

Buckeye Hills Regional Council

Request for Proposal: PY 2024-25 Alzheimer's Respite Services

Application Forms and Instructions

**BUCKEYE HILLS REGIONAL COUNCIL
APPLICATION FORMS AND INSTRUCTIONS
ALZHEIMER'S AND SCS RESPITE FUNDS PY 2024-25**

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INTRODUCTION

1. This document (Application Forms and Instructions) contains instructions and the following required forms:
 - Agency Authorization to Submit Certification Form
 - Terms and Conditions Form
 - General Assurance Form
 - Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion
 - Agency Overview Questions
 - Compliance to Rules
 - Service Application Questions
2. The following are required forms to be submitted by bidder:
 - Organizational chart
 - Proof of registration with the Secretary of State as a non-profit organization or as a for-profit business
 - Documentation of commercial liability insurance coverage
 - evidence of insurance coverage for consumer loss due to theft or property damage
 - copy of the written procedure describing the step-by-step instructions a consumer may follow to file a claim
 - Mission Statement
 - Current Annual Report (*If available*)
 - Most recent Audit or Financial Statement
 - Status of Pending Litigation
 - New Applicant Questions (if applicable)
3. The contract workbook (Excel format) contains the following required forms:
 - Contact Sheet
 - Contract Services Pages (CSP)
 - Budget Narrative
4. The completion check forms are contained in this document.

Ohio Department of Aging Rules are found at the Ohio Department of Aging website:

<https://aging.ohio.gov/agencies-and-service-providers/rules-and-forms>

To respond to the questions in this application, click inside the gray text box and begin typing.

DOCUMENT CHECKLIST FORM

Document CHECKLIST	Application Document Order	You Provide	Form in This Document	Forms in Excel Workbook	Your Checklist
Document Checklist	1		This Form		<input type="checkbox"/>
Contact Sheet Form	2			x	<input type="checkbox"/>
Agency Authorization to Submit Certification Form	3		x		<input type="checkbox"/>
Terms and Conditions Form	4		x		<input type="checkbox"/>
General Assurance Form	5		x		<input type="checkbox"/>
Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion	6		x		<input type="checkbox"/>
Status of Pending Litigation	7	x			<input type="checkbox"/>
Agency Overview Questions	8		x		<input type="checkbox"/>
Compliance to ODA Rules	9		x		<input type="checkbox"/>
Organizational Chart	10	x			<input type="checkbox"/>
Service Application Questions	11		x		<input type="checkbox"/>
Contract Service Pages and Budget Narratives for Each Service				x	<input type="checkbox"/>
Proof of registration with the secretary of state as a non-profit organization or as a for-profit business	12	x			<input type="checkbox"/>
Documentation of commercial liability insurance coverage	13	x			<input type="checkbox"/>
Written step-by-step instructions for consumer claim	17			x	<input type="checkbox"/>
New Applicant Questions	18	x			<input type="checkbox"/>

Please use this checklist to organize all application documents for the final submission.

This application packet includes all materials needed to apply for PY 2024-25 Alzheimer's Respite and Senior Community Service Block Grant funding.

One (1) complete application in hard copy or electronic copy via email must be received by BHRC at 1400 Pike Street, Marietta, Ohio 45750 by 4:00 p.m. on April 7, 2023.

- If mailed via USPS, bidder is required to use certified return receipt.
- If hand delivered, bidder will be given a receipt at time of delivery.
- If e-mailed, a return email acknowledgement of receipt will be sent to the sender's email address.

Document CHECKLIST (cont.)	Application Document Order	You Provide	Form in This Document	Forms in Excel Workbook	Your Checklist
Applicant – Attachments					
Mission Statement	14	×			<input type="checkbox"/>
Current Annual Report	15	×			<input type="checkbox"/>
Most recent Audit or Financial Statement	16	×			<input type="checkbox"/>

Time stamp on e-mail must be prior to 4:00 p.m. on April 7, 2023; time stamp on email after 4:00 p.m. and proposal will be rejected. Email completed proposals to dherbert@buckeyehills.org with the subject line of PROPOSAL TO PROVIDE ALZHEIMER'S RESPITE FUNDED SERVICES. Send with high priority.

