Western Connecticut Area Agency, Inc.
84 Progress Lane, Waterbury, CT 06705
203-757-5449

SFY 2025
INSTRUCTIONS FOR PREPARING ALZHEIMER AIDE GRANT APPLICATION

1. Complete ALL forms in the attached application kit. Submit (1) original application with signatures and FIVE (5) copies to the WCAAA.

2. Attach the following to the original application:

   a. Accounting Systems Certification
   b. Lobbying Certification
   c. Certification through the Peer Review Process
   d. Client fee schedule(s)
   e. Most recent copy of the weekly or monthly activity plan
   f. Latest fire inspection report
   g. Compliance with the Department of Health and Human Services Regulation

3. Submit one (1) original and five (5) copies of this application to:

   Western CT AAA
   84 Progress Lane, Floor 2
   Waterbury, CT 06705

4. Deadline for receipt of applications by the WCAAA office is Monday, March 4, 2024 (4:00 p.m.). No extensions will be granted. **NO FAXED COPIES WILL BE ACCEPTED**. PLEASE DO NOT RENUMBER THE PAGES.

5. For additional information, please contact:
   Spring Raymond, MSW, Executive Director
   SRaymond@wcaaa.org (203)757-5449 Ext.108
   or
   Jose Carchi Maposito, Grants Manager
   JCarchi@wcaaa.org (203)757-5449 Ext.170

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.

3. Type/Training Offered Alz. Aide — Title/Qualifications of Trainer

   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)

_____ Title_____
(Recipient's mailing address)

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.