**Tennessee Home and Community Based Services Network**

**REQUEST FOR PROPOSAL APPLICATION (RFPA)**

TO DELIVER

IN-HOME SERVICES AND ADULT DAY CARE

UNDER OPTIONS FOR COMMUNITY LIVING, OLDER AMERICANS ACT AND THE NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

**Application Deadline (Insert Deadline)**

Contract Period: July 1, 2022– June 30, 2026

*TO APPLY, PLEASE OBSERVE THE FOLLOWING INSTRUCTIONS:*

* *Type the RFPA.*
* *Before delivery, be sure the RFPA bears an original, authorized signature.*
* *Maintain a copy of your application for your records.*
* *Submit a signed and dated (1) original, three (3) copies.*

**Purpose/Background**

The Tennessee Commission on Aging and Disability (TCAD) contracts with nine Area Agencies on Aging and Disability (AAAD) to administer home and community based programs for older adults and other adults with disabilities (consumers) throughout Tennessee. In turn, each AAAD enters into contracts to purchase the delivery of service activities from approved service providers. Through the RFPA process, the goal of the AAAD is to contract with a minimum of two (2) service providers \_\_maximum number for each service per county. Funding sources include State of Tennessee Options for Community Living funds, federal Older Americans Act Title IIIB Supportive Services funds, and federal Older Americans Act Title IIIE Family Caregiver funds. Following is a brief description of each program:

1. Tennessee’s **Options for Community Living Program** is designed to enable consumers to live independently in their homes by providing a limited amount of services such as homemaker services, personal care services and/or home delivered meals. With the assistance of these limited services, along with the support of family and others, the consumer may be able to avoid or prolong admission into institutional care.
2. The **Older Americans Act (OAA) Title IIIB** provides an array of supportive services for persons age 60 and over. Services are designed to allow older persons to reside in the community and in their own homes with the maximum amount of dignity for as long as possible. Title IIIB services are targeted to older individuals with the greatest economic need, with particular attention to low-income minority individuals, those with the greatest social needs and those residing in rural areas. For the purpose of this RFPA, the Older Americans Act funding will be used to provide funding for in-home services such as homemaker, chore, personal care, minor home modifications, personal emergency response systems, and adult day care.
3. The **National Family Caregiver Support Program** provides an infrastructure of program resources and assistance for family caregivers, grandparents, and older individuals who are relative caregivers through the designated AAAD, its service providers and other appropriate consumer organizations. In accordance with program directives, information, assistance and counseling can be provided to any caregiver, but respite and supplemental services are limited to caregiver support for older individuals who are unable to perform at least two activities of daily living, or, due to a cognitive or other mental impairment require substantial supervision. Priority is to be given to older individuals and families with the greatest social and economic need, with particular attention to low-income older individuals and older individuals caring for persons with severe disabilities.

**General Provider Requirements**

The following General Requirements apply to all providers delivering services under Options, OAA, and the Family Caregiver Support Program:

1. Applicants that neglect to accurately fill out and return the completed RFPA by the designated deadline, including required signatures, certifications and proof of licenses shall be disqualified from this process.
2. The Applicant must submit a signed and dated original, one (1) copy, and an electronic copy via email of the entire RFP application to each AAAD for the county or counties for which services are being proposed, to be received no later than the date specified.
3. The Provider Application must include the following information and documentation:
   1. Service(s) including specific activities to be provided, as defined in the Service Descriptions/Standards;
   2. Assurance that Provider and/or Provider staff meet appropriate federal or state requirements for licenses and liability insurance.
4. Acceptance of a Provider Application and subsequent approval of the Provider does not guarantee selection by eligible consumers or reimbursement of services by an AAAD.
5. Providers must update the application information to the appropriate AAAD as changes occur during the course of the contract period.
6. The service provider must provide a 10% local match for all OAA and Title III sevuces

**Requirements for Home and Community Based Services (HCBS) Providers**

The following General Requirements apply to all HCBS programs unless otherwise specified:

1. Service providers may expend Federal and State funds only for those services for which they have received authorization through a contract from the AAAD.
2. Each service provider must adhere to the service descriptions to be eligible to receive reimbursement. Although units of service are reported when a qualified consumer receives direct service, each service provider must comply with all requirements specified in the service descriptions. See Attachment 3 for Service Descriptions.
3. Services shall be provided only to consumers who meet eligibility criteria as determined by the AAAD.
4. Consumers shall not be denied or limited services because of their income or financial resources. Distance from provider shall not be used to deny services as this practice violates the mandate for special emphasis to rural residents, residents with disabilities and isolated consumers.
5. No service provider staff shall, without prior approval of the provider agency supervisor, pay bills, cash checks, or in any way handle the consumer’s money. All transactions involving money must be documented using a standardized form. At a minimum the form must state name of worker(s), purpose of errand, dollar amount given to worker, signature of worker and consumer. A receipt and the amount of change returned to the consumer should also be on the form.
6. No service provider agent shall solicit or accept gratuities, favors, or anything of monetary value from a consumer, service provider, contractor, or potential contractor.
7. No paid or volunteer staff person of any service provider may offer for sale any type of merchandise or service; nor may they seek to encourage the acceptance of any particular belief or philosophy by any program consumer.
8. Each service provider must have procedures to protect the confidentiality of information collected about consumers. The procedures must ensure that no information about a consumer is obtained or disclosed by a service provider in a form that identifies the person without the “informed written consent” of that person or of his or her legal representative. Disclosure may be allowed by court order, or for program quality assurance by authorized federal, state, or AAAD staff so long as access is in conformity with the Privacy Act of 1974. All consumer information must be maintained in controlled access files. (Exception: A written release of information when making a referral for Adult Protective Services is not required).
9. Each service provider who is considered a Covered Entity as governed by the laws of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will follow the HIPAA laws to further protect the privacy of consumers.
10. All service providers must respond to requests for information from TCAD and AAADs.
11. Each service provider shall have sufficient insurance to indemnify loss of federal, state and local resources due to casualty or fraud.
12. Each service provider shall employ a responsible supervisor designated by name and title for contracted service activities. The supervisor shall ensure that services are provided on a day-to-day basis according to the contract, governing statutes, and Provider Authorization/Notification of Change documents.
13. The provider agency should offer an influenza vaccine to their employees. A policy will be in place to assure that personnel contracting infectious illness/disease do not provide services to the consumer until they are without symptoms.
14. All service provider agencies, contractors and subcontractors must verify individual background information for employees and volunteers who provide direct care for, have direct contact with, or have direct responsibility for the safety and care of consumers in their homes prior to contact with consumers.
15. Each provider agency must document in its personnel files for each employee or volunteer (who provide direct care for, has direct contact with, or has direct responsibility for the safety and care of consumers in their homes) the following:

* The applicant’s statement of any prior convictions
* The results of its check of personal and/or employment references
* The results of the check of all Tennessee Department of Health databases of licenses health professionals including Certified Nursing Assistants (CNA)
* The results of any other checks which may have been requested by the provider agency, including background checks by the National Sex Offender Registry, Tennessee Felony Offender Registry, Tennessee Abuse Registries, and local or state law enforcement background checks
* Justification/explanation of the decision to employ an individual if the background check identified negative information.

1. Every service provider staff or volunteer who enters a consumers’ home in an official capacity must display proper identification which is (1) either an agency picture identification card; or, (2) some other form of agency identification presented with a valid driver’s license.
2. Service provider staff is to participate in training relevant to their major job responsibilities and/or which is designated by the AAAD or TCAD.
3. Each service provider must follow grievance procedures developed by the AAAD when a consumer is dissatisfied with service(s) being provided. All individuals must be informed of their right to file a grievance and the procedure to be followed.
4. Any individual applying for or receiving services funded through the AAAD and TCAD has a right to disagree with decisions made about services received.
5. Quality Assurance will be an ongoing process in which all entities including TCAD, AAAD, service providers and consumers will play a role.
6. Service providers will be monitored by the AAAD at least annually using monitoring tools approved by TCAD that are based on TCAD’s Program and Policy Manual.
7. All provider agencies will comply with all federal, state, and local civil rights rules and regulations.

REQUEST FOR PROPOSAL APPLICATION (RFPA)

Contract Period: July 1, 2022 – June 30, 2026

|  |  |
| --- | --- |
| Applicant Organization Name: | |
| Mailing Address: | |
| Office Address: | |
| Contact: | |
| Name & Title |  |
| E-Mail Address: | |
| Telephone:       . | Fax:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Emergency Contact (Name & #): | |
| Fiscal Contact (Name & #): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Date of Application: | | |
| Employer ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Place of Establishment\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

# COVER LETTER

* 1. Cover Letter – At a minimum, this letter must include the following:
* A statement that the accompanying application is in response to this RFPA.
* A statement that the applicant is willing, if selected, to execute a contract with the Area Agency on Aging and Disability (AAAD).
* A statement identifying the individual(s) authorized to finalize a contract with the AAAD on behalf of the Applicant.