- Faxed proposal applications will be rejected.

Applications will be reviewed for completeness and compliance with required formats and must meet the Minimum Criteria. It is not the responsibility of BHRC, upon receipt of the proposal application, to notify applicants if they have not met any of the above listed application deadline requirements for completeness and/or compliance with required formats, even if the proposal is submitted before the application deadline.

PLEASE NOTE:

- If you are submitting a proposal to provide service(s) for more than one county, you are required to submit only one copy of the following. Please include required documents in the original copy noting that "required documentation is included in this original packet":
- Organizational Chart
- Proof of registration with the Secretary of State as a non-profit organization or as a for-profit business
- Documentation of commercial liability insurance coverage
- Written step-by-step instructions for consumer claim
- Mission Statement
- Current Annual Report (*If available*)
- Most recent Audit or Financial Statement
- If you are proposing to provide the same service in different counties, you must submit a separate proposal for each county. Bidders submitting proposals for multiple counties in one packet will be deemed non-compliant and may be rejected.

Agency Authorization to Submit Certification Form

AGENCY: _____ We, the undersigned certify that all information (including funding levels) is true to the best of our knowledge. This application was approved and authorized for submission to the BHRC by _____(NAME OF GOVERNING BOARD) during a meeting held _____..... (DATE OF MEETING)

Should this agency receive the grant(s) applied for, we will fulfill the intent of the application.

We further understand that additional documentation will be required after grants are awarded and agree to comply with BHRC requirements regarding it.

President, Governing Board: _____
(PLEASE TYPE NAME)

Signature of President _____

Director of Agency: _____
(PLEASE TYPE NAME)

Signature of Director: _____

Date: _____

Terms and Conditions Form

The undersigned understands and agrees that:

- 1) Funds awarded as a result of this proposed request shall be expended for the purposes set forth herein and in accordance with all applicable laws, regulations, policies and procedures of the Buckeye Hills Regional Council and the Ohio Department of Aging.

- 2) The Applicant's employment practices, the provision of services, and the purchasing or subcontracting of goods and services shall be non-discriminatory in accord with all applicable laws and regulations. The Applicant further assures that no portion of its program(s) for which Buckeye Hills Regional Council funding is sought will in any way discriminate against, deny benefits to, deny employment to, or exclude from participation any persons on the grounds of race, color, national origin, religion, age, sex, handicap, or political affiliation or belief. Effort shall be made by Applicant to make programs and facilities accessible to eligible qualified handicapped and disabled persons.

- 3) The Applicant assures that it complies with all federal wage and hour laws, and all workers' compensation laws.

- 4) Any proposed changes in the proposal as approved shall be submitted in writing by the applicant and upon written notification of approval by the Buckeye Hills Regional Council shall be deemed incorporated into and become part of this Agreement.

Funds awarded by the Buckeye Hills Regional Council may be terminated at any time for violation of any terms, conditions and/or requirements of this agreement.

SIGNATURE OF PERSON AUTHORIZED TO SIGN
PROPOSAL FOR APPLICANT AGENCY

DATE

TYPED NAME & TITLE OF AUTHORIZED SIGNATORY

TYPED ADDRESS OF AUTHORIZED SIGNATORY

General Assurance Form

General Assurance of Compliance with Ohio Administrative Code, Ohio Department of Aging and Buckeye Hills Regional Council, Policies and Procedures

The Applicant Service Provider Agency hereby assures and certifies that it will comply with the Ohio Administrative Code Rules, Ohio Department of Aging and Buckeye Hills Regional Council policies and procedures as they relate to the application, acceptance and use of Alzheimer's Respite and Senior Community Service Block Grant funds for the Applicant's proposed aging services program. Also, the Applicant Agency assures and certifies that:

1. It recognizes that although quality assurance practices and procedures are mandated and monitored by the Ohio Department of Aging and Buckeye Hills – Regional Council, it is the provider agency that must retain ultimate responsibility for the quality assurance function. It further recognizes that the overall responsibility for ensuring quality rests within the provider's organization.
2. It shall comply with the Ohio Administrative Code Rules, Ohio Department of Aging and Buckeye Hills Regional Council policies and procedures, which focus on agency operations and consumer care. Ohio Administrative Code Rules, Ohio Department of Aging and Buckeye Hills Regional Council policies and procedures are accessible through the BHRC website.
3. It shall comply with the rules, policies and procedures for the following services: Adult day care, homemaker and personal care. The applicant acknowledges responsibility as to compliance and awareness that failure on its part to comply may constitute sufficient basis for (1) a finding by BHRC of lack of administrative capability, and (2) imposition by BHRC of appropriate sanctions. Rules, policies and procedures are accessible through the BHRC website.

The Applicant Agency also recognizes and agrees that Alzheimer's and SCS Respite funds will be extended in reliance on the representation and agreements made in this Assurance and that the ODA and BHRC will have the right to enforce this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below as authorized to sign this Assurance on behalf of the applicant agency.

The Assurance obligates the provider agency for the period of their service contract to proceed in good faith and in cooperative effort to bring those services subject to quality assurance which are contracted for into compliance with all applicable quality assurance standards and requirements.

NAME OF APPLICANT AGENCY (TYPE)

SIGNATORY NAME (TYPE)

TITLE OF SIGNATORY (TYPE)

SIGNATURE OF AUTHORIZED OFFICIAL

DATE

**Certification Regarding
Debarment, Suspension, Ineligibility and Voluntary Exclusion
Lower Tier Covered Transactions**

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, 29 CFR Part 98, Section 98.510, Consumers' responsibilities. The regulations were published as Part VII of the May 26, 1988 Federal Register (pages 19160-19211).

- (1) The prospective recipient of Federal assistance funds certifies, by submission of this proposal, that neither it nor its principles are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
- (2) Where the prospective recipient of Federal assistance funds is unable to certify to any of the statements in this certification, such prospective participation shall attach an explanation to this proposal.

NAME OF APPLICANT AGENCY (TYPE)

SIGNATORY NAME (TYPE)

TITLE OF SIGNATORY (TYPE)

SIGNATURE OF AUTHORIZED OFFICIAL

DATE

STATUS OF PENDING LITIGATION

All Bidders must provide a written statement from their legal counsel, which provides a description of any pending litigation, or a statement that there is no pending litigation.

Agency Overview Questions

In the space provided below please answer the listed questions.

Please **do not** attach agency brochures, newspaper clippings or other materials. All questions must be answered as instructed. Points will be deducted for unanswered questions.

Agency Description

Describe the geographic area your agency will serve with the proposed service(s).

Describe the population to be served by the proposed service(s) in your area.

Provide a detailed description of your agency's **experience in providing the proposed service(s)**.

How does your agency identify and plan for new or changing service trends for the proposed service(s).

How will your agency provide services to low-income minority individuals, older persons with limited English proficiency, and older persons residing in rural areas?

Does your agency conduct an annual consumer satisfaction survey?

How are the results of this survey used in creating your agency's quality improvement plan?

Please describe your agency's interaction with the Alzheimer's Association(s) in your service area.

Please describe your agency's interaction with support groups for individuals who care for those with Alzheimer's Disease.

Describe your agency's policy and procedure for correcting poor employee performance.

Describe your agency's policy and procedure for handling consumer complaints.

Provide an example of your agency's employee development plan.

Provide your agency's procedure in dealing with the accusation of theft involving medication.

