

NORTH CENTRAL AREA AGENCY ON AGING, INC. (NCAAA)

SFY 2025 APPLICATION FOR ALZHEIMER'S AIDE PROJECT

A. IDENTIFYING INFORMATION

1. Name of Sponsoring Agency: _____

Address: _____

Contact Person: _____ Email: _____

Telephone: _____ Fax: _____

2. Name and Address of Adult Day Care Center (ADC):

Contact Person: _____ Email: _____

Telephone: _____ Fax: _____

3. Center Type:

Medical Model _____ Social Model _____

Private non-profit _____ Municipal _____ Proprietary _____

4. Center Structure & Affiliations:

a. Affiliated with a nursing home/skilled nursing facility:
_____ No _____ Yes (Specify SNF: _____)

b. Affiliated with a hospital:
_____ No _____ Yes (Specify Hospital: _____)

c. Collocated with elderly services: _____ No _____ Yes

d. Freestanding: _____ No _____ Yes

5. Are local zoning, licensing (e.g. kitchen services etc.), fire, and safety requirements being met by the ADC? Yes _____ No _____

6. Is the facility handicapped accessible? Yes _____ No _____

7. How many days per week does the center operate? _____

8. What are the hours the ADC is open to clients? _____

9. How many clients can the ADC accommodate daily*?

Total number of clients _____ Number of Alzheimer clients _____

* It is understood these figures are difficult to estimate.

B. PROGRAM OPERATIONS

1. How many unduplicated clients do you serve per week? _____
2. What is the ratio of ADC clients to client care staff (exclusive of volunteers but including Title V positions) on duty on premises at all times** of ADC operation? (Include Alzheimer Aide in the ratio).

Client to Staff Ratio: _____ Clients per _____ Client Care Staff

3. Is there a nurse on duty at all times? _____ On call? _____
RN? _____ LPN? _____ If necessary, provide an explanation below.

Does the nurse supervise the aide funded under this grant?

Yes _____ No _____ If not, who supervises? (Title)

Credentials: _____

4. Is there a social worker on duty at the center at all times? _____
 - a. On call? _____ If not, explain hours: _____
5. Are there written Policies and Procedures, including admission and discharge, related to client care? Yes _____ No _____
6. The funding legislation requires a physician's diagnosis for client served under this grant.
 - a. The staff member responsible for obtaining and filing the physicians' letter is:

(Title) _____
 - b. Letters are on file for all current clients served under this grant:
Yes _____ No _____

7. What arrangements have been made for distributing and storing participant's medication?

8. List the amount and carrier of the ADC liability insurance

Amount: _____

Name of Carrier: _____

** This refers to all hours of operation. Do not use peak hours.

C. SERVICE PROFILE

1. Please describe the specific support services for family and/or other caregivers through your program. Indicate the frequency of support group meetings and the average attendance during the past year.
2. Directions for Completing the Service Profile Chart (page 4):

Complete the Service Profile Chart, indicating the availability of services by doing the following:

- Column I - Frequency: For each service offered by the Center, indicate how often the service is provided by placing a check mark under the appropriate category, i.e., daily, bi-weekly, weekly, monthly, etc.
- Column II - by placing a check mark under the appropriate category (“Yes” or “No”), indicate if the Center offers each service at an additional charge.
- Use an asterisk to indicate which of the services listed on the next page are provided by the aide funded under this grant, and be sure to asterisk the service even if the aide helps another staff member provide the service.

C. SERVICE PROFILE CHART

INSTRUCTIONS: Check block as appropriate to indicate availability of service and place asterisk next to services provided by aide. (See Directions on preceding page for details).

| SERVICE | I. FREQUENCY | | | | | II. SERVICE PROVIDED AT ADDITIONAL CHARGE | |
|---|--------------|-----------|---------|-------|--------------|---|----|
| | Daily | Bi-weekly | Monthly | Other | Not Provided | Yes | No |
| Counseling: Individual | | | | | | | |
| Counseling: Group | | | | | | | |
| Care Planning | | | | | | | |
| Progress Notes | | | | | | | |
| Services Referral | | | | | | | |
| Meals | | | | | | | |
| Special Diets | | | | | | | |
| Dietary Counseling | | | | | | | |
| Personal Hygiene | | | | | | | |
| ADL Assistance (walking, eating, toileting, grooming) | | | | | | | |
| Mental Health Assistance (milieu therapy, reality orientation, etc.) | | | | | | | |
| Therapeutic Recreation (physical activities, discussion groups, arts and hobbies, etc.) | | | | | | | |
| Therapeutic Recreation (intellectual activities) | | | | | | | |
| Outings | | | | | | | |
| Sedentary Activities | | | | | | | |

