ThriveAlliance
Enhancing lives. Building communities.

OLDER AMERICANS ACT

TITLE III-B APPLICATION

FISCAL YEAR 2016/2017

JULY 1, 2016 THROUGH JUNE 30, 2017

For technical assistance questions, please contact
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THRIVE ALLIANCE
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Columbus, IN 47201-1302
www.thrive-alliance.org

PLEASE NOTE THE FOLLOWING CHANGES TO THE 2016/17 PROPOSAL PACKET:

- NO REVIEW IS NEEDED BEFORE COUNTY COUNCILS ON AGING DUE TO CHANGES IN THE STRUCTURE OF COUNTY PROGRAMS.

- PLEASE SUBMIT ONE ORIGINAL APPLICATION WITH ORIGINAL SIGNATURES BY 5:00 PM, May 27, 2016.

- PLEASE BE VERY CONSERVATIVE IN YOUR REQUEST FOR FUNDING.

PROPOSAL FOR
OLDER AMERICANS ACT TITLE III-B FUNDING

FINAL Application should be submitted to Thrive Alliance on or before Friday May, 27 2016, at 5:00 p.m.

20% Non-Federal matching funds are required from approved applicants.

DEMOGRAPHIC AND SUMMARY BUDGET INFORMATION

1. **Title of Project**

2. **Legal Name and Address of Applicant**

   Director's Name:

   Telephone:

   Fax:

   E-mail:

   Website:

3. **Name and Address of Project (if different from above)**

   Project Director's Name:

   Telephone:

   Fax:

   E-mail:

4. Type of Application

New _____
Revision _____
Continuation _____
Supplement _____

5. Project Period

Beginning Date: _____
Ending Date: _____

6. Service Area

Check counties to be served:

Bartholomew County _____
Brown County _____
Decatur County _____
Jackson County _____
Jennings County _____
All five counties _____

7. Target Area to be served by project

Township _____
City _____
County _____
Multi-county _____

8. Organization Information

Are you a Public Agency? If so, please check:

City _____ County _____
State _____ Other _____

Are you a Non-Profit, 501C3 tax exempt organization?

Yes _____ No ____

If yes, provide your Federal ID number: _____.

9. Estimate of Total Unduplicated Number of People to Receive Services: _____

10. Services to be Funded (PLEASE CIRCLE)

A. ACCESS Services

Transportation
Outreach
Information and Referral
Escort

Other

B. COMMUNITY Services
- **Legal/Related Services**
- **Client Counseling**
- **Renovation/Repair**
- **Health Services**
- **Weatherization**
- **Recreation**
- **Protection/Crime Prevention**
- **Other**

C. SERVICES/ CARE Facilities
- **Ombudsman/Complaint**
- **Placement Assistance**
- **Group Services**
- **Other**

D. SUPPORT Services
- **Advocacy**
- **Activities Coordination**
- **Program Development**
- **Other**

In one or two sentences, what will your program do in 2016-2017?

_____
_____
_____
_____

11. Total one year request for funding:

Provider match must be at least 20% of total.

Title III-B Funds Requested	$ _____
Client Funds and Donations	$_____
Other Local Funds (***Please specify your sources for Local funds:*** _____	$ _____
Non-cash In-Kind	$ _____
Total Service Budget	**$ _____**

TITLE III-B SOCIAL SERVICES BUDGET FOR
JULY 1, 2016 TO JUNE 30, 2017

SUB GRANTEE: _____ **SERVICE:** _____

Cost Category	(1) In-Kind Resources	(2) Project Income	(3) Local Resources	(4) III-B Expense	(5) Service TOTAL
Personnel					
Employee Benefits & Related Expenses					
Rent & Utilities					
Contracts for Services					
Materials & Supplies					
Travel / Transportation					
Equipment					
Other Costs					
TOTAL COSTS					
Percentage of Budget, not to exceed 80%					

PROGRAM SUMMARY AND PROJECT NARRATIVE

1. **Describe briefly how older Hoosiers were involved in the development of this plan.**

2. **Describe your efforts to encourage involvement of older Hoosiers who are experiencing significant social and economic need.**

3. **Describe the process you use to monitor and evaluate the proposed program and/or services.**

4. **Describe your procedures for handling project income.**

5. **List holidays on which your facility is closed and the method used for determining winter closures.**

6. **This grant will provide services for older Hoosiers at the following locations:**

   Town _____

   Street Address _____

   Telephone _____

   Days Open _____

   Hours Open _____

   Person in Charge _____

ESTIMATE OF TOTAL AGENCY CLIENT CHARACTERISTICS

REMEMBER, an individual should be counted ONLY ONCE, no matter how many services he or she receives in the 12-month period.

