Region 9 Area Agency on Aging

Request for Proposal FY 2022

Title IIIE National Family Caregiver Support

(Complete only if you are applying for funding in a category below)

Section I - Agency Information

Name of Applicant Organization: _____

Chief Contact Person**:** _____

Address: _____

Phone: _____ Fax: _____

E-Mail: _____

Purpose of Organization:

Nonprofit ☐ **Profit** ☐

Federal ID No. _____ DUNS No. _____

Geographical area to be served:

Check area to the left if bidding on program and enter amount requested to the right.
*Complete one budget for **each** different category below for which funding is being requested.*

		Amount Requested
☐	**1. Caregiver Education, Support and Training (C-20)**	_____
☐	**2. Respite care to enable caregivers to be temporarily relieved from their caregiver responsibilities (B-10)**	_____
☐	**3. Kinship (grandparent) funds (C-18)**	_____
☐	**4. Creating Confident Caregivers (C-17)**	_____
☐	**5. Evidence-Based Disease Prevention (C-6)**	_____

For more detail regarding service standard requirements referenced in parenthesis above, see the Aging and Adult Services Aging (formerly OSA) Operating Standards.

Section II – Project Narrative

Respond to the following questions in the order given.

1. **Provide a brief description of your organization (i.e. years of operation, services provided, etc.)**

2. **Provide a project overview. (Project name, project time frame, project description, etc.)**

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

4. **What goal of the Region 9 Area Agency on Aging Multi-Year Plan (MYP) does the proposed program support? Explain. How does the program comply with the AASA 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 this project.**

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

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

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

12. *If the proposed service was not selected from the provided list of approved evidence-based disease prevention programs, explain how it meets Level III criteria and attach supporting documentation.

13. If an emergency situation such as the recent pandemic arises or continues, what measures will be put in place to ensure the proposed project will take place?

Section III – Budget

Title IIIE National Family Caregiver Support Award

Budget Fiscal Year 2022

Applicant Organization: _____

Project Name: _____

Amount of funds requested: _____

Service Category: TITLE IIIE National Family Caregiver Support

Source of Revenue	Amount Requested	Support from Other Resources	Total Project
Federal			$ 0.00
Program Income			$ 0.00
Cash Match			$ 0.00
Total Revenue	$ 0.00	$ 0.00	$ 0.00

Budget Line Item	Amount Requested	Support from Other Resources	Total Project
Salaries/Wages			$ 0.00
Fringe Benefits			$ 0.00
Transportation			$ 0.00
Supplies			$ 0.00
Equipment			$ 0.00
Occupancy			$ 0.00
Communications			$ 0.00
Service Contracts			$ 0.00
Other Costs			$ 0.00
Total Projected Expenses	$ 0.00	$ 0.00	$ 0.00

In-Kind Match			$ 0.00

	Contracted Units	EBDP Only	
***Units to be provided**		**Expected # of Attendees**	
Unduplicated Participants to be served		**Expected # of Completers**	

*** See Standards B-10, C-6, 17, 18 and 20 to address units of service.**

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 and/or attendees/completers were calculated:

Other Funding Sources:

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 Aging and Adult Services Agency (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 programs for which funding is requested. You only need to complete this form once.)

_____

_____

_____

_____

_____

_____

_____

_____

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 Board Chairperson

_____

Date