

## WCAAA TITLE III GRANT APPLICATION

Grant Year: October 1, through September 30,

**Organization Name:**

**Address:**

**Organization Website:**

**DUNS #:**

**EIN #**

**Type of Agency**

Private Non-Profit

Public

Private For-Profit

**Project Name:**

**Project Address:**

**Project Director:**

**Phone:**

**Project Director Title:**

**Project Director Email:**

**1. Amount of WCAAA Grant Request:**

**2. Organization Annual Operating Budget:**

**3. Proposed Total Project Budget:**

**4. Percent of Organizational Budget:**

**5. Indirect Cost Rate:**

*Fields 1, 3, and 4 are automatically extracted from the Project Budget Overview table on page 2.*

**Brief Summary of Project Purpose:**



**NOTICE - Grant Payments**

For WCAAA to process grant payments, the Grantee’s MIS reports must be received by the 10th of the month following the month the service was rendered. For example, the month of December MIS is due to WCAAA no later than January 10th. Failure to provide monthly MIS reports by the deadline, will result the grant being identified as out of compliance and will disqualify the grantee for reimbursement for the out-of-date reporting.

The processing of late grant payments, or makeup billing are not guaranteed.

**APPLICATION TERMS:**

In submitting this application, the : 1) funds awarded as a result of this request are to be expended for the purposes set forth herein and in accordance with all applicable laws, regulations, policies and procedures of the Area Agency, the State Unit on Aging and Administration on Aging, U.S. Department of Health and Human Services (see attached compliance) ; 2) any proposed changes in the proposal as approved will be submitted in writing by the applicant and upon notification of approval by the Area Agency shall be deemed incorporated into and become a part of this agreement: and 3) Title III (federal) Print Name: funds must be expended after all other funds are used; 4) funds awarded by the Area Agency may be terminated at any time for violations of any terms/ conditions / requirements of this agreement or reduction federal funds; 5) if funds are awarded, I am authorized to accept the grant / contract and proceed with full implementation within 30 days.

Monthly service reporting (MIS) requires collection of demographic information for each new client and reporting the number of services provided to each client on a monthly basis.

**Name and Title of Individual authorized to apply for funds and sign contracts:**

Print Name:		Title:	
Signature:		Date Signed:	

Check each of the Towns Served in this project: (not service area)

<b>Northwest</b>	<input type="checkbox"/> Barkhamsted	<input type="checkbox"/> Kent	<input type="checkbox"/> Norfolk
	<input type="checkbox"/> Bethlehem	<input type="checkbox"/> Litchfield	<input type="checkbox"/> Salisbury
	<input type="checkbox"/> Canaan	<input type="checkbox"/> Morris	<input type="checkbox"/> Sharon
	<input type="checkbox"/> Colebrook	<input type="checkbox"/> New Hartford	<input type="checkbox"/> Torrington
	<input type="checkbox"/> Cornwall	<input type="checkbox"/> North Canaan	<input type="checkbox"/> Warren
	<input type="checkbox"/> Goshen	<input type="checkbox"/> New Milford	<input type="checkbox"/> Winchester
<b>Other</b>	<input type="checkbox"/> Bridgewater	<input type="checkbox"/> Roxbury	<input type="checkbox"/> Washington
	<input type="checkbox"/> Sherman	<input type="checkbox"/> Southbury	<input type="checkbox"/> Woodbury
<b>Greater Danbury</b>	<input type="checkbox"/> Bethel	<input type="checkbox"/> New Fairfield	<input type="checkbox"/> Redding
	<input type="checkbox"/> Brookfield	<input type="checkbox"/> Newtown	<input type="checkbox"/> Ridgefield
	<input type="checkbox"/> Danbury		
<b>Greater Waterbury</b>	<input type="checkbox"/> Beacon Falls	<input type="checkbox"/> Naugatuck	<input type="checkbox"/> Waterbury
	<input type="checkbox"/> Cheshire	<input type="checkbox"/> Prospect	<input type="checkbox"/> Watertown
	<input type="checkbox"/> Harwinton	<input type="checkbox"/> Thomaston	<input type="checkbox"/> Wolcott
	<input type="checkbox"/> Middlebury		

## APPLICATION - TITLE III FUNDS

### **PROFILE OF APPLICANT AGENCY**

Describe the organization that is applying for Title III funds and that will provide fiscal and programmatic oversight for the proposed project. Include the Mission and background of applicant agency, including specific experiences in servicing the targeted populations. All applicants must provide updated information. (Essay form)

