



**Region 9 Area Agency on Aging**  
**Request for Proposal FY 2027-2029**  
**Legal Assistance**

**Section I – Agency Information**

Name of Applicant Organization: \_\_\_\_\_  
Chief Contact Person: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Purpose of Organization: \_\_\_\_\_

**Not for Profit**                      **For Profit**

**Federal ID No.** \_\_\_\_\_ **DUNS No.** \_\_\_\_\_

**Geographical area to be served:**

*Check area to the left if bidding on service and enter amount requested (obtained from the Tentative FY 2027 Allocation worksheets) to the right.*

	<u><b>Amount Requested</b></u>
____ 1. Legal Assistance (C-10)	

*For more detail regarding service standard requirements referenced in parenthesis above, see the Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards.*



**3. Describe the program's measurable objectives. How will they be measured?**

- 4. What goal(s) of the Region 9 Area Agency on Aging Multi-Year Implementation Plan (MYP) does the proposed program support? Explain. How does the program comply with the ACLS Bureau Operating Standards? Explain.**

**5. What impact will the program have on the participants?**

**6. Identify the population and the priority in which it is to be served. Address the criteria to be used when the demand for services exceeds resources.**

**7. Describe the strategy for reaching the target population.**

**8. Identify staff positions, their qualifications, and their duties as they relate to the program.**

**9. Identify the organization's experience in providing this service.**

**10. List all collaborative partners and the role they will play in this project (if applicable).**

**11. Describe the plan for program sustainability if funding were to cease.**

## **Required Attachments for Contractors:**

Attach a Letter of Support from the County Board of Commissioners

Minimum Standards Assurance

Facilities Data

Agency Data

Services/Programs Info

Additional Resources

*Section III - Budget*

**Title IIIB Legal Assistance Award  
Budget Fiscal Year 2027-2029**

**Applicant Organization:** \_\_\_\_\_

**Project Name:** \_\_\_\_\_

**Amount of funds requested:** \_\_\_\_\_

**Service Category:** Legal Assistance

Source of Revenue	Amount Requested	Support from Other Resources	Total Project
Federal			
Program Income			
Cash Match			
<b>Total Revenue</b>			

Budget Line Item	Amount Requested	Support from Other Resources	Total Project
Salaries/Wages			
Fringe Benefits			
Transportation			
Supplies			
Equipment			
Occupancy			
Communications			
Service Contracts			
Other Costs			
<b>Total Project Expenses</b>			

<b>In-Kind Match</b>			
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	Contracted Units
<b>*Units to be provided</b>	
Unduplicated Participants served	

I certify that the information on this statement is accurate to the best of my knowledge and that the projected expenses stated herein will be incurred in accordance with the conditions of this award.

\_\_\_\_\_  
Signature of Authorized Official

\_\_\_\_\_  
Date

**Section III - Budget Narrative (REQUIRED)**

*Address the rationale for each projected expense line item. Also, include how units and unduplicated clients were calculated. List other fund sources.*

**Salaries/Wages:**

**Fringe Benefits:**

\_\_\_\_\_ % of Salaries/Wages

Fringe benefits include:

**Transportation/Travel:**

Mileage:

Per Diem:

Lodging:

Registrations:

**Supplies (Expendables):**

**Equipment (\$5,000 or more):**

**Occupancy** (Space, rent, mortgage, etc.):

**Communications:**

Postage:

Printing:

Copying:

Telephone:

**Service Contracts:**

**Other:**

**How units and unduplicated participants were calculated:**

**Other Funding Sources:**

## Facilities Data

Complete one Facilities Data Sheet for each location – Center/Site  
(To be completed for those services that are facility-based)

1. Name and Address of Facility

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2. If you do not own the facility do you have a current lease? \_\_\_ Yes \_\_\_ No  
If yes, expiration date: \_\_\_\_\_

3. What geographic area does this facility serve? Indicate as specifically as possible.

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4. What days and hours of the week is this facility open to participants?

<u>Days Open</u>	<u>Hours Open</u>	<u>Additional Evening Hours</u>
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

5. Is the facility accessible by public transportation? \_\_\_ Yes \_\_\_ No
6. Do you provide transportation services to and from this facility? \_\_\_ Yes \_\_\_ No
7. Is there a charge for participant transportation? \_\_\_ Yes \_\_\_ No  
If yes, how much?

8. Is the facility accessible to mobility impaired individuals?  Yes  No
9. If the facility is not accessible to mobility impaired individuals:
- A. Has it been determined that the facility can be made barrier free?  Yes  No
  - B. Has the agency applied for funding to make the facility barrier free?  Yes  No
  - C. Is barrier free renovation underway?  Yes  No
  - D. Is agency searching for a new facility that would be barrier free?  Yes  No
10. Describe how you will provide services to mobility impaired participant if the facility is not barrier free.

## Agency Data

Provide a list of your organization's Board of Directors and contact info. (Please attach list)

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1. Agency has by-laws on file? \_\_\_Yes \_\_\_No
  - a. Date by-laws were last reviewed \_\_\_\_\_
2. Agency has its Incorporation papers on file? \_\_\_Yes \_\_\_No
3. Agency has Personnel Policies on file? \_\_\_Yes \_\_\_No
4. Are services available to non-English speaking clients? \_\_\_Yes \_\_\_No

If yes, specify other languages: \_\_\_\_\_

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5. Do you maintain participant records in a locked file? \_\_\_Yes \_\_\_No
6. Does your organization currently have a system for generating monthly reports of:
  - A. Number of participants \_\_\_Yes \_\_\_No
  - B. Number of units of service provided \_\_\_Yes \_\_\_No
  - C. Cost of service provided \_\_\_Yes \_\_\_No
7. What is the date of your last audit? \_\_\_\_\_
8. Who performed the last audit? \_\_\_\_\_





## Minimum Standards Assurance

All services funded by the Region 9 Area Agency on Aging (AAA) must be in compliance with the service definitions, unit definitions and minimum service standards for operation of the Bureau of Aging, Community Living, and Supports (of the MDHHS) and the AAA. The only exception will be for specific standards for which compliance has been waived by the AAA, according to prescribed policy waiver procedures not related to law or regulation.

I hereby enter this assurance of compliance.

\_\_\_\_\_, (hereinafter called the Contractor), HEREBY ASSURES that persons involved in implementing the proposal contract have read the minimum standards on each of the services for which funds are being requested.

FURTHERMORE, the Contractor assures that it is completely in compliance with all standards for the following services: (List all services for which funding is requested)

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This assurance is given in consideration of and for the purpose of obtaining Federal and State funds, contracts or other financial assistance from the AAA. The Contractor recognizes and agrees that any approved financial assistance will be extended based on agreements made in this assurance and that the AAA shall have the right to seek enforcement of this assurance.

This assurance is binding on the Contractor, its successors, transferees and assignees.

\_\_\_\_\_  
Project Director

\_\_\_\_\_  
Project Chairperson

\_\_\_\_\_  
Date