the delivery of these services; what will each be doing? |

# APPENDIX A: PRIORITY POPULATION DEFINITIONS

**For Alzheimer’s Respite Contracts**

WRAAA requires that providers target services to priority populations within a defined geographic area of service and record demographic data in order to track progress toward goals.

* **Minority Status:** 
  + **American Indian or Alaskan Native**
  + **Asian**
  + **Hispanic or Latino**
  + **Black or African American**
  + **Native Hawaiian or Other Pacific Islander**
* **In Poverty** – Those whose income is at 100% of, or below, the official poverty guideline.
* **Disabled** – A person with mental or physical impairment, or a combination of mental or physical impairments, that result in substantial functional limitations in 1 or more of the following areas of major life activity: (A) self-care, (B) receptive and expressive language, (C) learning, (D) mobility, (E) self-direction, (F) capacity for independent living, (G) economic self-sufficiency, (H) cognitive functioning, and (I) emotional adjustment.
* **Rural** – A person living in any area that is not urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.
* **Living Alone** – A person living in a one-person household, where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.
* **Frail** – A person who is unable to perform at least two activities of daily living (bathing, dressing, toilet use, eating, walking, and transfer - for example, from bed to chair) without substantial human assistance, including verbal reminding, physical cueing, or supervision. In this context, ‘Frail’ has the same meaning as ‘At Risk of Institutionalization’.

**APPENDIX B: CONTRACT WORKBOOK (EXCEL) INSTRUCTIONS**

All the templates are contained in one Excel document, **ContractWorkbook.xls**.

***INSTRUCTIONS (First Tab):*** Click on this tab to open a sheet with tips on navigating through and entering your information into the templates.

**STEP 1: COMPLETE THE APPLICANT INFORMATION *SHEET* (Second Tab)**

Click on the second tab at the bottom of the Excel workbook, entitled ‘The Applicant Information Sheet,” to open this sheet*.* All Applicants are required to submit contact information on the Applicant Information Sheet.

A hard copy of the final Applicant Information Sheet must be printed and attached to the proposal packet. There are two sections:

*A. Applicant Information:* Provide the **legal name** of the Applicant. Your mailing address should include the zip code with 4-digit extension. You may use the drop-down box for the Applicant’s county. Provide the name and other details for your Proposal Contact. This should be the person who administers and is very knowledgeable about the details of your program.

*B. Requested Services:* Use the drop-down boxes to list each service you are applying to provide.

Save your work before moving on. ***One Set of Service Pages includes an Alzheimer’s Respite Contract Service Page (CSP), Alzheimer’s Respite Cost of Service Detail Page, and Alzheimer’s Respite Sources of Revenue and Narrative Page.*** A set must be completed for each proposed service. If a service is proposed to be provided in more than one county, a separate set must be completed for each county. Two (2) **CSP, Cost of Service Detail and Sources of Revenue and Narrative page sets are provided in the Excel Workbook ContractWorkbook.xls.**  If more are needed, a second copy of **ContractWorkbook.xls** may be downloaded and saved under a different file name.

It is helpful to think of the *Contract Service Page* as a summary or overview of the service proposal. The *Cost of Service Detail Page* provides supporting information in the form of a breakdown of expense categories. The *Sources of Revenue and Narrative Page* provides supporting information for the revenue streams, and a place to provide narrative, describe cost saving initiatives, and document any anticipated changes that may affect your projections.

A hard copy of the final *Contract Service Page, Cost of Service Detail Page, and Sources of Revenue and Narrative Page Sets* must be printed and attached to the proposal packet.

Please note that some data is linked between the pages within the set. This is to ensure consistency of the numbers on the pages. It is helpful to enter data in the order described on the next pages. Cells are locked (ie, data cannot be entered into them) if the value is calculated or linked to another page.

**STEP 2: FILL OUT *SECTION A OF THE CONTRACT SERVICE PAGE* (Third Tab)**

Click on the third tab at the bottom of the Excel workbook, entitled ‘CSP’, to open the next worksheet. You do not have to re-enter the Applicant name on the *Contract Service Page, Cost of Service Detail Page, or Sources of Revenue and Narrative Page*. The Applicant Name will populate at the top of each page, based on the legal name as entered on Line A1 of the Alzheimer’s Respite *Applicant Information Sheet*.