### **STATEMENT OF NEED FOR PROPOSED PROJECT**

Provide data in list format to substantiate the needs existing in the area for the proposed service in which funding is being requested. (i.e. waiting lists)

**DESCRIPTION OF PROPOSED PROJECT:**

Describe the **proposed project**: Describe the service(s) to be provided, including major components of the project. Include details of the **implementation plan**, i.e. how often the service will be provided and where (i.e. individual's home or facility)

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1. **Project Goals:** Identify project goals to describe what you expect to accomplish with your proposed PROJECT during the new grant period. The GOALS must relate to the NEED identified in this application and should be measurable and time oriented. For each goal, explain (1) the overall goal, and (2) how the project outcomes will be measured.

	<i><b>Overall Goal:</b></i>	<i><b>How will project objectives be measured:</b></i>
1		
2		

2. **Proposed SERVICE TARGETS:** (Choose Service Name from the appropriate Title III MIS Service Definitions list at [www.WCAAA.org](http://www.WCAAA.org).) List MIS activity, the proposed number of unduplicated persons, and the proposed number of service units to be provided.

***Project Activity to be provided:***

***Total number of unduplicated persons:***

***Total number of units of services:***

**3. PLAN TO REACH TARGET POPULATIONS.** The Older American’s Act requires outreach efforts to certain target populations. Outreach for each chosen population must be specific to the population. Indicate which target group(s) will be identified and encouraged to participate in the program/project. NOTE: Only select the group(s) that will be specifically targeted (However, all groups will be reported on the monthly MIS). There is no need to select all.

Individuals Identified As:	Proposed number of people in target population	Comments (if any)
<input type="checkbox"/> Low Income (100% of federal poverty level or below)		
<input type="checkbox"/> Low Income Minority		
<input type="checkbox"/> Living in Rural Areas		
<input type="checkbox"/> Minority Population Group		
<input type="checkbox"/> At or below 150% Poverty		
<input type="checkbox"/> Limited English Proficiency		
<input type="checkbox"/> Severe Disabilities		
<input type="checkbox"/> Alzheimer’s & related Disorders		
<input type="checkbox"/> Risk of Institutionalization		
<input type="checkbox"/> Other:		
Total Population (not sum of rows above)		

4. Outreach Methods, Tracking and Measurement: Identify and describe how prospective clients will be made aware of this project and how contact will be maintained with current clients in each selected target population group? How will outreach be tracked and measured?

5. Current WCAAA grantees should include information on past outreach efforts including specific activities aimed at targeting the groups mentioned above. Previous service data should be used to discuss progress and barriers encountered in meeting goals.

6. All returning applicants must discuss the current grant(s) awarded and compare the previous grant Actual Performance to this grant request proposed Target(s)

	Proposed Grant Request	Previous Year Grant Awarded	Previous Year Actual Expenses	Difference
Grant Amount				

➤ *Comparison of performance / Explanation of Difference noted.*

**COORDINATION WITH COMMUNITY RESOURCES:**

1. Describe how the proposed program / service will be coordinated with other appropriate services in the area. Provide specific examples and plans.

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2. How is the proposed project / service(s) different from other projects / services in the area?





**CONTRACTS / REIMBURSEMENTS** Indicate the names of agencies with which you have contracts/ agreements for reimbursement, rate of reimbursement, purposes, last date negotiated for services such as those being proposed in this application by type; indicate if Medicare certified, rate of Medicaid reimbursement for proposed service. All applicants must append a copy of the most recent DSS-CHCP rate notice if reimbursement is part of this project's budget.

**APPLICANT'S POLICIES & PROCEDURES**

Please list the types of policy and/or procedure manuals used by your agency which will affect this project. Has your agency adopted a personnel policy or protocol manual?

**PROPOSED COST OF SERVICE**

Total # of units of service proposed:

*Figures automatically  
pulled from the budget  
table on page 2*

Title-III total cost

Title-III reimbursement rate:

Total project cost:

Total project unit cost:

**STEP 3. COST-SHARING**

If you are proposing UOS cost-sharing, please list your proposed cost-sharing for resources. (e.g.: who is paying the difference between total cash cost and AAA cash cost?)

