**Nevada Aging and Disability Services Division (ADSD)**

**Competitive Subaward Application  
  
Assisted Living Supportive Services (Facility Expansion or Establishment)**

**State Fiscal Year 2021**

|  |  |
| --- | --- |
| **Agency/Organization Name:** |  |



**PROJECT NARRATIVE**

*(reference the instruction file)*

* + 1. **Proposal**

* + 1. **Target Population, Service Area and Targeting Plan**

* + 1. **Organizational Capacity and Partnerships**

* + 1. **Cost-Effectiveness and Sustainability**

* + 1. **Evaluation**

**ORGANIZATIONAL STANDARDS AND APPLICANT QUESTIONNAIRE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Provide a detailed answer to each of the following questions, or choose N/A, as applicable:** | | | |
| 1. **When was the agency incorporated?** | |  | |
| 1. **Does the agency have bylaws?**   *(If so, ADSD may request a copy at a later date.)* | | **Yes**  **No  N/A** | |
| 1. **Is the agency a:** | | | |
| **Public agency - Identify governing body:** | | | |
| **Private, for-profit agency** **- Identify headquarters/legal ownership:** | | | |
| **Private, non-profit agency – select option below** | | | |
| **Check the box if you agree to this statement:** **The agency has a Board of Directors that is active, responsible and holds regular meetings. Members have no material conflicts of interest and serve without compensation.** | | | |
| **If the above box for non-profit Board of Directors is not checked, explain the reason and plan of action to remedy the situation:** | | | |
| 1. **Financial Accountability:** | | | |
| **Check the box if you agree to this statement:** **Agency has a system for generating profit/loss statement (if for-profit) or statement of activities (if non-profit/governmental) and a detailed transaction report. Agency has a separate accounting for each subaward, if more than one.** | | | |
| **If the above box for financial accountability is not checked, explain the reason and plan of action to remedy the situation:** | | | |
| 1. **What are the agency’s days and hours of operation?**   **Proposed service hours, if different:**       **N/A – Same as agency** | | | | |
| 1. **Is the agency closed on days other than state and/or federal holidays, when services would not be available to clients? If yes, list the tentative dates in FY21 and explain the reason for the closure.  N/A – No other office closures** | | | | |
|  | | | | |
| 1. **If the proposed assisted living facility is not currently in operation, when will provision of supportive services begin and when will the facility become fully operational?** | | | | |
| **N/A – Facility is fully operational and providing the service** | | | | |
| 1. **Is this application for Assisted Living Facility:**   **Establishment  Expansion**  **Comments:** | | | | |
| 1. **Does, or will, the assisted living facility provide supportive services for older adults pursuant to the provisions of the home and community-based services waiver in** [**NRS 422.3962**](https://www.leg.state.nv.us/NRS/NRS-422.html#NRS422Sec3962)**?** | | | | |
| **Yes, Currently Meets. Describe services provided according to the NRS:**        **Yes, Will Meet. Describe plan to provide services in the NRS:**        **No (Applicant Ineligible)** | | | | |
| 1. **Does, or will, the assisted living facility meet the certification criteria of** [**NRS 319.147**](https://www.leg.state.nv.us/NRS/NRS-319.html#NRS319Sec147)**, as required in** [**NRS 439.630**](https://www.leg.state.nv.us/nrs/NRS-439.html#NRS439Sec630) and [**422.3962**](https://www.leg.state.nv.us/NRS/NRS-422.html#NRS422Sec3962)**?** | | | | |
| **Yes, Currently Meets. Describe how facility meets the NRS:**        **Yes, Will Meet. Describe plan to meet the NRS:**        **No (Applicant Ineligible)** | | | | |
| 1. **Is the applicant an Assisted Living provider for the Home and Community-Based Services Medicaid Waiver (HCBW)?** | | | | |
| **Yes. Provider Identifier:**  **No. Comments:** | | | | |
| 1. **How many beds does, or will, the facility have if funds are awarded?**   **Of those beds, how many will be reserved for HCBW clients age 65 and older?**  **Comments:** | | | | |
| 1. **Does the agency agree to give service priority to eligible individuals referred by ADSD who are at risk of institutional placement or have been a victim of abuse?**   **Yes  No, comments:** | | | | |
| 1. **Funding will be disbursed as monthly or quarterly reimbursements. Advance funding may be approved on a temporary basis only, with a documented hardship, and will not be approved to provide a cushion of funding. Please choose one of the following:** | | | | |
| **I agree to these terms and will submit reimbursements.** | | | | |
| **I agree to these terms but would like to document a hardship to be considered for temporary advance funding. Please explain the hardship and number of months for which you may need advance funding (do not request the entire fiscal year):** | | | | |
| 1. **If the agency is not currently funded by ADSD, list three professional references below (name, address, phone number and business affiliation with your agency).**   **N/A: Current ADSD Grantee** | | | | |
|  |  | |  | |