Region 9 Area Agency on Aging

Request for Proposal FY 2027 - 2029

Homemaking, Personal Care, Respite, Congregate Meals, Home-Delivered Meals, Carry-Out Meals, Transportation

Section I – Agency Information

Name of Applicant Organization: _____
Chief Contact Person**:** _____
Address: _____
Phone: _____ Fax: _____
E-Mail: _____
Purpose of Organization:

Not for Profit ☐ **For Profit** ☐ **Government Entity** ☐

Federal ID No. _____ **DUNS No.**_____

Geographical area to be served:

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

		Amount Requested
☐	**1. Homemaking (B-4)**	_____
☐	**2. Personal Care (B-8)**	_____
☐	**3. Respite (B-10)**	_____
☐	**4. Congregate Meals (C-3)**	_____
☐	**5. Home Delivered Meals (B-5)**	_____
☐	**6. Carry-out Meals**	_____
☐	**7. Transportation**	_____

	# of Participants to be served	**Units of service to be provided**
Homemaking		
Personal Care		
Respite		
Congregate Meals		
Home Delivered Meals		
Carry-Out Meals		
Transportation		

Carry-Out Meals shall not exceed 25% of Title III, C-1 (Federal Congregate Meal) funding.
Transportation services will be supported through Title III-B funds, which will result in a reduction of federal allocations for homemaking and personal care services. As a result, program allocation percentages will be adjusted to reflect these funding changes.

1. If Transportation was selected, provide a project overview. (Project name, project time frame, project description, impact, sustainability, etc.)

Required Attachments for bidders:

- AAA Summary Budget (Excel workbook 7 pages)
- Attach a Letter of Support from the County Board of Commissioners
- Minimum Standards Assurance
- Facilities Data
- Agency Data
- Services/Programs Info
- Additional Resources

Facilities Data

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

1. Name and Address of Facility

_____

_____

_____

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.

_____

_____

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

Days Open	Hours Open	Additional Evening Hours
☐ 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 participants 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)

_____

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: _____

    _____

5. Do you maintain client records in a locked file? ___Yes ___No

6. Does your organization currently have a system for generating monthly reports of:

    A. Number of clients ___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? _____

Services/Programs

List all services or programs currently offered to persons over 60 by your organization regardless of funding source. List the total number of clients and units provided in the last six months. Note geographic area served if other than your usual coverage area.

Services/Programs	**Geographic Area**	**Units Provided**	**Unduplicated 60+ Clients**

Additional Resources

As an indicator of inadequate federal and state funding, list other resources administered by your agency for all Aging Programs for the past fiscal year. Do not include grant funds awarded by the Region 9 Area Agency on Aging.

Service Provided	Dollar Amount	Millage/Other Resource (If Other resource, please specify)

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)

_____

_____

_____

_____

_____

_____

_____

_____

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