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

**Competitive Subaward Application ~ Part 2, Narrative  
Title III-E Innovation Projects, Project Period: 12/01/19 – 9/30/20**

|  |  |
| --- | --- |
| **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**

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| --- | --- | --- | --- |
| **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** – Does the agency have a Board of Directors that is active, responsible and holds regular meetings? Members must have no material conflicts of interest and must serve without compensation.  Yes  No, Explanation and plan of action: | | | |
| 1. **Financial Accountability:** | | | |
| Does the agency have a system for generating a profit/loss statement (if for-profit) or a statement of activities (if non-profit/governmental) and a detailed transaction report with separate accounting for each subgrant award, if more than one?  Yes  No, Explanation and plan of action: | | | |
| 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 within the budget period and explain the reason for the closure.  N/A – No other office closures** | | | | |
|  | | | | |
| 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 reimbursements. If your agency cannot administer the service with reimbursed funding, a request for advance payments is necessary and the justification must be approved by ADSD. Please choose one of the following:** | | | | |
| **Agency will request funding as monthly or quarterly reimbursements.** | | | | |
| **Agency requires advance payments. *Checking this box indicates that the agency is unable to function on a reimbursement basis.* Provide thorough justification for your request here for ADSD consideration:** | | | | |
| 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** | | | | |
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