APPENDIX G2

SERVICE PROVIDER APPLICATION

FORMATS

Provider Name: _____

Contract Period: _____

Funds Requested: _____

Contents

A. PROGRAM MODULE

A.I. SERVICE PROVIDER SUMMARY INFORMATION

PSA:__

ORIGINAL SUBMISSION [ ]
REVISION [ ]

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

6. FUNDS REQUESTED:

[ ] OAA Title IIIB	[ ] CCE	[ ] CCPE
[ ] OAA Title III-C1	[ ] HCE	[ ] OTHER (SPECIFY)
[ ] OAA Title III-C2	[ ] ADI	
[ ] OAA Title IIID	[ ] LSP	
[ ] OAA Title IIIE	[ ] Contracted Services	
[ ] OAA Title VII	[ ] HCBS	
[ ] USDA	[ ] EHEAP	

7. SERVICE AREA: [ ] Single County _____
[ ] Multi county: List:

Selected Communities of a County. Specify:

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

9. CERTIFICATION BY AUTHORIZED AGENCY OFFICER:

I hereby certify that the contents of this document are true, accurate and complete statements. I acknowledge that intentional misrepresentation or falsification may result in the termination of financial assistance.

Name:_____ Signature:

Title:_____ Date:

A. II. GENERAL INFORMATION

A.II.1. NEEDS ASSESSMENT: (Describe the methods used to determine service needs in the area. Include process and use of waiting list information. The DOEA contract Client Services Manual should be reviewed for specific program requirements)

A.II.2. TARGETING: (Specify how the service needs of low-income minority individuals and older individuals residing in rural areas will be satisfied. Include how your agency will provide services to low-income minority individuals in accordance with their need for services rather than in proportion to their percentage of the population. A summary of other targeting efforts directed at groups included in the Older Americans Act should also be included. The DOEA Client Services Manual should be reviewed for requirements)

A.II.3. ELIGIBILITY AND ASSESSMENT/REASSESSMENT PROCESS, WHEN APPLICABLE TO THE SERVICE:(The DOEA Client Services Manual should be reviewed for specific program requirements) The agency's plan for each of the following must be addressed: (a) targeting and screening frail at risk seniors for eligibility for DOEA funded programs; (b) reviewing ongoing eligibility for transfer of consumers from general revenue funded programs into the Medicaid Waiver; (c) using all other available alternative resources for consumer services prior to using general revenue or federal funds; and (c) ensuring that assessments and reassessments are completed in a timely manner and entered accurately into CIRTS.

A.II.4. DESCRIBE SYSTEM FOR CONSUMER PRIORITIZATION: (The DOEA Client Services Manual should be reviewed for specific program requirements.) The agency's process for handling each of the following must be addressed: (a) Adult Protective Services and CARES referrals; (b) consumers who no longer need services and consumers who are capable of managing with reduced services; and (c) Elder Helpline referrals.

A.II.5 QUALITY ASSURANCE:(The DOEA Client Services Manual should be reviewed for specific program requirements.)

a. *Consumer Satisfaction*: Describe the process, including the frequency, for determining consumer satisfaction with service delivery.

b. *Internal Evaluation Process*: Describe internal methods to assure delivery of quality services by staff and/or subcontractors:

A.III. DESCRIPTION OF SERVICE DELIVERY

SERVICE: _____ PROGRAM(S)**:** _____

A.III.1. SITE LOCATION: (Provider may attach a list of site locations.)

A.III.2. DAYS AND HOURS OF OPERATION:

A.III.3. DESCRIBE THE SPECIFIC ACTIVITIES YOUR AGENCY WILL PROVIDE UNDER THIS SERVICE (The DOEA Client Services Manual should be reviewed for service requirements.) **Case management agencies must specify how consumers in common programs, i.e., CCE, ADI, MW, HCE or OAA, will be case managed on the "Case Management Description of Service Delivery" form. A separate "Description of Service Delivery" form for HCE Special Subsidy must be completed to indicate how consumers will be provided subsidy services. In-home services such as homemaker, personal care, respite and chore may be combined for description purposes.** Providers of OAA Titles III-C1 and III-C2 must include a description of plans for provision of meals to older persons during weather related emergencies:

A.III.4. NUTRITION EDUCATION SCHEDULE

REQUIREMENT: In the space below, please describe your plan to provide nutrition education semiannually:

C-1 Lesson Topics (Please describe):

C-2 Lesson Topics (Please describe):

A.III.5. NUTRITION ASSURANCES

In accordance with Section 339(1) of the OAA which requires each nutrition project to be established and administered with the advice of dieticians (or individuals with comparable expertise), and Section 339(2)(F) which requires compliance with applicable state or local laws regarding safe and sanitary handling of food, equipment, and supplies used in the storage, preparation, service, and delivery of meals to elderly nutrition program participants,

_____

(Name of Nutrition Consultant)

will provide Nutrition Consultation for the nutrition project of

_____

(Name of Provider)

_____

(Name of Nutrition Consultant)

is a registered/licensed dietitian whose current registration number from the Commission on Dietetic Registration is _____and/or whose license number from the Florida Department of Professional Regulation is _____ or whose qualifications have been approved by the area agency's nutrition consultant or the Department of Elder Affairs.

