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

**Competitive Subaward Application

Services and Support - Fiscal Year 2021**

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

**PROJECT NARRATIVE**

* + 1. **Proposed Intervention**

* + 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 in FY21 and explain the reason for the closure. [ ]  N/A – No other office closures**
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|       |
| 1. **If the agency is currently providing this service, please answer the following questions: [ ]  N/A – Agency is not currently providing this service. (Skip to #8)**
 |
|  | **7a. # of Clients Served in 2019\*:**      ;  **# of Units of Service in 2019\*:**       ***(\* Used [ ]  Calendar Year -or- [ ]  Fiscal Year, Oct-Sept)***  |
|  | **7b. What funding sources were used?**       |
|  | **7c. Does the program use a sliding-fee scale or a cost-sharing procedure?****[ ]  Yes** (If yes, attach a copy of the scale/procedure to the application.)**[ ]  No** |
|  | **7d. Does the agency have a waiting list for this program?  [ ]  Yes [ ]  No** |
|  | **If yes:** | 1. **How many people are on the waiting list?**
2. **How many have been assessed as eligible?**
3. **What is the average time spent on the waitlist?**
4. **Would additional funding alleviate the waitlist? [ ]  Yes [ ]  No, explain:**
	1. **If yes, how much funding and what expenses would the funds cover?**
5. **Is the program operating at capacity? [ ]  Yes [ ]  No**
 |
|  | **7e. What is the suggested donation amount, by unit of service?** $      **Comments:**      **[ ]  Not Established** |
|  | **7f. What filing system is used for client information: (check all that apply)** **[ ]  Hardcopy [ ]  Electronic [ ]  In Process of Transitioning to Electronic Filing** **Comments:**       |
|  | **7g. Has a resource listing been posted to** [**www.Nevada211.org**](http://www.Nevada211.org)**, which contains accurate and up-to-date information for the agency and this service?** **[ ]  Yes [ ]  No – Explanation Required:**       |
| 1. **If the proposed program is not currently in operation, when will service provision begin and when will the program become fully functional?**
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|       **[ ]  N/A – Program is fully functional and providing the service** |
| 1. **Provide a thorough justification for the level of funding requested from ADSD in this application. If an increase or decrease was requested for a current subaward, address the reason for the request.** (*e.g., the increase/decrease in demand for service; specific program expenses rising/falling; staffing needs; impact of loss/gain of funding, etc. )*
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|       |
| 1. **What percentage of the *total* cost of providing this service would the ADSD requested amount represent?**      **% 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. **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 – Explanation Required:**       |
| 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** |
|       |       |       |

**Goals and objectives**

**Goal 1:**

| **Objective(s)** | **Activities** | **Due Date(s)** | **Staff Responsible****(Name and Title)** | **Documentation Retained for ADSD Verification** |
| --- | --- | --- | --- | --- |
| 1.
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| 1.
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| 1.
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**Goal 2:**

| **Objective(s)** | **Activities** | **Due Date(s)** | **Staff Responsible****(Name and Title)** | **Documentation Retained for ADSD Verification** |
| --- | --- | --- | --- | --- |
| 1.
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**Goal 3: Quality Improvement and Effectiveness**

| **Objective(s)** | **Activities** | **Due Date(s)** | **Staff Responsible(Name and Title)** | **Documentation Retained for ADSD Verification** |
| --- | --- | --- | --- | --- |
| 1. Meet or exceed Projected Output Measures as submitted in the approved subaward application
 | Complete data entry and/or submit other required reportingConduct Outreach to reach target populationsDevelop partnerships      |       |       |       |
| 1. Quality Improvement
 | Administer and Analyze Surveys, Implement Improvements1. Satisfaction, client feedback, meal surveys
2. Performance Indicators

c.       |       |       |       |
| 1.
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