

WCAAA APPLICATION FOR ALZHEIMER'S AIDE PROJECT

Name and title of individual authorized to apply for funds and sign contracts:

Print Name: _____ Signature: _____

Title: _____ Date: _____

A. Identifying Information

1. Name of Sponsoring Agency: _____

Address: _____

Contact Person _____ Telephone _____ DUNS # _____

Email _____ EIN # _____ Fax: _____

2. Name of Adult Day Care Center (ADC): _____

Address: _____

Contact Person: _____ Telephone: _____

Email _____ Fax: _____ INDIRECT COST RATE _____

3. Is this center ☐ Private Non-profit ☐ Municipal ☐ Proprietary

4. Type of certification received from CAADC: ☐ Medical ☐ Social

5. Is this center affiliated with: ☐ a nursing home ☐ Assisted Living
☐ Co-located with elderly services ☐ free standing

If affiliated, name organization: _____

6. Is the facility handicapped accessible? ☐ YES ☐ NO

7. Does the facility have any outstanding violations of applicable zoning, licensing, fire code and safety laws and regulations? ☐ YES ☐ NO If yes, please describe in detail and furnish report of citation.

8. Please list days and hours of operation

DAYS OF THE WEEK	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

* 9. How many clients can the ADC accommodate daily?

Total number of clients _____ Number of Alzheimer clients _____

B. Program Operations

1. How many unduplicated clients do you serve per week? _____

* It is understood these figures are difficult to estimate.

2. What is the ratio of all ADC clients to client care staff (exclusive of volunteers but including Title V positions) on duty on premises at all times** of ADC operation? (Include Alzheimer's Aide in the ratio)

3. a. Is there a nurse on duty at all times? _____ On call _____ RN? _____ LPN?
If necessary, provide an explanation _____
- b. Does the nurse supervise the aide funded under this grant? ____YES ____NO
If not, who supervises? (Title) _____
Credentials: _____

4. Is there a social worker on duty at the center at all times? _____ On call? _____
If not, explain hours: _____

5. Does the ADC have on file written Policies and Procedures, including admission and discharge, related to client care? ____YES ____NO (Please Attach)

6. This funding legislation requires a physician's diagnosis for clients served under this grant:
 - a. The staff member responsible for obtaining and filing the physician's letter is: (title):

 - b. Are letters on file for all current clients served under this grant? ____YES ____NO

7. What arrangements have been made for distributing and storing participant's medications?

8. List amount and carrier of the ADC liability insurance:
Amount: _____
Name of Carrier: _____

C. Service Profile

1. Please describe the specific support services for family and/or other caregivers through your program. Indicate the frequency of support groups meetings and the average attendance during the past year.

2. **DIRECTIONS:** Indicate the availability of services by completing the Service Profile Chart and doing the following: Column 1/Frequency: For each service offered by the Center, indicate how often the service is provided by placing a check mark under the appropriate category, i.e., daily, bi-weekly, weekly, monthly, etc. Then fill in Column 2 by placing a check under the appropriate category ("Yes" or "No") to indicate if the Center offers each service at an additional charge. Use an asterisk to indicate which of the services listed on the next page are provided by the aide funded under this grant, and be sure to asterisk the service even if the aide helps another staff member provide the service.

** This refers to all hours of operation. Do not use just peak hours.

C. SERVICE PROFILE CHART

INSTRUCTIONS:

Check block as appropriate to indicate availability of service and place asterisk next to services provided by aide. (See Directions on Page 2 for details)

SERVICE	I. FREQUENCY					II. SERVICE PROVIDED AT ADD'L CHARGE	
	Daily	Bi-Weekly	Monthly	Other	Not Provided	Yes	No
Counseling: Individual							
Counseling: Group							
Care Planning							
Progress Notes							
Service Referral							
Meals							
Special Diets							
Dietary Counseling							
Personal Hygiene							
ADL Assistance (walking eating, toileting, grooming)							
Mental Health Assistance (milieu therapy, reality orientation, etc.)							
Therapeutic Recreation (physical activities, discussion groups, arts and hobbies, etc)							
Therapeutic Recreation (intellectual activities)							

C. SERVICE PROFILE CHART (CONTINUED)

INSTRUCTIONS:

