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

SFY 2026 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_____

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* 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 2/01/2024 to 1/31/2025.

2. Day Care Clients WITH Alzheimer's Disease

	Current Year 02/01/24 – 01/31/25	Projected Year 07/01/25– 06/30/26
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 02/01/24 – 01/31/25	Projected Year 07/01/25– 06/30/26
a. Total number of unduplicated clients without Alzheimer's Disease	_____	_____

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* 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 02/01/24 – 01/31/25	Projected Year 07/01/25 – 06/30/26
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 07/01/23 to 06/30/24 by the total number of service days provided to Alzheimer clients for 02/01/24 to 01/31/25.

F. BUDGET FOR CURRENT FISCAL YEAR

Agency Budget for FY_____ which starts from _____ to _____.

1.	a.	Income			
		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.	Revenues			
		Client Fees			
		Per Diems CCCI			
		Other (specify)			
		Total			
	c.	Provider Agency Resources			
		Total			
2.		Expenses	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.)

*	Position	FTE	Cost (Salary & Fringe Benefits)
	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_____

G. **SUPPLEMENTAL INFORMATION**

Complete this page if your Agency is a new applicant or if you have previously answered one of these questions and a change has occurred since that time. If you are answering the question because of a change, indicate the date when the question was previously answered.

1. Attach resume of current director and other professional staff.

2. Add (or attach) a job description for the Aide position.

3. Type/ Training Offered Alz. Aide — Title/ Qualifications of Trainer

Initial Training_____ (# of hours) _____

On the Job_____ (how often) _____

In Service_____ (how often) _____

Other_____ (type & frequency) _____

Other_____ (type & frequency) _____

Other_____ (type & frequency) _____

4. Indicate procedures for client intake and eligibility determination.

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.

SFY 2026 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 2025 - 2026 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