Region 9 Area Agency on Aging

Request for Proposal FY 2024

Title IIID Evidence-Based Disease Prevention

(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** **Government Entity**

Federal ID No. ______________________ DUNS No. ______________________

Geographical area to be served:

Check the subcategories for programs on left and include the amount requested to the space provided on right. Complete one budget form for all programs requested under IIID. In the budget narrative, clearly define the program(s) to which each expense applies.

Evidence-Based Disease Prevention Health Promotion (C-6)	Amount Requested
Stanford Chronic Disease Self Mgmt Program (PATH)	
Diabetes Self Mgmt Program (Diabetic PATH)	
Chronic Pain Self Mgmt Program	
Healthy IDEAS	
Healthy Moves for Aging Well	
A Matter of Balance (MOB)	
Tai Chi: Moving for Better Balance	
AEA Arthritis Foundation Exercise Program (AFEP)	
Tai Chi for Arthritis	
Walk with Ease	
Fit and Strong	
*Other:______________________	
*(Program must be Level III – Evidence Based per TL #2012-244)	
Total	________

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

Submittal address: 2569 US 23 South Alpena, MI 49707

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 Annual Implementation Plan (AIP) 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 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 prevention programs, explain how it meets Level III criteria and attach supporting documentation.

Section III – Budget

Title IIID Evidence-Based Disease
Prevention Budget Fiscal Year 2024

Applicant Organization: ____
Project Name: ____
Amount of funds requested: _______________________

Service Category: TITLE IIID Evidence-Based Disease Prevention

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

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

*# of Units to be provided	
Expected # of Attendees	
Expected # of Completers	

*** One activity session or hour of related service provision, as appropriate.**

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 participants 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 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 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 programs for which funding is requested. You only need to complete this form once.)

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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 Board Chairperson

____

Date