

Appendix E
 AGING & COMMUNITY SERVICES OF SOUTH CENTRAL INDIANA, INC.
 APPLICATION TO TITLE III-B OF THE OLDER AMERICANS ACT

1. Title of Project: _____ _____ 2. Applicant Agency: _____ _____ <div style="text-align: center;">Name</div> _____ <div style="text-align: center;">Address</div> _____ 3. Type of Application: <input type="checkbox"/> New <input type="checkbox"/> Revision <input type="checkbox"/> Continuation <input type="checkbox"/> Supplement 4. Project Director: _____ _____ <div style="text-align: center;">Name</div> _____ <div style="text-align: center;">Address</div> _____ Phone: _____ 5. Project Location: (complete chart on page 1a) 6. Project Period: _____ Beginning Date _____ Ending Date _____ Project Year: (circle one) 1 2 3 4 5 6 7 8 _____ 7. Circle target area to be served by the project: Township City County Multi-County 8. Budget Summary: <div style="text-align: right; margin-left: 100px;">Proposed/Existing</div> Estimated Total Cost _____/_____ 15% Required Match _____/_____ Other Local _____/_____ Support _____/_____ Total Federal and State _____/_____ 9. Program Income (estimate) _____/_____	10. Estimate of Total Un-duplicated Number of people to Receive Services: _____ 11. Services to be funded: A. Access Services <input type="checkbox"/> transportation <input type="checkbox"/> outreach <input type="checkbox"/> Information & Referral <input type="checkbox"/> Escort <input type="checkbox"/> Other B. In Home Services <input type="checkbox"/> Homemaker <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Telephone Reassurance <input type="checkbox"/> Chore/Home Maintenance <input type="checkbox"/> Other C. Community Services <input type="checkbox"/> Legal/Related Services <input type="checkbox"/> Client Counseling <input type="checkbox"/> Res./Repair Renovation <input type="checkbox"/> Health Services <input type="checkbox"/> Weatherization <input type="checkbox"/> Energy Emergency <input type="checkbox"/> Recreation <input type="checkbox"/> Project/Crime Prevent <input type="checkbox"/> Other D. Services/Care Facilities <input type="checkbox"/> Ombudsman/Complaint <input type="checkbox"/> Placement Assistance <input type="checkbox"/> Group Services <input type="checkbox"/> Other E. Support Services <input type="checkbox"/> Advocacy <input type="checkbox"/> Coord. Activities <input type="checkbox"/> Program Development <input type="checkbox"/> Other 12. Type of Applicant: <u>Public Agency</u> -(check one) <input type="checkbox"/> city <input type="checkbox"/> county <input type="checkbox"/> state <input type="checkbox"/> other(specify) _____ <u>Private Nonprofit Organization</u> <input type="checkbox"/> new established nonprofit <input type="checkbox"/> nonprofit/prior concern for older adults <input type="checkbox"/> institution of higher education <input type="checkbox"/> other(specify) _____ 13. List name of person authorized to receive funds: _____ _____ 14. This application was reviewed and approved by the: _____County Council on Aging on _____. Signed: _____ (County Council President)
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15. THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS FULL AUTHORITY, AS RECORDED IN THE MINUTES OF THE APPLICANT AGENCY, DATED _____, TO SUBMIT THIS APPLICATION ON BEHALF OF THE APPLICANT AGENCY. IN ADDITION, THE APPLICATION IS TRUE AND CORRECT, AND THE UNDERSIGNED WILL COMPLY WITH ALL APPLICABLE LAWS, REGULATIONS AND CONDITIONS IF HE/SHE RECEIVES THE FUNDS REQUESTED.

Name: _____ Title: _____

THIS GRANT PROVIDES SERVICES FOR OLDER HOOSIERS AT THE
FOLLOWING LOCATION(S):

TOWN	LOCATION STREET ADDRESS	PHONE NUMBER

DAYS OPEN (circle)	HOURS OPEN	PERSON IN CHARGE
M T W TH F S		
M T W TH F S		

ESTIMATE OF TOTAL AGENCY CLIENT CHARACTERISTICS

(Remember, an individual will be counted only once, no matter how many services they receive in the 12 month period.)