1. **Total number of <u>different</u> people to be served by this grant: _____**

2. **Identify the major community(ies) you will be serving by this grant and complete the following:**

Total Number of People Receiving Service(s)	From City or Town
Total Number of People Receiving Service(s)	**From Rural Townships (not towns)**

3. **Of the total unduplicated number in Question #1, estimate how many are:**

American Indian	_____	Alaskan Native	_____
Asian/Pacific	_____	Black, not Hispanic	_____
Hispanic	_____	White, not Hispanic	_____

4. **Social Need. Estimate how many in Question #1 above are:**

Low Income	_____
Persons with disabilities 60 years of age or older	_____
Age 75 and older	_____
Minority persons 60 years and older	_____

DETAILED SERVICE DATA

Complete a separate form for EACH service to be provided.

Service to be funded: _____

ESTIMATED MEASURABLE OUTPUT PER SERVICE CATEGORY

1. **Unduplicated number of persons 60 and over to be served:**
   - Projected for FY 2016/17 _____
   - Provided last year _____
2. **Number of minority group persons 60 and over to be served in 2016/17:**
   - American Indian _____
   - Alaskan _____
   - Asian or Pacific _____
   - Black, not Hispanic _____
   - Hispanic _____
3. **How many are:**
   - Low Income _____
   - Persons with disabilities 60 and over _____
   - Persons aged 75 and over _____
4. **Units of service:**
   - Total units to be provided by this grant _____
   - Actual units provided last year _____

ESTIMATED COST OF PROVIDING SERVICE

5. Total cost of program		_____
6. Less In-Kind (non-cash)	-	_____
7. Less cash project income	-	_____
8. Less local cash resources	-	_____
9. Equals Federal / State funds	=	_____

10. Estimated Unit Cost

Total Cost of Program (#5)		_____
Divided by Units of Service (#4)	/	_____
Equals Estimated Unit Cost	=	_____

OBJECTIVES OF SERVICE

11. Describe the <u>action steps</u> planned for each of the proposed services.

Refer to local surveys, needs assessments, statistics, and other objective data that support the need.

FOR THIS FUNDING CYCLE, LOCAL PARTNERING TO ENHANCE AND/OR EXPAND YOUR SERVICES IS REQUIRED. WHO IS YOUR LOCAL PARTNER AND WHAT WILL THEY BRING TO YOUR PROGRAM?

WHAT CAN YOUR LOCAL PARTNER EXPECT TO GAIN FROM THE CONNECTION WITH YOUR PROGRAM?

SPECIFICALLY, WHAT HAS YOUR COMMUNITY PARTNER OFFERED? WHAT IS BEING PLANNED?

***We hereby certify that we have full authority to submit this application on behalf of the Applicant. We also certify that this authority to act, the above information and all supporting documentation are in accordance with the action of the <u>Applicant's Board of Directors or Governing Unit</u> and are recorded in their minutes, d*ated _____, 2016.**

_____ **Date:** _____

Signed: Director, Applicant Organization

_____

Printed Name

_____ **Date:** _____

Signed: Board Chair/President of Applicant Organization

_____

Printed Name

APPENDICES TO III-B PROPOSAL

ALL ITEMS MUST BE SUBMITTED
WITH PROPOSAL UNLESS OTHERWISE INDICATED.

The following must be attached by NEW APPLICANTS only. Applicants re-applying for funding only need to attach items if status has changed since submission of the original documents.

1. Articles of Incorporation or Certificate of Existence establishing nonprofit status from the Secretary of State

2. Evidence of nonprofit status with IRS (Letter of Determination)

3. Copy of governing by-laws

4. Names and contact information of Applicant's Board of Directors

5. Justification for in-kind values and supporting documentation

6. Justification for rental or space costs allocation, on approval of grant

7. Job Description for Project Personnel

8. Organizational Chart

The following must be completed and provided by EVERY APPLICANT for Title IIIb funding.

9. Statement of training emphasis within this grant proposal (staff meetings, training, community network involvement, etc.)

10. Certificates of Insurance for
    (a) Bonding of person and/or persons responsible for federal and state funds
    (b) Liability insurance covering project/premises
    (c) Auto and vehicle insurance for transportation
    (d) Thrive Alliance must be named as an additional insured.

11. Copy of minutes showing board approval of this project application

12. Copy of fire inspection completed on or before May 27, 2016.

13. Copy of health inspection report completed on or before May 27, 2016.

14. Year-end financial report for previous year (include copy of audit if applicable).

The following must be completed and provided by APPLICANTS providing a TRANSPORTATION SERVICE.

15. Transportation service providers should carry liability insurance coverage no less than $500,000. It is strongly recommended that such coverage be carried for $1,000,000.