Check block as appropriate to indicate availability of service and place asterisk next to services provided by aide. (See Directions on Page 2 for details)

SERVICE	I. FREQUENCY					II. SERVICE PROVIDED AT ADD'L CHARGE	
	Daily	Bi-Weekly	Monthly	Other	Not Provided	Yes	No
Outings							
Sedentary Activities							
Personal Health/Hygine Instruction							
Physical Assessment							
Physical Reassessment							
Health Status Monitoring							
Bath Service							
Nursing Care							
Transportation							
Physical Rehabilitation							
Support Group							
Counseling for Supporters							
Training for Supporters							
Other (List)							

D. Service Data

- | | | | |
|----|--|---|--|
| 1. | Our adult day care center was open _____ days this year from 7/1/_____ to 6/30/_____. \ | | |
| 2. | Day care clients with Alzheimer's Disease | Last Completed Year
7/1/_____ – 6/30/_____ | Projected Year
7/1/_____ – 6/30/_____ |
| a. | *Total number of unduplicated Alzheimer/
Dementia clients served (all funding sources) | _____ | _____ |
| b. | Total number of unduplicated Alzheimer/
Dementia clients served. | _____ | _____ |
| c. | Total number of days of service provided
(sum total of all days of services provided
to Alzheimer's clients at the center) | _____ | _____ |
| d. | Average daily attendance for Alzheimer
clients (line 2-c divided by number days
center was open (D-1 above)) | _____ | _____ |
| e. | Average number of persons who work
with Alzheimer clients daily** | _____ | _____ |
| 3. | Day care clients without Alzheimer's Disease | | |
| a. | Total number of unduplicated clients
without Alzheimer's Disease | _____ | _____ |
| b. | Total number of days of service
actually provided to clients without
Alzheimer's Disease | _____ | _____ |
| c. | Average daily attendance (line D-3-b
divided by number of days the
center was open) (D-1 above) | _____ | _____ |
| d. | Average number of paid staff persons present
daily who work with clients** | | |

If there are significant differences between the past year and the project year, please give the reasons.

* Do not count a client more than once no matter how many times they have been served.

** Do not include office workers, cooks, etc.

E. Budget for Current Fiscal Year

Agency Budget for FY _____ which starts from _____ to _____

1. INCOME	CASH	IN-KIND	TOTAL
a. Grants			
OAA Title IIIB (Grants)	_____	_____	_____
OAA Title IIIC (Meals)	_____	_____	_____
OAA Title V	_____	_____	_____
USDA Commodities	_____	_____	_____
Specify Other Grants	_____	_____	_____
(eg. town(s), foundations, charities, etc.)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
TOTAL	_____	_____	_____
b. Revenues			
Client Fees	_____	_____	_____
Essential Services (DHR)	_____	_____	_____
Per Diems	_____	_____	_____
CTHOME CARE PROGRAM	_____	_____	_____
DIM	_____	_____	_____
Other (specify)	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Provider Agency Resources			
TOTAL	_____	_____	_____
2. Expenses	CASH	IN-KIND	TOTAL
Salaries	_____	_____	_____
Fringe Benefits	_____	_____	_____
Non-personnel Services	_____	_____	_____
Rent	_____	_____	_____
Utilities	_____	_____	_____
Operating Expenses	_____	_____	_____
(supplies, medical supplies, postage, printing, telephone)			
Transportation	_____	_____	_____
Congregate meals	_____	_____	_____
Food	_____	_____	_____
Professional Services	_____	_____	_____
(Legal, accounting, auditing)			
Insurance	_____	_____	_____
Equipment	_____	_____	_____
TOTAL	_____	_____	_____

3. Personnel/Budget Explanation

(Please note current staff assigned to Alzheimer's clients)

a. Position FTE Cost (Salary & Fringe Benefits)

Director

Secretary

Program Coordinator

Registered Nurse

L.P.N.

Health Aide

Social Worker

Therapist

Program Aide

Volunteers

Drivers

Cook

Custodial/Housekeeping

Other

b. Does the center have an annual audit done which covers all revenues and expenses and identifies this funding separately? _____

CPA Firm _____

Other (Specify) _____

c. Aide Salary Explanation

1) Is this request for a new position or continued funding for current aide(s)? _____

Salary \$ _____ per _____

Hours/week employed _____

Total Salary \$ _____

Fringe Benefits \$ _____

Total Request \$ _____

2) Is the proposed salary equal to the rate of current aide positions?