The Nutrition Consultant Agreement for Services and a current resume of the Nutrition Consultant will be included in the application at the beginning of each bid cycle and updated when there is a staff change.

_____

(Name of Provider)

also assures meals provided through the project comply with the Dietary Guidelines for Americans and provide to each participant a minimum of 33 and 1/3 percent of the daily recommended dietary allowances if one meal per day is provided; a minimum of 66 and 2/3 percent of the allowances if two meals per day is provided; and 100 percent of the allowances if three meals per day is provided.

A.III.6. USDA COMMODITY FOODS/CASH IN LIEU OF COMMODITIES STATEMENT

_____

(Name of Provider)

will participate in the USDA Commodity Foods Program during FY_____ and has opted to receive the item checked:

___ Commodity Foods in the Amount of $
___ Cash-In-Lieu of Commodities
___ Combination of Cash and Commodity Foods
(1) Total Amount $
(2) Dollar Value of Commodity Foods $

III.A.6.2. Complete only if electing to receive commodity foods.

_____

(Name of Provider)

assures that these foods will be used as efficiently as possible. Commodity foods received will be stored in the following manner(s):

___ In Storage Provided by Caterer
___ In Rental Storage Space
___ School System will Provide Storage Space
___ Other (Describe)

Storage costs will be paid by (List all):

Handling and/or transportation costs will be paid by (List all):

A. IV. TRAINING

a. Provide your agency's 12 month training plan (This is what trainings you plan to provide or to send staff to attend)

b. Describe internal methods to track training attendance

A.V. NEW SERVICE/NEW PROVIDER BUSINESS PLAN

(This format is to be used by new applicant agencies and current providers offering a new service. This format must address the "phase in" process. Attach continuation sheets as needed.)

SERVICE:_____ ESTIMATED # OF CONSUMERS:

ANTICIPATED START DATE OF SERVICE:

BUSINESS PLAN TO ACHIEVE SERVICE OBJECTIVE

START-UP ACTIVITIES (Briefly describe tasks and estimated completion dates related to initiating and maintaining provision of quality services):

TASKS:

A.VI. GOALS, OBJECTIVES AND PERFORMANCE MEASURES

(See RFP pages 23-27)

GOAL
OBJECTIVE
STRATEGIES/ACTION STEPS:
OUTCOME:
OUTPUT:

B. CONTRACT MODULE

B.I. PERSONNEL ALLOCATION WORKSHEET

Please insert the completed
"Personnel Allocation Worksheet" from the
DOEA UNIT COST METHODOLOGY
as specified in Appendices G1 and G3

B. II. COST ALLOCATION WORKSHEET

Please insert the completed
"Cost Allocation Worksheet" from the
DOEA UNIT COST METHODOLOGY
as specified in Appendices G1 and G3

B.III. SUPPORTING BUDGET SCHEDULE BY PROGRAM ACTIVITY

Please insert the completed
"Supporting Budget Schedule by Program Activity" from the
DOEA UNIT COST METHODOLOGY
as specified in Appendices G1 and G3

B.IV. MATCH COMMITMENT OF CASH DONATION

Agency Name: _____

Donor Identification:_____

Name: _____

Street: _____

City:_____

State:_____

Zip:_____

Phone: _____

Authorized Representative: _____

Total Amount $_____

Payments _____

Amount/Payment $_____

Contribution Period _____

Special Conditions:_____

Donor Certification:_____

I hereby certify intent to make the cash donation set forth above for use in the specified program during the program's upcoming funding period. This cash is not included as match for any other State or Federally assisted program or contract and is not borne by the federal government directly under any federal grant or contract.

Signature of Donor or Representative:_____Date:_____

B.V. MATCH COMMITMENT FOR DONATION OF BUILDING SPACE

Agency Name: _____

Donor Identification:_____

Name: _____

Street: _____

City:_____

State:_____

Zip:_____

Phone:_____

Authorized Representative:_____

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

Provider Owned Space:_____

1. Number of square footage used by project: ____sq/ft

2. Appraised rental value per square foot: $_____

3. Total value of space used by project (1x2): $_____

Donor Owned Space:_____

1. Established monthly rental value: $_____

2. Number of months' rent to be paid by donor:_____mos.

3. Value of donated space (1x2): $_____

Special Conditions:_____

Donor Certification:_____

I hereby certify intent to donate use of the space set forth above for the program specified above during the program's upcoming funding period. This space is not being used as match for any other State or Federal program or contract.