16. A statement detailing how the project will monitor service to the elderly.

17. A statement about the Provider's enforcement plan of minimum transportation safety standards.

18. A statement noting projection of most critical transportation needs.

GENERAL ASSURANCES

The purpose of these assurances is to provide understanding and agreement so that Providers may deliver services to eligible individuals authorized to receive service through Social Service Block Grant, TIII Older Americans Act and/or Older Hoosier Act contracts with Aging and Community Services of South Central Indiana, Inc... Funding for services under this Agreement is provided through the Indiana Family and Social Services Administration.

1. General Administration. The Provider agrees to deliver services proposed evenly and consistently throughout the entire period covered by the proposal to ensure continuity of client care.

2. Service Area. Providers of service for specific geographic areas must make service available to all parts of the contracted area.

3. Civil Rights Protection. Pursuant to Title VI of the Civil Rights Act of 1964 as amended, the Provider shall not deny service to any individual on the basis of race, color, gender or national origin or otherwise deny benefits on the basis of such discrimination.

4. ADA Compliance. The Provider will comply with all federal and state legislation and regulations for the provision of accessible services and non-discrimination on the basis of disability.

5. Client Contributions. The Provider agrees to make provision to afford the client an opportunity to contribute, in a confidential manner, to the cost of the service. Each participant will be permitted to determine what amount he or she is able to contribute to the cost of the service.

6. Residency and Citizenship. The Provider shall not impose residency or citizenship requirements as a condition for client participation in any service.

7. Coordination of Resources. The Provider agrees to coordinate with and utilize all other public and private resources, including Medicaid Waiver, to expand services where applicable.

8. Recognition of Funding Source. The Provider agrees to recognize Thrive Alliance as a funding source on all promotional material (i.e., newsletters, brochures, annual reports) and to display any materials provided by Thrive Alliance.

9. Minority Representation and Service. The Provider agrees to attempt to serve minority individuals in proportion to the number of low income minority persons in the population of the service area.

10. Nursing Home Diversion. The Provider agrees to assist Thrive Alliance. In its attempts to identify and reach low income and minority individuals in danger of nursing home placement.

11. Benefits Awareness. The Provider agrees to assist participants with locating staff and resources that will allow them to take advantage of benefits under other programs (i.e. SSI, Medicaid, Medicaid Waiver, CHOICE, HDMs, etc.).

12. Smoke-Free Environment. The Provider agrees to ensure a smoke-free environment for participants of Title III-B services.

13. Drug-Free Workplace. The Provider will provide a drug-free workplace by:

(a) Providing its employees a statement prohibiting manufacture, distribution, dispensing, possession or use of controlled substances at the workplace and the penalties that will be imposed for violations of this prohibition;
(b) Establishing and conducting a drug-free awareness program for employees;
(c) Requiring all employees notify the Provider within five days after a conviction for violation of a criminal drug statute;
(d) Notifying in writing the contracting State Agency and the Indiana Department of Administration within ten days of receiving notice of an employee's conviction for violation of a criminal drug statute;
(e) Imposing sanctions on an employee for conviction of drug abuse violations up to and including termination or requiring such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program; and
(f) Making a good faith effort to maintain a drug-free workplace through the implementation of the terms of this provision.

14. Purpose of Title III Funding. The Provider recognizes the purpose of the Title III program is to foster the development of comprehensive and coordination service systems for older persons within the Thrive Alliance service area.

(a) The objectives of the Title III Program are to secure and maintain independence and dignity in a home environment for older persons capable of self-care with appropriate supportive services; and to remove individual and social barriers to economic and personal independence for older persons, including the provision of opportunities for employment and volunteer activities in the communities where older persons live.
(b) The resources provided through Title III grants are designed to
    1) enable providers to obtain commitments from public and private sources to offer cooperative arrangements that permit maximum utilization of existing resources;
    2) make existing social services more accessible to older persons in need through the development of supportive services that increase visibility and awareness throughout the community; and
    3) promote comprehensive services for older persons through the development and support of social services that are not otherwise available.

15. Standards and Licensing. Where state or local jurisdictions require licensure and conformance with state and local standards for fire, health, safety and sanitation, the Provider will obtain and maintain such license and observe the standards prescribed in law or regulations.

16. Evaluation. The Provider will cooperate and assist any efforts by Thrive Alliance, the Indiana FSSA Division of Aging and the US Administration on Aging to evaluate the effectiveness, feasibility and cost of activities conducted under this application for Title III funds.

17. Confidentiality. The Provider agrees that no personal information obtained from an individual in conjunction with the project shall be disclosed in a form that identifies said individuals without the written and informed consent of the individual concerned.