Organizational Chart Instructions

Please submit an organizational chart with your application for funding. The organizational chart submitted must identify all staff involved in the delivery of Alzheimer's Respite services. The staff names, titles, full or part time status, and lines of authority.

Adherence to OAC Rules, ODA/BHRC Policies and Procedures

Answers to these questions must reflect **current practices** for your agency.

Points will be deducted for unanswered questions or failure to answer questions as instructed.

Organizational Structure	Yes	No
Does your agency have a mission statement defining the purpose of business or service agency, policies and directives, bylaws, or articles of incorporation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a written table of organization that clearly identifies managers, supervisors, staff and lines of authority?	<input type="checkbox"/>	<input type="checkbox"/>
Do you operate in compliance with all applicable federal, state, and local laws, and have a written statement supporting compliance with : non-discrimination laws, federal wage and hour laws, and workers compensation laws in the recruitment and employment of individuals; non-discrimination laws in the provision of services?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a written affirmative action plan that is used by the organization when posting open positions and making hiring decisions?	<input type="checkbox"/>	<input type="checkbox"/>
Personnel	Yes	No
Do you have written job descriptions including qualifications for each position involved in the delivery of services?	<input type="checkbox"/>	<input type="checkbox"/>
Do you provide performance appraisals or a development plan for all employed, contract workers, and volunteers involved in providing services?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a signed and dated document indicating completion of employee orientation including: employee position description and expectations, personnel policies, reporting procedures and policies, an organizational table, and a code of ethics?	<input type="checkbox"/>	<input type="checkbox"/>
Policies and Procedures	Yes	No
Do you have a system to document services delivered, billed, and reimbursed that complies with the rules, policies and procedures referenced in this application document?	<input type="checkbox"/>	<input type="checkbox"/>
Can you provide evidence detailing financial responsibility in the coverage of consumer loss due to theft, property damage, or personal injury, as well as written procedures which identify the steps a consumer must take to file a liability claim?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have written procedures regarding business operations and provisions of service?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a written procedure for reporting and documenting all consumer incidents including significant changes that affect service delivery or imminent health or safety risks?	<input type="checkbox"/>	<input type="checkbox"/>

Policies and Procedures Continued	Yes	No
Do you maintain a file for each consumer that includes: name, address, telephone number, DOB, gender, emergency contact person or caregiver information, functional abilities and limitations relevant to authorized services, demographic data as requested by BHRC, and the service provider's contact information?	<input type="checkbox"/>	<input type="checkbox"/>
Do you maintain documentation of each consumer contact and each service delivered?	<input type="checkbox"/>	<input type="checkbox"/>
Do you obtain written approval from the consumer to release any consumer information?	<input type="checkbox"/>	<input type="checkbox"/>
Do you retain all consumer records for at least six years or until an audit is completed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a written procedure for follow-up and investigation of consumer complaints and grievances?	<input type="checkbox"/>	<input type="checkbox"/>
Do you provide the opportunity for consumers to make voluntary contributions for services?	<input type="checkbox"/>	<input type="checkbox"/>

Compliance	Yes	No
Does your organization deliver services in compliance with OAC Rule, ODA and BHRC policies and procedures?	<input type="checkbox"/>	<input type="checkbox"/>
Do you maintain documentation demonstrating that all requirements have been met when delivered either directly or by sub-contract?	<input type="checkbox"/>	<input type="checkbox"/>
Are you willing to allow access to ODA, BHRC, and other representatives with a need to access the provider's facility, policies, procedures, records, and other documents related to the provision of Alzheimer's respite services?	<input type="checkbox"/>	<input type="checkbox"/>
Do you demonstrate compliance with OAC Rules 173-9-01 through 173-9-10 regarding background investigations of direct service workers?	<input type="checkbox"/>	<input type="checkbox"/>

Comments

Please provide a brief written explanation regarding each question for which a "NO" response was given:

SERVICE APPLICATION QUESTIONS

Adult Day Respite Questions

The following questions are required for those agencies applying for **Alzheimer's Respite Adult Day Services**.