# ORGANIZATIONAL STRUCTURE AND INFORMATION

|  |
| --- |
| **Please provide a W-9** |

* 1. Please indicate the status of your agency (check all that apply):

|  |  |
| --- | --- |
| minority owned/operated  small business  none of the above | women owned/operated  faith-based organization |
| * 1. Date Established: | |
| State where Licensed/Incorporated: | |

* 1. History/Organizational Capacity
     1. History: *(Provide a brief history of the organization and its service delivery system for proposed Home and Community Based Services.)*
     2. Governing Body: *(Describe structure and responsibilities. Provide a list of the present membership of the Board of Directors or other governing body of the applicant. The list must include each member’s name, address, sex, race and whether he or she is a person with a disability. Also include the method used for selecting and replacing board members.)*
     3. Organizational Chart: *(For overall agency and single organization unit responsible for delivering proposed service(s).)*
     4. Experience: *(Describe within two pages organizational experience in working with older persons and/or adults with disabilities. Include the number of years in business.)*
  2. Mission & Values: Briefly describe the approach and plans for service implementation, including:
     1. Mission Statement
     2. Values and/or guiding principles
  3. Personnel:
     1. Identify the key personnel who will be involved with the program. Please make available upon request a resume for each of the key personnel.
     2. Identify the supervisory structure related to proposed service delivery.
     3. Describe the qualifications and required competencies for persons who will serve as direct service workers. Include job descriptions.
     4. Include the proposed training approaches and curriculum to be used to keep staff current in service delivery and best practices in services and supports.
  4. Financial Capacity: *(Describe the organization’s financial management capacity. Include at a minimum the following information.)*
     1. Most recently-completed audited financial statements of submitting organization. The audited financial statement is preferable; however, if an organization does not have this information, IRS tax reporting forms / tax return is appropriate for the submitting organization.
     2. A copy of the organization’s business status must be attached (i.e., 501(c), Business License, etc.)
     3. A copy of a valid certificate of insurance indicating liability insurance in an amount sufficient to cover any potential liability arising as a result of a contract pursuant to this RFPA.

**NOTE→**

* + 1. A copy of the verification of Workers Compensation Insurance.

**If an audited financial statement is available, do not complete numbers 5 and 6.**

* + 1. A current written bank reference, in the form of a standard business letter, indicating that the applicant's business relationship with the financial institution is in positive standing.
    2. Two current written positive credit references in the form of standard business letters from vendors with which the applicant has done business, or documentation of a positive credit rating determined by an accredited credit bureau within the last 6 months.

Note →

* 1. Organizational Conduct: **(Answer each question):**
     1. Has the organization and/or any of the organization’s employees, agents, independent contractors been convicted of, pled guilty to, or pled no contest to any contracted crime involving a public contract?       (If the answer is yes, attach an explanation)
     2. Has the organization and/or any of the organization’s employees, agents, independent contractors been convicted of, pled guilty to, or pled no contest to a felony?       (If the answer is yes, attach an explanation)
     3. Has the organization and/or any of the organization’s employees, agents, independent contractors been civilly liable in an action that involved fraud, misrepresentation, material omission, misappropriation, moral turpitude, theft, or conversion? (If the answer is yes, attach an explanation)
     4. Has the organization and/or any of the organization’s employees, agents, independent contractors been relieved of responsibility by a court, employer, or client for actions involving fraud, misrepresentation, material omission, misappropriation, moral turpitude, theft, or conversion? (If the answer is yes, attach an explanation)
     5. Is your organization currently under Federal or State debarment?

# ASSURANCES & CERTIFICATIONS

By signing this application, the Applicant agrees:

* To certify that, under penalty of perjury, your provider organization has completed this Provider Application independent of any outside influence which may result in your receiving privileged information about this RFPA.
* To certify that this RFPA factually represents your administrative capabilities and proposed services, and that if your organization is approved, you agree to abide by the terms and conditions of the Provider Contract.
* To certify that if your organization is approved, you agree to contract with the AAAD for services at your usual and customary charges not to exceed the maximum charges outlined in Section V of this provider application.
* To certify that your organization is in compliance with the specific Service Description and Standards required by the State for each proposed service activity. See Attachment 3 for Service Descriptions
* To certify that your organization has written policies regarding the following:

|  |  |
| --- | --- |
| * Personnel Policies | * Affirmative Action Policy |
| * Non-discrimination in Hiring Policy | * Confidentiality Policy |
| * Non-discrimination in Service Delivery Policy | * Civil Rights Compliance Policy *(Title VI and VII)* |
| * ADA Compliance Policy | * Certification Regarding Lobbying |
| * Drug Free Workplace Policy |

* To certify that your organization has secured all required licenses, certifications, permits and accreditation (as required by the State and/or Federal governments). **Attach copies (include most recent PSSA or other licensing entity’s monitoring report)**.