C. SERVICE PROFILE CHART (Continued)

INSTRUCTIONS: Check block as appropriate to indicate availability of service and place asterisk next to services provided by aide. (See directions on Page 3 for details).

| SERVICE | I. FREQUENCY | | | | | II. SERVICE PROVIDED AT ADDITIONAL CHARGE | |
|---------------------------------------|--------------|-----------|---------|-------|--------------|---|----|
| | Daily | Bi-weekly | Monthly | Other | Not Provided | Yes | No |
| Personal Health / Hygiene Instruction | | | | | | | |
| Physical Assessment | | | | | | | |
| Physical Reassessment | | | | | | | |
| Health Status Monitoring | | | | | | | |
| Bath Service | | | | | | | |
| Nursing Care | | | | | | | |
| Transportation | | | | | | | |
| Physical Rehabilitation | | | | | | | |
| Support Group | | | | | | | |
| Counseling for Supporters | | | | | | | |
| Training for Supporters | | | | | | | |
| Other (List) | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

D. **SERVICE DATA**

1. Our Adult Day Care Center was open _____ days this year from 2/01/2023 to 1/31/2024.

2. Day Care Clients WITH Alzheimer’s Disease

| | Current Year 02/01/23 – 01/31/24 | Projected Year 07/01/24– 06/30/25 |
|--|-------------------------------------|--------------------------------------|
| a. Total number unduplicated* Alzheimer Clients served. | _____ | _____ |
| b. Total number of days of service provided (sum of all days of service provided to Alzheimer clients at the center). | _____ | _____ |
| c. Average Daily Attendance for Alzheimer clients [Line 2.b divided by number of days center was open (Line 1 above).] | _____ | _____ |
| d. Average number of persons who work with Alzheimer clients daily.** | _____ | _____ |

3. Day Care Clients WITHOUT Alzheimer’s Disease

| | Current Year 02/01/23 – 01/31/24 | Projected Year 07/01/24– 06/30/25 |
|---|-------------------------------------|--------------------------------------|
| a. Total number of unduplicated clients without Alzheimer’s Disease | _____ | _____ |

* Refers to all Alzheimer-type clients who receive services under this grant. Do not count a client more than once no matter how many times the client has been served.

** Include regular volunteers, but not office workers, cooks, etc.

3. Day Care Clients WITHOUT Alzheimer’s Disease (continued)

| | Current Year 02/01/23 – 01/31/24 | Projected Year 07/01/24 – 06/30/25 |
|---|-------------------------------------|---------------------------------------|
| b. Total number of days of service actually provided to clients without Alzheimer’s Disease. | _____ | _____ |
| c. Average Daily Attendance [Line 3.b divided by number of days the center was open (Line 1)]. | _____ | _____ |
| d. Average number of persons present daily who work with clients. (Include regular volunteers, but not office workers, cooks, etc.) | _____ | _____ |

E. FOR CURRENT GRANTEES ONLY

1. What is the cost per service unit? _____
 Divide the total actual amount of State Alzheimer funding received from 07/01/22 to 06/30/23 by the total number of service days provided to Alzheimer clients for 02/01/23 to 01/31/24.

F. BUDGET FOR CURRENT FISCAL YEAR

| Agency Budget for FY _____ | | which starts from _____ | to _____ | | |
|----------------------------|----|---|----------|-----------|--------------|
| 1. | a. | <u>Income</u> | | | |
| | | Grants | Cash | In - Kind | Total |
| | | OAA Title IIIB (Grants) | | | |
| | | OAA Title IIIC (Meals) | | | |
| | | OAA Title V | | | |
| | | USDA Commodities | | | |
| | | Specify Other Grants (e.g. town(s), foundations, etc.) | | | |
| | | | | | |
| | | Total | | | |
| | | | | | |
| | b. | <u>Revenues</u> | | | |
| | | Client Fees | | | |
| | | Per Diems CCCI | | | |
| | | Other (specify) | | | |
| | | | | | |
| | | Total | | | |
| | | | | | |
| | c. | <u>Provider Agency Resources</u> | | | |
| | | Total | | | |
| | | | | | |
| 2. | | <u>Expenses</u> | Cash | In - Kind | Total |
| | | Salaries | | | |
| | | Fringe Benefits | | | |
| | | Non-personnel Services | | | |
| | | Rent | | | |
| | | Utilities | | | |
| | | Operating Expense (supplies, postage, printing, telephone) | | | |
| | | Transportation | | | |
| | | Congregate Meals | | | |
| | | Food | | | |
| | | Professional Services (Legal, Accounting, Auditing) | | | |
| | | Insurance | | | |
| | | Equipment | | | |
| | | Other - Explain | | | |
| | | | | | |
| | | Total | | | |

3. Personnel/ Budget Explanation

* (Please note current staff assigned to Alzheimer's clients.)