1. Total number of different people to be served by this grant:

_____.

2. Identify the major community you will be serving by this grant and complete the following:

Total People Receiving Service(s)
(A)

From (city/town)
(B)

Total People Receiving Service(s)

From Rural Townships
(not town)

3. Of the total unduplicated number in Question #1, estimate how many are:

- A. American Indian _____ B. Alaskan Native _____
C. Asian/Pacific _____ D. Black, not Hispanic _____
E. Hispanic _____ F. White, not Hispanic _____
G. GRAND TOTAL: _____ (should equal #1 above)

4. Social Need: (estimate how many are)

- A. Low Income _____
B. Handicapped persons 60 years or older _____
C. Aged 75 and older _____
D. Minority persons 60 years and older _____

DETAILED SERVICE DATA
(Complete one for each service)

SERVICE TO BE FUNDED: _____
(COMPLETE FOR EACH SERVICE)

ESTIMATED MEASURABLE OUTPUT

ESTIMATED COST OF PROVIDING SERVICE

1. Unduplicated number of persons 60 and over to be served:

_____ _____
Projected Provided last yr.

2. Number of minority group persons 60+ to be served:

American Indian _____

Alaskan _____

Asian or Pacific _____

Black, not Hispanic _____

Hispanic _____

3. Estimate how many are:

Low Income _____

60+ handicapped persons _____

75+ persons _____

4. Units provided:

_____ _____
Total units pro- Actual units pro-
vided this grant vided last year

_____ _____
Actual units pro- vided last year

5. Total cost program _____

6. Less (non cash) inkind _____

7. Less cash project income _____

8. Less local cash resources _____

9. Equals Fed./State funds _____

10. Estimated Unit Cost: Total cost of program -5; divided by units provided -4. - equals estimated unit cost: _____

10. STATE OBJECTIVES OF SERVICES: i.e. WHO will benefit by the service: HOW will they benefit: WHAT special benefit will the service provide: and WHO is responsible for seeing program carried out.

11. DESCRIBE ACTION STEPS IN DELIVERING SERVICE:

12. STATE WHY THIS SERVICE IS NEEDED (give reference to survey, needs assessment, statistics pointing to need:

DETAILED SERVICE DATA
(Complete one for each service)

SERVICE TO BE FUNDED: _____
(COMPLETE FOR EACH SERVICE)

ESTIMATED MEASURABLE OUTPUT

ESTIMATED COST OF PROVIDING SERVICE

1. Unduplicated number of persons 60 and over to be served:

_____ Projected _____ Provided last yr.

2. Number of minority group persons 60+ to be served:

American Indian _____

Alaskan _____

Asian or Pacific _____

Black, not Hispanic _____

Hispanic _____

3. Estimate how many are:

Low Income _____

60+ handicapped persons _____

75+ persons _____

4. Units provided:

_____ Total units provided this grant

_____ Actual units provided last year

5. Total cost program _____

6. Less (non cash) inkind _____

7. Less cash project income _____

8. Less local cash resources _____

9. Equals Fed./State funds _____

10. Estimated Unit Cost: Total cost of program -5; divided by units provided -4. - equals estimated unit cost: _____

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TITLE III-B SOCIAL SERVICES BUDGET FOR JULY 1, ___ TO JUNE 30, ___

SUBGRANTEE:

SERVICE:

COST CATEGORY	(1) SERVICE TOTAL	(2) IN-KIND RESOURCES	(3) PROJECT INCOME	(4) LOCAL RESOURCES	(5) III-B EXPENSE
A. PERSONNEL					
B. EMPLOYEE BENEFITS & RE- LATED EXPENSES					
C. RENT & UTILITIES					
D. TELEPHONE & POSTAGE					
E. CONTRACTS FOR SERVICES					
F. MATERIALS & SUPPLIES					
G. TRAVEL/TRANS- PORTATION					
H. EQUIPMENT					
I. OTHER COSTS					
J. TOTAL COST					
K. PERCENTAGE OF BUDGET (NOT TO EXCEED 85%					