18. Records and Reports. The Provider will keep such records and make such reports in such form and containing such information as may be required by Thrive Alliance and the Indiana FSSA Division of Aging and Board of Accounts. The Provider will maintain accounts and written records that will permit expeditious determination to be made at any time of the status of funds received from Thrive Alliance and charges claimed against said funds. Thrive Alliance and the Indiana Attorney General's Office have the right of access to and the right to examine all records, books, papers or documents related to this grant.

19. Federal and State Laws and Regulations. The Provider assures that it will comply with all Federal and State laws and regulations, including but not limited to the Civil Rights Act, the ADA, the Hatch Act, the Social Security Administration, the Fair Labor Standards Act, and Federal Office of Management and Budget administrative requirements.

20. Provider Policies. The Provider will establish and enforce policies to prohibit employees from using their positions for a purpose that is or give the appearance of being motivated by a desire for private gain for themselves or others, particularly those with whom they have family, business, or other ties.

21. Convictions. The Provider certifies that no official, agent or employee of the Applicant Agency has been convicted of bribery or attempting to bribe an officer or employee of the State of Indiana in that office or employee's official capacity or has made an admission of guilt of such conduct which is a matter of record but has not been prosecuted for such conduct.

CERTIFICATION

In the event the application for Title III funding is approved, the Provider Organization certifies that it will comply with the above assurances.

Authorized Official of the Provider Organization:

_____ _____

Signature Date

_____

Printed Name and Title

BUDGET NARRATIVE

LOCAL RESOURCES – TOTAL FOR ALL SERVICES

1. PROGRAM INCOME

Match must be 20% or more of federal funds requested.

Source Description Amount

_____

_____

_____

TOTAL PROGRAM INCOME **$** _____

2. CASH RECEIVED FROM ALL SOURCES FOR ALL SERVICES

A. Cash Public (cash from local governmental units)

Source Description Amount

_____

_____

_____**Subtotal (Cash Public)**

$ _____

B. Cash Non-Public (cash from service clubs, United Way, other local groups, etc.)

Source Description Amount

_____

_____

_____**Subtotal (Cash Non-Public)**

$ _____

TOTAL CASH RECEIVED
FROM ALL SOURCES FOR ALL SERVICES **$** _____

3. IN-KIND FROM ALL SOURCES FOR ALL SERVICES (NON CASH DONATIONS)

A. In-Kind Public (non-cash contributions from local governmental units)

Source	Description	Amount

Subtotal (In-Kind Public) **$ _____**

B. In-Kind Non-Public (non-cash contributions from service clubs, United Way, other local groups, etc.)

Source	Description	Amount

Subtotal (In-Kind Non-Public) **$ _____**

TOTAL IN-KIND CONTRIBUTIONS RECEIVED FROM ALL SOURCES FOR ALL SERVICES **$ _____**

4. TOTAL LOCAL RESOURCES

Total of Numbers 1, 2 and 3 above **$ _____**

AGENCY / STAFF COORDINATION

1. List agencies with which services are coordinated.

2. Staff description.

A. TOTAL number of full time equivalent (FTE) staff paid by this grant: _____

B. TOTAL number of staff (employees) paid by this grant: _____

C. TOTAL wages/fringe benefits of staff paid by this grant: $_____

3. List employment programs (Experience Works, Title V, Work One, etc.) that support the services listed in this grant by providing labor at no cost to the program.

Source of Employment	Number of Positions Provided	Service Provided

MEMORANDUM OF UNDERSTANDING
FOR
EQUIPMENT PURCHASED USING TITLE III FUNDS

All equipment purchased with Older Americans Act Title III funds by _____ (Applicant) using funds through a grant awarded by the Board of Directors of Thrive Alliance will be utilized for the purposes outlined in the Proposal Application.

Upon termination of the grant, equipment will continue to be used for such purposes or will revert back to the Board of Thrive Alliance or to the Indiana Family and Social Services Administration or the Federal government solely as determined by the Thrive Alliance Board of Directors.

It is the policy of the board of Thrive Alliance to require assurance that any publication, equipment, or publicity purchased with Title III grant funds or regarding this grant shall identify Thrive Alliance as the source of funding.

_____
Signature, Authorized Official for Provider Agency

_____
Printed Name

_____
Title

_____
Date

EQUIPMENT INVENTORY FORM (IF APPLICABLE)

List ONLY equipment that has been purchased with Federal Funds.

Location: _____

Date this form was filled out: _____

Person who filled out this form: _____

Description of Equipment	Quantity	Date Acquired	Purchased or Donated	Original Value	Location of Item	Condition Gd/F/Poor

For each item of equipment, please list **Funding Source** for its purchase:

Equipment	Funding Source

~END OF DOCUMENT~