Please do not attach agency brochures, newspaper clippings or other materials. All questions must be answered as instructed. Points will be deducted for unanswered questions or failure to answer questions as instructed.

Purpose of Alzheimer's Respite Adult Day Services	Yes	No	N/A
Is the <i>Adult Day Program</i> provided by your agency designed to meet the needs of consumers with Alzheimer's or related dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the <i>Adult Day Program</i> designed to provide respite for the consumer's Caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the <i>Adult Day Program</i> staff trained to understand the unique needs of consumers with Alzheimer's or another related dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the space below please describe how your organization will continue the provision of this service in the event of an emergency.

Adult Day Consumer Service Management	Yes	NO	N/A
Does a licensed healthcare professional whose scope of practice includes health assessments perform an initial health assessment which identifies the consumer's physical, cognitive and psychosocial needs in the Adult Day Program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is a care plan created that addresses the consumer and Caregiver needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the agency convene interdisciplinary care conferences for each consumer at least every six months at which time care plans are reviewed and revised according to changes in the consumer's status?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the agency maintain documentation of physician's authorization prior to administering medications, nursing services, nutrition counseling, or therapeutic services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are daily and monthly planned activities posted in full view of consumers and caregivers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are consumer activities planned and supervised by an Activity Coordinator?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adult Day Respite (Continued)

Staff Qualifications and Training for Adult Day Services	Yes	No	N/A
Does your agency ensure that an RN or LPN under RN supervision will be on-site a minimum of eight hours per month while consumers are in attendance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency provide <i>task-based training</i> to all direct care staff prior to working with consumers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can your agency ensure that the <i>staff to consumer</i> ratio will be at least one staff person to every six consumers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency require eight hours of in-service continuing education for Adult Day staff for each twelve-month period, excluding agency and program-specific orientation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List all staff members that will participate in the delivery of the proposed services. Include job titles and credentials:

Staff Name	Job Title	Credentials

Facility Requirements	Yes	NO	N/A
Does your facility have a separate, identifiable space available for ADS where at least sixty square feet is available per consumer and at least one accessible, working toilet per each ten consumers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are all medications and toxic substances kept locked and stored away from consumers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have a documented and posted fire and emergency safety plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency engage in and document periodic inspections and routine maintenance of fire extinguishers, smoke alarms, and quarterly evacuation drills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency provide noon meals and snacks planned by a licensed dietician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency provide or arrange for transportation to the Adult Day Program as specified in OAC 173-3-06.1(B)(2)(a)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Alzheimer's Respite Institutional Care Questions

The following questions are required for those agencies applying for ***Alzheimer's Respite Institutional Care Services***.

Please do not attach agency brochures, newspaper clippings or other materials. All questions must be answered as instructed. Points will be deducted for unanswered questions or failure to answer questions as instructed.

Purpose of Alzheimer's Respite Institutional Care Services	Yes	No	N/A
Is the <i>Alzheimer's Respite Institutional Care</i> provided by your agency designed to meet the needs of consumers with Alzheimer's or related dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the <i>Alzheimer's Respite Institutional Care</i> designed to provide respite for the consumer's Caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the <i>Alzheimer's Respite Institutional Care</i> staff trained to understand the unique needs of consumers with Alzheimer's or other related dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the space below please describe how your organization will continue the provision of this service in the event of an emergency.