**Section A.** SERVICE GOAL STATEMENT

Refer to the Application Overview and the Rules posted at [http://aging.ohio.gov](http://aging.ohio.gov/information/rules/current.aspx) for service specifications, service definitions and unit of service measures.

**1**. **Line A1: Service County**

Indicate the County to be served. If the Applicant is serving more than one county, a contract service page set must be created for each county. ‘County’ is determined by the residential address of the consumer.

* 1. **Line A2: Funding Category**

Alzheimer’s Respite: This is completed for you.

* 1. **Line A3: Service Name and Code**

Choose from a drop down menu.

* 1. **Line A4: Service Definition**

See service definitions and choose the unit definition that corresponds with the service

* 1. **Line A5: Total Units Provided with Total Service Budget on Line D8**

Care should be taken to reasonably project the number of service units, since WRAAA requires delivery of 100% of the contracted units in order to be eligible for receipt of 100% of the Alzheimer’s Respite award.

Units of Service may be determined by using any of the two methods described below:

1. Calculations based on actual annual operating experience and/or projected service expansion.

ii. Calculations based on the average number of incremental units that are proposed to be provided with Alzheimer’s Respite funding per day, multiplied by the number of service days in the contract year. For a five day a week service, use 250 contract days (5 days / week x 52 weeks / year minus 10 holidays = 250 contract days). The formula is:

**Average incremental ALZ Respite Units/Day** X **Number of Service Days/Year** = **Total ALZ Respite Units/Year\***

**\*NOTE:** Other factors may need to be considered for each service and Applicant (e.g., consumer turnover).

The number should include only the incremental units proposed to be supported with Alzheimer’s Respite funds. Do not include units supported primarily through other means (for example, PASSPORT or private pay).

* 1. **Line A6: Total Projected Unduplicated Clients to be Served**

Alzheimer’s Respite services benefit both the caregiver and the care Recipient. For these services, consider the caregiver as the consumer. The Care Recipient is the person who has been diagnosed with Alzheimer’s disease or related Dementia.

1. Base estimates of projected unduplicated Alzheimer’s Respite clients to be served on actual operating experience and/or projected outreach and service expansion.
2. Determine the average number of units each Alzheimer’s Respite client is projected to receive per year and divide into the total units, which equals unduplicated client count. The formula is:

**Total ALZ Respite Units** / **Average Units per ALZ Respite Client** = **Projected** **Unduplicated Clients**

1. **Line A7a-k: Total Projected Unduplicated Clients to be Served in each Priority Population**

Project the number of clients to be served according to the stated Priority Population characteristics. Refer to the definitions of the Priority Populations in Appendix A. Do not report as a percentage.

1. **Line A8a and b: Number and Percent of Unduplicated Clients from Line A6 not Classified in any of the above Priority Population categories.**

Input the projected number of unduplicated clients who do **not** qualify for Priority Population status. The percent of the total unduplicated clients who do not qualify for Priority Population status will be calculated. Outreach should be focused on Priority Populations; optimally, the calculated percentage will be lower than the overall demographics for the community indicate.

1. **Line A9: Amount of Donation Suggested for Service**

This suggested donation amount (per unit of service) should be posted or published to encourage donations, which are reported in aggregate as Program Income on Line B5. The suggested donation amount should be provided in your service description literature.

1. **Line A10: Hours of Service**

Indicate the actual hours that the service is offered. For example, an Adult Day Service may be provided from 10:00 AM to 3:00 PM on Monday – Friday.

1. **Line A11: Location of Service Delivery**

Indicate the facility where the Alzheimer’s Respite service is to be delivered; multiple facilities may be listed if the service is proposed to be offered at several sites.

**STEP 3: COMPLETE THE *COST OF SERVICE DETAIL PAGE* (Fourth Tab)**

At this point, it is recommended that the Contract Service Page be saved. Click on the next tab entitled ‘COST’ to open the *Cost of Service Detail worksheet*. Here, the total service budget for the number of units proposed to be served with Alzheimer’s Respite funding (on Line A5 of the Contract Service Page) can be built up from its cost elements. The cells where data can be entered are outlined in bold.