___ YES ___ NO

3) Is the salary of the proposed position specified under a binding personnel agreement? ___ YES ___ NO

F. Supplemental Information

Complete this page if your Agency is a new applicant or if you have previously answered one of these questions and change has occurred since that time. If you are answering the question because of a change indicate the date when the question was previously answered.

1. Attach resumes of current director and other professional staff.
2. Add a job description for the Aide position.

<u>Type/Training Offered Alz. Aide</u>	<u>Title/Qualifications of Trainer</u>
Initial Training_____	_____
(# of hours)	_____
On the job_____	_____
(how often)	_____
In service_____	_____
(how often)	_____

4.
 - a) Attach procedures for client intake and eligibility determination
 - b) Attach your intake application for client
 - c) Attach any policy statements you have on:
Discharging clients
Wandering clients

5. Describe the Agency's capacity and experience to serve Alzheimer clients and include information on the Center's strengths in serving this population.

G. Agreement

The _____ agrees to do the following:

(Agency Name)

1. Comply with statistical reporting requirements and the requirement for an independent audit as described in the Request for Proposal.
2. Comply with all applicable state and federal regulations, Executive Orders and state statutes regarding non-discrimination.
3. Assure that the center has licensed professional staff providing supervision of aides and services needed by Alzheimer's clients.
4. Assure that the aide hired under this grant will be appropriately trained in both physical care of and method of interaction with these clients.
5. Assure that clients served under, this grant will have a physician with whom the center can work who will certify by letter that the physician has done an appropriate medical work up and that the client's diagnosis is an irreversible and deteriorating dementia of the Alzheimer's type.
6. Assure that records on daily attendance are maintained and that documentation is kept on each unduplicated client under this program sufficient to establish that the client is in fact a medically documented victim of Alzheimer's disease or a related dementia.

Signature

Title

_____/_____/_____
Date

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, 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 undersigned shall complete and submit Standard Form -LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients 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 civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Organization

State

Authorized Signature

Title

Date

**ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES REGULATIONS UNDER
TITLE VI OF THE CIVIL RIGHTS ACT OF 1964**

_____ (hereinafter called the "Recipient of Award")

(Name of Applicant or Contractor)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the regulation, no person in the United States shall, on the grounds or race, color, or national origin, be excluded from participation in, be denied the benefits of, or be other-wise subjected to discrimination under any program or activity for which the Recipient of Award receives Federal financial assistance from the Western Connecticut Area Agency on Aging, Inc. (WCAAA), the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Recipient of Award by WCAAA, this assurance shall obligate the Recipient of Award or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Recipient of Award for the period during which the Federal financial assistance is extended to it by WCAAA.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Recipient of Award by WCAAA, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Recipient of Award recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that WCAAA or the United States or both shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Recipient of Award, its successors, transferees, and assignees, and their person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Recipient of Award.

Dated _____

(Recipient of Award)

By _____
(President, Chairperson of Board, or
comparable authorized official)

(Recipient's mailing address)

Title _____

ACCOUNTING SYSTEMS CERTIFICATION

FISCAL COMPONENTS AND PROCEDURES

(This form must be submitted by all applicants).

1. Do you maintain a general ledger monthly including this program?
2. Do you maintain separate cash receipts and disbursements journals?
3. Do you require an independent, certified audit annually? If not, why not?

If not annually, how often?

Please provide name of current contractor for independent audit services.

4. Do you employ a paid bookkeeper? _____

If yes, please provide bookkeeper's name: _____

If not, please explain who is responsible for the maintenance of financial record keeping system and provide some explanation of person's financial qualifications. _____

5. Who is authorized to sign checks for your agency?

What are their positions?

Is the person who maintains fiscal records (named above) also authorized to sign checks?

Are corporation resolutions on file for authorized check signers?

6. Please describe your agency's insurance and bonding coverage relevant to the proposed project. Include copy of bonding document and mandated insurance in the appendix.

7. Please describe how salary ranges and increases are set by your agency.