Alzheimer's Respite Institutional Care Consumer Service Management	Yes	NO	N/A
Does an RN perform an initial health assessment which identifies the consumer's physical, cognitive and psychosocial needs in the Alzheimer's Respite Institutional Care Program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the agency maintain documentation of physician's authorization prior to administering medications, nursing services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are daily and monthly planned activities posted in full view of consumers and caregivers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are consumer activities planned and supervised by an Activity Coordinator?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Staff Qualifications and Training for Alzheimer's Respite Institutional Care Services	Yes	No	N/A
Does your agency provide <i>task based instruction</i> to all direct care staff prior to working with consumers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can your agency ensure that the <i>staff to consumer</i> ratio will be at least one staff person to every six consumers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Alzheimer’s Respite Institutional Care Questions (cont.)

List all staff members that will participate in the delivery of the proposed services. Include job titles and credentials:

Staff Name	Job Title	Credentials

Facility Requirements	Yes	NO	N/A
Does your facility have a separate, identifiable space available for Alzheimer’s Respite Institutional Care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are all medications and toxic substances kept locked and stored away from consumers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have a documented and posted fire and emergency safety plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency engage in and document periodic inspections and routine maintenance of fire extinguishers, smoke alarms, and quarterly evacuation drills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency provide noon meals and snacks planned by a licensed dietician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency provide or arrange for transportation to the Alzheimer’s Respite Institutional Care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Personal Care Respite and Homemaker Respite Questions

The following questions are required for those agencies applying for **Alzheimer’s Respite In-Home Services**, which include **Homemaker and Personal Care**.

Please do not attach agency brochures, newspaper clippings or other materials. All questions must be answered as instructed. Points will be deducted for unanswered questions or failure to answer questions as instructed.

Indicate Proposed Service(s): **Homemaker** **Personal Care**

Purpose of Alzheimer’s Respite In-Home Services	Yes	No	N/A
Is the <i>In-Home Service Program</i> provided by your agency designed to meet the needs of consumers with Alzheimer’s or related dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the <i>In-Home Service Program</i> designed to provide respite for the consumer’s Caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is <i>In-Home</i> staff trained to understand the unique needs of consumers with Alzheimer’s or other related dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the space below please describe how your organization will continue the provision of this service in the event of an emergency.

Delivery of In-Home Services	Yes	No	N/A
Does your agency have the capacity to deliver Homemaker services five (5) days a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have the capacity to deliver Personal Care services five (5) days a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have a backup service delivery plan that will ensure consumers receive services despite changes in staffing levels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency maintain a consumer record of each service visit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the service record document specific tasks performed, in home staff signatures, arrival and departure times, and the consumer’s or caregiver’s signature upon completion of service delivery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the space below list factors that helps your agency determine a consumer’s visit pattern and length of visit:

In the space below, describe how you arrange for the provision of service in the event that the scheduled direct care worker is not available (e.g., due to illness) to provide the service at the scheduled day and time that service is to occur.

Alzheimer’s Respite In Home Services (Continued)

In Home Staff Qualifications and Training	Yes	No	N/A
Does your agency require eight hours of in-service continuing education for In Home staff for each twelve-month period, excluding agency and program-specific orientation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe the qualifications of In-Home staff providing services.

In Home Staff Supervision	Yes	No	N/A
Prior to service initiation, does the supervisor complete and document a consumer home visit to define the expected activities of the In-Home staff and prepare a written care plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the supervisory staff evaluate In Home staff’s compliance with the care plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the supervisory staff evaluate consumer and caregiver satisfaction with service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the supervisory staff evaluate changes in Consumer status that may affect the care plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are visit patterns and length of visit changed to better meet Caregiver needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does supervision include an in-home visit at least once every 60 days to observe care provided for Personal Care Service per OAC 173-39-02.11 (C) (4) (b)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does supervision include an in-home visit at least once every 90 days to observe care provided for Homemaker Service per OAC 173-39-02.8 (B) (6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe the qualifications of supervisory staff:

Describe your agencies back up plan for supervisory coverage in the event that a supervisor resigns.

Provide a copy of your tracking documentation form that ensures timeliness of visits.