The Applicant’s name, Service Name and Code, and Service County will populate the top of the Cost of Service Detail worksheet from data entered in the previous CSP.

The Cost of Service Detail documents the expenses associated with providing the service. This includes staff salary, wages and benefits, program supplies and materials, and all other expenses incurred while providing the Alzheimer Respite service. Similar expenses can be grouped together. However, a reasonable portrayal of the costs associated with the provision of the service should be shown. The categories are discussed in more detail below.

**Cost allocation formulas must be developed, documented and utilized when cost items are chargeable to more than one funding source or program budget. The percentage applicable to Alzheimer’s Respite units can be entered into the Cost of Service Detail page. (The basis for the percentage does not need to be submitted with this application, but should be retained and available for later financial audit review.)**

Costs of non-Alzheimer’s Respite funded programs or services should not be reflected in the Unit Cost Detail.

**Category**

*Direct Service Staff:* List titles and indicate if full-time, part-time or volunteer. Direct Service Staff includes only those who work directly with the clients (for example, Adult Day Activity Coordinator, Registered Nurse, Home Health Aides). Enter the annual wages or salary of the direct staff. Estimate the % of their time allocated to provide the proposed units of Alzheimer’s Respite service. The spreadsheet will calculate the total dollars of their salary allocated to providing this Alzheimer Respite service.

*Direct Service Benefits:* List the titles of those Direct Service Staff who receive benefits, and the annual cost of those benefits. Indicate the % of their time allocated to provide the proposed units of Alzheimer’s Respite service.

*Supplies and Materials:* List similar types of supplies and materials that are consumed in your program or while providing your service (For example, Adult Day Service would consume craft supplies), Estimate the annual cost for those supplies, and indicate the percentage that would be consumed in support of the proposed Alzheimer’s Respite units.

*Service Travel and Transportation:* List the annual cost of travel related to your service. For Adult Day Service, this may include travel for training or supervision of several sites, but it should not include Transportation of your clients to your site.

*Other Direct Service Costs:* List other broad groups of other costs that you incur. For example, Adult Day programs will incur meal, rent and utility costs for the site.

*Indirect Administrative Staff:* List the titles, and indicate if full-time, part-time or volunteer, for staff members who support the provision of service indirectly. This may include a director, an A&D entry clerk, and staff in Finance who prepare the Request for Payment.) Enter the annual cost of salary and wages. Estimate the % of their time allocated to support the proposed units of Alzheimer’s Respite service.

*Indirect Administrative Staff Benefits:* List the titles of those indirect service staff who receive benefits. Enter the annual cost of those benefits. Estimate the % of their time allocated to support the proposed units of Alzheimer’s Respite service.

*Other Indirect Costs:* List other broad groups of other costs that you incur, for example, the cost of liability insurance.

The Total Cost Allocated to this Alzheimer’s Respite Service will be calculated. The data will also populate the Unit Cost Detail in Section D of the Contract Service Page.

Save your work, and click on the Third Tab entitled ‘CSP’ and return to the Contract Service Page. Review the data in Section D, Unit Cost Detail. Ensure that the calculated Total Service Budget,

Cost / Unit, and Percentages are accurate. If needed, return to the *Cost of Service Detail Page* to make corrections.

**STEP 4: FILL OUT SECTION B OF THE *CONTRACT SERVICE PAGE* (Third Tab)**

Now that the Total Service Budget has been built up from cost components, the Proposed Revenue Sources (Section B of the CSP) can be developed.

1. **Line B1: Alzheimer’s Respite Funds**

Enter the amount of funds that you are requesting from WRAAA for the provision of the units of service described in Section A.

1. **Line B2 and B3:**

These lines are not required for Alzheimer’s Respite funding.

1. **Line B5: Program Income (Required)**

This is the estimated aggregate amount of donations received through the term of the contract. All services require the ability and willingness to collect Program Income. A value larger than $0.00 must be entered on this line.