| * <u>Position</u> | <u>FTE</u> | <u>Cost (Salary & Fringe Benefits)</u> |
|-------------------------|------------|--|
| Director | _____ | _____ |
| Secretary | _____ | _____ |
| Program Coordinator | _____ | _____ |
| Registered Nurse | _____ | _____ |
| L. P. N. | _____ | _____ |
| Health Aide | _____ | _____ |
| Social Worker | _____ | _____ |
| Therapist | _____ | _____ |
| Program Aide | _____ | _____ |
| Volunteers | _____ | _____ |
| Drivers | _____ | _____ |
| Cook | _____ | _____ |
| Custodial/ Housekeeping | _____ | _____ |
| Other (Specify: _____) | _____ | _____ |

4. Does the center have an annual audit done which covers all revenues and expenses and identifies this funding separately? _____

CPA Firm _____

Other (Specify) _____

5. Aide Salary Explanation

- a. Number of Aides Requested? _____
Is this request for a new position or continued funding for current aide(s)?

| | Aide 1 | | Aide 2 | |
|----------------------|----------|-----------|----------|-----------|
| Salary | \$ _____ | Per _____ | \$ _____ | Per _____ |
| Hrs./Wk. Employed | _____ | | _____ | |
| Total Salary | \$ _____ | | \$ _____ | |
| Fringe Benefits | \$ _____ | | \$ _____ | |
| Total Request | \$ _____ | | \$ _____ | |

- b. Is the proposed salary equal to the rate of current aide positions? _____
If not, explain.

- c. Is the salary of the proposed position specified under a binding personnel agreement? Yes _____ No _____

[Empty rectangular box for text entry]

5. Describe the Agency's capacity and experience to serve Alzheimer's clients and include information on the Center's strengths in serving this population.

[Empty rectangular box for text entry]

SFY 2025 STATE ALZHEIMER'S AIDE PROJECT

AGREEMENT

1. Services to be Provided

The Adult Day Care Center agrees to provide adult day care services to participants with Alzheimer's disease (AD) and/or related dementias. Services will be provided in accordance with the terms specified in the 2024 - 2025 program application.

2. Record Keeping Requirements

- A. The Adult Day Care Center will maintain records for each participant under this program which are sufficient to establish that each participant is medically documented with Alzheimer's disease or a related dementia. The records should include a daily attendance log that documents the service(s) delivered to AD participants. Records should also include the participants' plan of care and progress notes.
- B. The center will maintain fiscal records showing the amounts expended for the Alzheimer's Aide grant. These records will be kept in a manner which follows accepted accounting practices and will enable NCAAA to verify the amounts spent and that the funds were expended only on grant activities.
- C. Funded Adult Day Centers must be serving individuals with a diagnosis of Alzheimer's and related dementias, as defined by the National Institute on Aging as irreversible and deteriorating dementias that may include but are not limited to : Frontotemporal disorders, Lewy Body Dementia, Vascular Dementia/Vascular Cognitive Impairment, or Mixed Dementias. Participants must have had a comprehensive medical evaluation that has ruled out unrelated conditions such as depression, TBI, alcoholism, and drug interactions. Clients will be expected to have a physician with whom the center can work and who will certify by letter that he or she has done an appropriate medical work up and that the patient's diagnosis is an irreversible and deteriorating dementia as listed above. Documentation to that effect should be on file at the funded adult day center.

3. Reporting Requirements

- A. The center will submit a final year-end service report listing the number of service days provided to AD participants and the number of unduplicated AD participants served (total/age 60+). The center will also submit monitoring and/or statistical reports (as requested by NCAAA).
- B. The center will submit a quarterly financial report of funds expended for salaries and fringe benefits under this grant.

C. Final financial and service program reports must be submitted within fifteen (15) days after termination of the grant.

4. Terms of Payment

NCAAA will make quarterly reimbursements upon acceptance of fiscal reports submitted by the Adult Day Care Center. NCAAA reserves the right to withhold grantee payments if acceptable progress reports, expenditure reports, etc. are not received on a timely basis.

5. Compliance with State and Federal Laws, Conditions and Assurances

- A. The Adult Day Care Center agrees to comply with any and all State and Federal Equal Opportunity Employment and Non-Discrimination regulations.

- B. The Adult Day Care Center agrees that funded centers will be required to comply with all applicable federal and state laws regarding confidentiality, including the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the associated regulations, 45 C.F.R. parts 160-164, as may be amended (the “Privacy Rule”) and 45 C.F.R. Section 142.308(a)(2), as may be finalized and amended (the “Chain of Trust” requirement).

- C. The Adult Day Care Center agrees to abide by all here within specified requirements and attached Conditions and Assurances.

Grantee Agency

Name and Title of Authorized Person (Typed)

Authorized Signature

Date