Signature of Donor or Representative:_____Date:_____

B.VI. MATCH COMMITMENT OF SUPPLIES

Agency Name:_____

Donor Identification: _____

Name: _____

Street: _____

City:_____

State:_____

Zip:_____

Phone:_____

Authorized Representative:_____

The below described supplies are committed for use by the project for the period of:

Description of Supplies:_____
_____
_____

Computation of value method: _____

Value to be claimed by project: $_____

Donor Certification:_____

These supplies are not included as contributions for any other State or Federally assisted program or contract and are not borne by the Federal Government directly or indirectly under any Federal grant or contract except as provided for under _____ (cite the authorizing Federal regulation or law if applicable).

Signature of Donor or Representative:_____Date:_____

B.VII. MATCH COMMITMENT OF EQUIPMENT

Agency Name:_____

Donor Identification: _____

Name:_____

Street:_____

City:_____

State:_____

Zip:_____

Phone:_____

Authorized Representative: _____

The below described equipment is committed for use by the project for the period of:

Item Description	Number	Acquisition	Value to Project*	Cost
1.				
2.				
3.				
4.				
5.				

TOTAL VALUE CLAIMED: $

* Items that are currently owned by the Grantee or are loaned or donated to the project are valued at an annual rate of 6-2/3 percent of the acquisition value.

Donor Certification:

This equipment is not included as match for any other State or Federally assisted program or contract and are not borne by the Federal Government directly or indirectly under any Federal grant or contract except as provided for under _____ (cite the authorizing Federal regulation or law if applicable).

Signature of Donor or Representative:_____Date:_____

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

Agency Name:_____

Donor Identification:_____

Name:_____

Street: _____

City:_____

State:_____

Zip:_____

Phone: _____

Authorized Representative:_____

The personal services described below are committed for use by the project for the period of:

Description of Positions:

Position Title	Service Annual Salary	Hourly Rate or Hours Worked	# Value to Project
1.			
2.			
3.			
4.			
5.			

TOTAL - $

* Value to project = (# of hours provided) x (hourly rate of annual salary).

Donor Certification: It is certified that the time devoted to the project will be performed during normal working hours.
These services are not included as match for any other State or Federally assisted program or contract and are not borne by the Federal Government directly or indirectly under any Federal grant or contract except as provided for under _____ (cite the authorizing Federal regulation or law if applicable).

Signature of Donor or Representative:_____Date:_____

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

Agency Name: _____

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

Describe Volunteer Effort:_____

Position Title	Equivalent Hourly Rate	# of Hours	Value to Project
1.	$		
2.	$		
3.	$		
4.	$		
5.	$		
TOTAL VALUE TO AGENCY	$		

Equivalent Hourly Rates were determined by:

[ ] Rates for comparable positions within own agency.
[ ] State Employment Service estimate of rates for type of work.
[ ] Rates for comparable positions within other local agencies.

Estimated Mileage X Rate per mile = Value

_____ _____ $

Donor Certification:_____

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

Signature of Agency Official:_____Date:_____

B.X. AVAILABILITY OF DOCUMENTS

The undersigned hereby gives assurance that the following documents are maintained in the administrative office of the provider and are accessible for review by the AAA.

1. Current Board Roster
2. Articles of Incorporation
3. Municipal Charter, Code of Ordinances, Corporate By-Laws
4. Advisory Council By-Laws and Membership
5. Current Equipment Inventory
6. Bonding Verification
7. Staffing Plan
    a. Position Descriptions
    b. Organizational Chart
8. Personnel Policies Manual
9. Financial Procedures Manual
10. Operational Procedures Manual
11. Affirmative Action Plan
12. Outreach Plan, if applicable
13. Americans With Disabilities Act Assurance
14. Staff Development and Training Plan
15. Unusual Incident File
16. Service Subcontracts
17. Co-Pay and Contribution System
18. Civil Rights Compliance Documentation
19. HIPAA policy and procedure
20. Conflict of interest policy and procedure
21. Financial statements and accounting records

CERTIFICATION BY AUTHORIZED AGENCY OFFICIAL:

I hereby certify that the documents identified above currently exist and are available for review upon request.

_____ _____

Signature Date

_____ _____

Name of Authorized Individual Title of Authorized Individual