New Applicant Questions

NEW APPLICANT QUALIFICATIONS

Give a brief history of your organization. Include the year your organization was started and share significant milestones that shaped the organization.

List the services your agency provides for older persons and how long your agency has been providing these services.

What proportion of the total consumers served by your agency is age 60 and over? How many have Alzheimer's or related dementias? How many have family caregivers? How long have you been working with persons with Alzheimer and their caregivers?

Do you do cost sharing or charge a fee? If so, include your policies with the application.

APPENDIX A
Demographic Categories and Definitions for
SFY2024-25 Alzheimer's SCS Respite Contracts

BHRC requires that providers target services to priority populations within a defined geographic area of service and record demographic data in order to track progress toward goals.

- **Minority Status:**
 - **American Indian or Alaskan Native**
 - **Asian**
 - **Hispanic or Latino**
 - **Black or African American**
 - **Native Hawaiian or Other Pacific Islander**
- **In Poverty** – Those whose income is at 100% of, or below, the official poverty guideline.
- **Disabled** – A person with mental or physical impairment, or a combination of mental or physical impairments, that result in substantial functional limitations in 1 or more of the following areas of major life activity: (A) self-care, (B) receptive and expressive language, (C) learning, (D) mobility, (E) self-direction, (F) capacity for independent living, (G) economic self-sufficiency, (H) cognitive functioning, and (I) emotional adjustment.
- **Rural** – A person living in any area that is not urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.
- **Living Alone** – A person living in a one-person household, where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.
- **Frail** – A person who is unable to perform at least two activities of daily living (bathing, dressing, toilet use, eating, walking, and transfer - for example, from bed to chair) without substantial human assistance, including verbal reminding, physical cueing, or supervision. In this context, 'Frail' has the same meaning as 'At Risk of Institutionalization'.
- **Limited English Proficiency** – A person whose primary language is not English.

Note: There is a discrepancy between this terminology and SAMS/Wellsky, which has been identified as a needed enhancement; however, it cannot be changed at this time. In SAMS/Wellsky, you have to enter the data in answer to the question "Understands English". Although the person may understand English, if it is not their primary language you should enter 'No', in order to capture the information we are targeting, which is "Limited English Proficiency".

BUCKEYE HILLS REGIONAL COUNCIL

Funds available for PY 2024-25 Alzheimer’s Respite and Senior Community Services Alzheimer’s Respite by county

The total Alzheimer’s Respite Program funding for State Fiscal Years (SFY) 2024-2025 is provided through the Ohio Department of Aging. The total available funding for this Request for Proposal is estimated to be approximately \$57,693.00 of which \$26,399.00 is Alzheimer’s Respite and \$31,354.00 is Senior Community Services Block Grant. However, the State of Ohio Budget for SFY 2024-2025 has not been finalized. Therefore, Funding amounts may be different when awards are granted. Awards may be reduced at any time if federal or state funding is reduced, even during the contract period.

It is the policy of the BHRC that available funds shall be allocated to each county in the PSA by formula. Each county will have only those funds allocated by formula available to it. In the event that a service gap is identified after reviewing all proposals received, BHRC reserves the right to allocate funds in a manner that ensures targeted service delivery.

Available Funding by County

	Alzheimer's Respite	SCS Alzheimer's Respite	Total County Allocation
ATHENS	\$5,053.37	\$6,015.54	\$11,068.92
HOCKING	\$3,105.14	\$3,696.37	\$6,801.52
MEIGS	\$2,804.52	\$3,338.51	\$6,143.04
MONROE	\$1,837.94	\$2,187.89	\$4,025.83
MORGAN	\$1,865.23	\$2,220.38	\$4,085.61
NOBLE	\$1,738.50	\$2,069.51	\$3,808.01
PERRY	\$3,223.02	\$3,836.69	\$7,059.71
WASHINGTON	\$6,711.26	\$7,989.10	\$14,700.37
	\$26,339.00	\$31,354.00	\$57,693.00