HENDERSON COUNTY
HOME & COMMUNITY CARE BLOCK GRANT
FY 2025 PROPOSAL SUMMARY

**** New for FY25 – Providers must submit a separate Proposal Summary for each program funding request. ****

APPLICANT INFORMATION

Name of Applicant Organization			
Type of Organization	☐ **Non-Profit – 501(c)(3)** ☐ **Private/For Profit** ☐ **Public Agency or Governmental Unit**		
Mailing Address			
City / State / Zip			
Name of Contact Person			
Email		**Telephone No.**	
Type of Program/ Service to be Provided			
Name of Service Provider (If Different From Applicant)			
Funds Requested	**HCCBG Funding Requested**	$	
	USDA/NSIP Funds (If Applicable)	$	
	TOTAL PROGRAM FUNDING	$	$ 0

By submission of this Proposal and acceptance of any funds awarded hereunder, the Applicant Organization agrees to comply with applicable local, state and/or federal requirements for the provision of services and the receipt, expenditure and accounting of funds provided under this program.

Authorized By:

_____

Signature of Authorized Representative

_____

Printed Name

_____

Title

_____

Date

PROGRAM NARRATIVE

NOTE: If additional space is needed to answer any questions, please attach an Addendum, making sure to reference the Question. It is important that all relevant information is communicated to the HCCBG Advisory Committee, however, please try to keep answers and information brief and on point.

1. Describe the aging service(s) provided by this program or service. What needs of older adults are addressed by this program or service?

2. (If known), identify any other local agencies that provide the same or similar services. How will your organization collaborate with other providers to achieve objectives?

3. What staff and volunteer resources will be committed to this service or program and in what ways? What are the staff and volunteer qualifications?

4. Please include the job title and number of employees who work for your organization who will be dedicated to providing the service. Please also include qualifications of those employees to provide the service.

5. How do you incentivize employees to join your workforce and what methods to you utilize to assist with employee retention? Do you provide mileage reimbursement?

6. How does your organization determine eligibility for services? Please provide confirmation that your organization is in compliance with 10A NCAC 05G.0302, *Client Priorities for the Receipt of Services*. You may include a summarization of interoffice policies, procedures placed into operation used to screen and prioritize clients, as well as specific data relative to the number of clients who fall into the six categories of prioritization. *NOTE: It is not necessary at this time to provide a copy of any policies or procedures. In the event this documentation is necessary, the Committee will request a copy.*

7. Provide information on how client-friendly your program or service is:

    a. What are your hours of operation?

    b. Do you provide interpreters when necessary?

    c. What methods are used to collect consumer contributions?

    d. What else do you want us to know regarding your services?

8. Define the unit of service (e.g., hour, day, trip, etc.). If proposed service is not unit based, describe the method used for calculating the cost reimbursement expected (e.g., actual expenses, $X per client, $X per repair, $X per month, etc.).

9. In **Table 1** below, identify:
   a. In Row 1, the total *unduplicated* number of older adults aged 60 or older served by this program in Henderson County (regardless of funding source) for each fiscal year identified in the Table.
   b. In Row 2, the total *unduplicated* number of older adults aged 60 or older served by the program with HCCBG funding for each year identified in the Table.
   c. In Row 3, the total units of service to older adults served by the program in Henderson County.
   d. In Row 4, the total HCCBG units of service to older adults served by the program in Henderson County.

ROW	IDENTIFY:	FY2023[1]	FY2024[1] YTD (as of Feb 1)	FY2024[1] ESTIMATED	FY2025 PROPOSED
1	**Total Unduplicated Number of Older Adults served by the Program**				
2	**Total Unduplicated Number of Older Adults served with HCCBG Funding**				
3	**Total Units of Service to Older Adults served by the Program in Henderson County**				
4	**Total HCCBG Units of Service to Older Adults served by the Program in Henderson County**				

Table 1 - Number of Older Adults Served

[1] If this is a new program, show zero.

10. It is very important that your organization properly maintain and update information pertaining to your waiting list in the ARMS System. Identify the following information with respect to older adults aged 60 or older who are currently on your organization's waiting list for the proposed service:

    What date was your waiting list last updated in the ARMS System? _____

    Number of older adults on waiting list: _____

    How long does someone remain on your waiting list prior to receiving service? _____

    Describe the system you use to compile and/or maintain your waiting list.

11. Do you prioritize private pay and those with higher reimbursement rates over block grant patients on the waiting list?

12. Do you anticipate any significant changes in organizational structure, procedures, or legislative issues that will have an impact on your organization or the delivery of services proposed?

13. In the event that your organization's funding is reduced, the Committee would like to know the effect that would have on the services you provide. Please use the following area to describe what effect a reduction in funding of 5%, 10%, and 20% would have on the services you provide:

14. Please explain how your organization will meet the 10% required matching funds for this grant.

ATTACHMENTS

**** Note: If submitting multiple Proposal Summaries, only 1 copy of the requested attachments is required. ****

15. Complete **ATTACHMENT A**: Preliminary Proposed Budget.

16. The following documents must be submitted from each Applicant Organization and labeled as **ATTACHMENT B**:

    a. **ONE** copy of the Applicant Organization's most recent independent certified audit, including the year-end Income Statement and Balance Sheet on which the audit is based.

    b. **ONE** copy of any management letter with respect to the audit along with the organization's response to the management letter (if applicable).

17. If the Applicant Organization was a recipient of Home and Community Care Block Grant (HCCBG) funds in a prior year, the following documents must be submitted from each Applicant Organization and labeled as **ATTACHMENT C**:

    c. **ONE** copy of the Area Agency on Aging's most recent Program Monitoring Review letter for each covered service.

    d. **ONE** copy of the Applicant Organization's response to the Program Monitoring Review letter and any remedial action plan, if a response or action plan was submitted.

18. If the Applicant Organization desires to submit additional supporting information (i.e. - brochures, etc.), such information should be submitted and labeled as **ATTACHMENT D.**

19. Please submit 6 packets as follows:
    a. The ORIGINAL Proposal Summary, Preliminary Proposed Budget, and all attachments.
    b. FIVE (5) copies of the Proposal Summary, Preliminary Proposed Budget, and all attachments.
    c. All 6 packets MUST be hole punched and paper clipped.
    d. NO STAPLES please.