TITLE III-B SOCIAL SERVICES BUDGET FOR JULY 1, ___ TO JUNE 30, ___

SUBGRANTEE:

SERVICE:

COST CATEGORY	(1) SERVICE TOTAL	(2) IN-KIND RESOURCES	(3) PROJECT INCOME	(4) LOCAL RESOURCES	(5) III-B EXPENSE
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H. EQUIPMENT					
I. OTHER COSTS					
J. TOTAL COST					
K. PERCENTAGE OF BUDGET (NOT TO EXCEED 85%					

BUDGET NARRATIVE
LOCAL RESOURCES - TOTAL FOR ALL SERVICES

1. **PROGRAM INCOME** - Adm. on Aging suggest this be 20% of federal funds.

<u>Source</u>	<u>Description</u>	<u>Amount</u>

TOTAL PROGRAM INCOME: _____

2. **CASH RECEIVED FROM ALL SOURCES FOR ALL SERVICES:**
 A. **CASH PUBLIC** (cash from local governmental units):

<u>Source</u>	<u>Description</u>	<u>Amount</u>

SUBTOTAL (CASH PUBLIC) _____

B. **CASH NON-PUBLIC** (cash from service clubs, United Way, etc.)

<u>Source</u>	<u>Description</u>	<u>Amount</u>

SUBTOTAL (CASH NON-PUBLIC) _____

TOTAL CASH RECEIVED FROM ALL SOURCES FOR ALL SERVICES _____

3. **IN KIND FROM ALL SOURCES FOR ALL SERVICES (NON CASH):**
 A. **INKIND PUBLIC** (from local governmental units):

<u>Source</u>	<u>Description</u>	<u>Amount</u>

3. IN KIND FROM ALL SOURCES FOR ALL SERVICES (NON CASH):
B. INKIND NON-PUBLIC (from service clubs, United Way, etc.)

<u>Source</u>	<u>Description</u>	<u>Amount</u>

SUBTOTAL (IN KIND PUBLIC) _____

TOTAL IN KIND FROM ALL SOURCES FOR ALL SERVICES _____

4. TOTAL LOCAL RESOURCES (totals of 1, 2, and 3) _____

AGENCY/STAFF COORDINATION

1. List agencies with whom services are coordinated:

2. Staff: Please list the following:

- A. Total number of full time equivalent staff paid by this grant _____
- B. Total number of employees paid by this grant _____
- C. Total wages/fringe benefits of staff paid by this grant _____

3. LIST EMPLOYMENT PROGRAMS (such as Green Thumb, Title V) THAT SUPPORT THE SERVICES LISTED IN THIS GRANT BY PROVIDING LABOR AT NO COST TO THE PROGRAM:

A. SOURCE OF EMPLOYMENT	B. NUMBER POSITIONS PROVIDED	C. TOTAL HOURS PER WEEK PROVIDED
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4. LIST MONIES, SOURCE OF MONIES, SERVICE PROVIDED FOR ALL MONIES RECEIVED BY THE AGENCY OTHER THAN IIIB FUNDS:

<u>S. SOURCE OF FUNDS</u>	<u>B. DOLLAR AMOUNT</u>	<u>C. SERVICE PROVIDED</u>
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PROGRAM SUMMARY/PROJECT NARRATIVE

1. Describe briefly how older Hoosiers outside your agency were involved in the development of this plan? Who are they?

2. Describe the efforts of your agency to encourage involvement of older Hoosiers in the greatest social and economic need?

3. Describe the process your agency uses to monitor and evaluate the agency program.

4. Describe your procedures for handling project income.

5. Specify holidays on which the facility will close and the method used in determining winter closings.