1. **Line B6: Client Cost Share (Optional)**

Under Alzheimer’s Respite funding, Client Cost Share is allowable and encouraged (but not required) for Adult Day Service and Institutional Care. If a cost share procedure is utilized, the aggregate amount of funds received from the sliding fee scale invoices should be projected and entered. If cost sharing is practiced, the procedure must comply with Rule 173-3-07.

1. **Line B7: Other Funds (Optional)**

If funds from other sources are utilized to provide the service, they should be reported here.

**STEP 5: ENSURE THAT THE TOTAL SERVICE BUDGET BALANCES**

The Total Service Budget is calculated by adding the Proposed Revenue Sources together on Line B8. It should be compared to the Total Service Budget calculated by adding the Cost of Service data on Line D8. **Adjustments must be made so that the Total Service Budget is the same whether calculated from the Proposed Revenue Sources or Cost of Service data.** The spreadsheet will indicate if Lines B8 and D8 agree and will provide a warning message when Lines B8 and D8 are not the same.

**Do not proceed until Lines B8 and D8 of the Contract Service Page agree.**

Once Lines B8 and D8 agree, save your work.

**STEP 6: COMPLETE THE SOURCES OF REVENUE AND NARRATIVE PAGE (Fifth Tab)**

Click on the fifth tab at the bottom of the workbook, entitled ‘REV’, to open the *Revenue Sources and Narrative Page*. The cells will populate from data on the CSP page. Provide concise narrative in the cells outlined in bold.

**STEP 7: COMPLETE A SET OF FORMS FOR EACH ADDITIONAL SERVICE**

Click on the sixth tab at the bottom of the workbook to open a new Contract Service Page entitled ‘CSP2’. Repeat STEPS 2 – 6 for each additional service that you propose to provide with Alzheimer’s Respite Funding, using the associated tabs ‘COST2’ and ‘REV2’.

Total funding is allocated via formula between the counties. Therefore, if you propose to serve the residents of more than one county, repeat STEPS 2 – 6 for the funding requested for each additional county.

For example, an Applicant proposes to provide Adult Day Service in Cuyahoga and Lorain counties. Two (2) sets of forms would need to be provided: Adult Day Service for Cuyahoga and Adult Day Service for Lorain.

If you need more sets of the forms, download another copy of the worksheet and save it with a different name.

**APPENDIX C: STANDARD AFFIRMATION AND DISCLOSURE FORM**

APPENDIX B

STANDARD AFFIRMATION AND DISCLOSURE FORM

Contractor affirms, understands, and will abide by the requirements of Executive Order 2019-12D and Executive Order 2022-02D regarding the prohibitions of performance of offshore services, locating State data offshore in any way, or purchasing from Russian institutions or companies, and both the Contractor and any subcontractor(s) shall comply with this prohibition.

The Contractor shall provide all the name(s) and location(s) where services under this Contract will be performed and where data is located in the spaces provided below or by attachment. Failure to provide this information may result in no award. If the Contractor will not be using subcontractors, indicate “Not Applicable” in the appropriate spaces.

1. Principal location of business of Contractor:

(Address) (City, State, Zip)

Name/Principal location of business of subcontractor(s):

(Name) (Address, City, State, Zip)

2. Location where services will be performed by Contractor:

(Address) (City, State, Zip)

Name/Location where services will be performed by subcontractor(s):

(Name) (Address, City, State, Zip)

3. Location where state data will be located, by Contractor:

(Address) (City, State, Zip)

Name/Location(s) where state data will be located by subcontractor(s):

(Name) (Address, City, State, Zip)

Contractor also affirms, understands, and agrees that Contractor and its subcontractors are under a duty to disclose to ODA any change or shift in the principal location of business and location of services performed by Contractor or its subcontractors before, during and after execution of any contract with ODA. Contractor agrees it shall notify ODA immediately of any such change or shift in location of its services of the Contractor or its subcontractors. ODA has the right to immediately terminate the contract, unless a duly signed waiver from ODA has been attained by the Contractor to perform the services outside the United States.

On behalf of the Contractor, I acknowledge that I am duly authorized to execute this Affirmation and Disclosure form and have read and understand that this form is a part of any Contract that Contractor may enter into with ODA and is incorporated therein.

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contractor Signature, Title, and Date

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