**STEP 4. COMPARISON OF PROPOSED COST SERVICE**

(Please compare the proposed UNIT OF SERVICE COST for your proposed service with at least one other existing and similar agency in your affected area which provides the same type of service; if no similar service exists in the area, please attempt to provide some other type of unit of service cost comparability)

**FUTURE FINANCING PLANS (MANDATORY SECTION)**

The WCAAA uses a “declining grant formula which, in effect, decreases the amount of Title III funds for the project each year. In view of this concept, please describe how you plan to ensure future financing of your project; if your plans include self-sufficiency in time, please indicate so, give length of time to achieve self-sufficiency, and explain how this will be achieved.

**FUNDRAISING PLANS**

The WCAAA strongly encourages fundraising in order to meet the declining grant concept above. Please list your planned fundraising activities which will benefit this program specifically and the target amount. **(MANDATORY SECTION)**

<u>Planned Activity</u>	<u>Target Month</u>	<u>Target Dollars</u>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

**CLIENT CONTRIBUTION SYSTEM**

Under the Older American Act, all clients must be given the opportunity to contribute to programs for services rendered. However, no senior may be denied service for failure to contribute.

Grantees are required to have a method for collecting and tracking client contributions. Reminder that all contributions should be made by envelopes or other confidential means; donations should be made into a locked box if possible. If you are seeking a waiver of this requirement, please indicate below and explain why.

1. Describe your client contribution and/or sliding-fee scale system and policies.

2. How is confidentiality conducted?

3. How are client contributions secured and maintained?

4. How are client contributions tracked?

## ACCOUNTING SYSTEMS CERTIFICATION

(This form must be submitted by all applicants).

1. Do you maintain a monthly general ledger including this program?
2. Do you maintain separate cash receipts, disbursements and payroll journals?
3. a) Do you require an independent, certified audit annually? If not, why not?  
  
b) If not annually, how often?  
  
c) Please provide name of current contractor for independent audit services.
4. a) Do you employ a paid bookkeeper?  
  
b) If yes, please provide bookkeeper's name:  
  
Name  
  
Email  
  
Phone  
  
c) 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. a) Who is authorized to sign checks for your agency and how many signatures are required?

b) What are their positions?

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

d) 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.

a. MIS reports are due monthly by the 10<sup>th</sup>. Who is responsible for preparing MIS reports?

Name:

Email:

Phone:

b. Who is the back up, in the event of the initial MIS coordinator's absence or conflict in schedule?

Name:

Email:

Phone:



(The budget narrative should include information for each cost category. Be specific about line items that include equipment and indirect costs). Please note indirect costs cannot be over 10% unless otherwise approved (If a higher indirect cost rate has been approved, attach copy of approval). Please provide a line-by-line justification of each budget item which should serve as back-up for the Budget Overview.

**PROJECT RESOURCE LIST\***

1. EXPECTED SOURCES OF NON-FEDERAL MATCH (\$ amount must match Project Budget)  
Please list the amount of non-federal match by source and type

	<u>SOURCE</u>	<u>CASH</u>	<u>IN-KIND</u>
a.			
b.			
c.			
d.			

2. OTHER RESOURCES *(total \$ amount must match amount of grant request on cover page)*

Please list by source, the amount of other support expected to be used for the Project (**other than above**) (e.g., Senior Aides, DSS reimbursements, Medicare/Medicaid payments, other contracts, fundraising and local municipal contributions if not reflected above in match.)

	<u>SOURCE</u>	<u>AMOUNT</u>
a.		
b.		
c.		
d.		

\* If WCAAA funds are awarded, documentation applicable to these resources must be available at the office of the grant applicant for AAA review.

**REDUCED FUNDING ALTERNATIVES (MANDATORY SECTION)**

**Please be specific in terms of staff reductions, and the reduced number of clients/units to be served in the two requests below. Applicants are cautioned to respond carefully as reduction should not be made solely to persons served or units of service to be provided. Please review your overhead/administrative costs for potential reductions that would correspond to less federal grant.**

1) Briefly describe how your program would change with a 25% reduction from the requested amount.

2) Briefly describe how your program would change with a 50% reduction from the requested amount.

# 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 ground 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.

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

(Recipient of Award)

By (President, Chairperson of Board, or Comparable authorized official)

Title

Recipient's mailing address

## Monthly Activity Calendar (MAC) FORM

**THIS FORM IS REQUIRED FOR ALL APPLICANTS.** PLEASE SUBMIT REQUIRED INFORMATION FOR ONE YEAR AS A LIST ON THIS FORM (OR SIMILAR FORMAT).

**PROPOSED ACTIVITIES**

**TARGET \$**

**VOL. NEEDED**

(October 1, 2025 – September 30, 2026)

October			
November			
December			
January			
February			
March			
April			
May			
June			
July			
August			
September			