# SERVICE DELIVERY

* 1. Explain, in detailed narrative format, the applicant’s plan for service delivery including daily operations, quality assurance measure, providing services during inclement weather, emergencies, etc.
  2. Complete Attachment 1 (3 pages), Scope of Work on attached format indicating services covered under this RFP. In the Service Delivery Area(s) section, check the names of those counties you are interested in serving during the contract period.
  3. Provide a timeline for implementation, which includes number of days between provider notification by service coordinator and start of service.
  4. Explain the organization's policy process for conducting and maintaining documentation on criminal background checks for staff and volunteers involved in service delivery related to this Application.
  5. Explain the organization’s policy process for conducting Customer Satisfaction Surveys and attach the results of your most recent Customer Satisfaction Survey Report showing the percentage of satisfied customers for the period.

# PROPOSED SERVICE UNIT REIMBURSEMENT RATE

In order to be approved as a Service Provider, the applicant must provide a unit rate for each service proposed. Applicants proposing to provide services through contracts with more than one Area Agency on Aging and Disability may have their proposed service rates jointly reviewed by the respective Area Agencies on Aging and Disability.

* 1. For Older Americans Act (OAA) services, including the National Family Caregiver Support Program (NFCSP), the Federal Reimbursement Rate for each authorized service will be established by the AAAD in your proposed service area
  2. Complete the Assurance and Certification of Usual and Customary Charge (Attachment 2). Reimbursement rates for OPTIONS and OAA services, including NFCSP are listed below:

**OPTIONS for Community Living (State-Funded)**

**Older Americans Act – Title III (Federally Funded)**

|  |  |
| --- | --- |
| **Service** | **Reimbursement Rate** |
| Personal Care – OAA Title III | *The lesser of* $21.32 per hr. or usual and customary charges\* |
| Personal Care – State Funds | *The lesser of* $21.32 per hr. or usual and customary charges\* |
| Homemaker Services – OAA Title III | *The lesser of* $21.32 per hr. or usual and customary charges\* |
| Homemaker Services – State Funds | *The lesser of* $21.53 per hr. or usual and customary charges\* |
| In-home Respite – OAA Title III | *The lesser of* $16.28 per hr. or usual and customary charges\* |
| Adult Day Care-OAA Title III/ State Funds | *The lesser of* $12.12 per hr. or usual and customary charges\* |

*\*For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.  The same requirements are to be applied in the above noted programs. Thus, only the lesser of the maximum rate as specified above or the usual and customary charges for each service should be billed.*

These are the maximum rates which may **not** be exceeded; a lesser amount should be billed and reimbursed, if the provider’s usual and customary charge to persons not participating in these programs is lower. Reimbursement rates for OAA and State-Funded services shall not exceed the TennCare reimbursement rates.

**AUTHORIZATION FOR SUBMISSION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| On this the | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | day of | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | , 20\_\_, |
|  |  | |  |  | | |  |
| {Name of Applicant Organization) | | Is submitting this application to become an approved provider | | | | | |
|  | | | | | | | |
|  | | | | | | | |
|  | | | | |  |  | |
| Executive Director / CEO / President Applicant Organization | | | | |  | Date | |
|  | | | | |  |  | |
| Chairman, Governing Body | | | | |  | Date | |

Attachment 1

**SCOPE OF WORK**

APPLICANT AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*All services may not be available within each Area Agency on Aging and Disability. If you have questions about particular service availability, please contact the AAAD)*

1. SUMMARY OF DIRECT SERVICE ACTIVITIES

Check services to be provided:

|  |  |  |
| --- | --- | --- |
| **NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM-III E** |  | **OLDER AMERICANS ACT** |
| ☐ Individual Counseling (1 hour) |  | ☐ Adult Day Care (1 hour) |
| ☐ Support Groups (1 session) |  | ☐ Homemaker (1 hour) |
| ☐ Caregiver Training (1 hour) |  | ☐ Personal Care (1 hour) |
| ☐ Personal Care (1 hour) |  | ☐ Chore (1 hour) |
| ☐ Homemaker (1 hour) |  | ☐ Home Modification/Repair (1 Repair) |
| ☐ Adult Day Care (1 hour) |  | ☐ Personal Emergency Response System (Installation, Monthly Fee) |
| ☐ Institutional Respite (Overnight, up to 24 hours) |  |  |
| ☐ Assistive Technology (1 purchase) |  |  |
| ☐ Home Modifications/Repairs (1 repair) |  |  |
| ☐ Medical Equipment/Supplies (1 purchase) |  |  |
| ☐ Personal Emergency Response System (Installation, Monthly Fee) |  | Maximum Allowable for PERS Monitoring: $29.95  Maximum Allowable for PERS Install: $52.55 |
| ☐ Pest Control |  |  |
| ☐ Relative Caregiver Services |  |  |
| ☐ In-home Adult Care (1 hour) |  |  |
| **OPTIONS PROGRAM** |  |  |
| ☐ Personal Care (1 hour) |  |  |
| ☐ Homemaker (1 hour) |  |  |
| ☐ Personal Emergency Response System (Installation, Monthly Fee) |  |  |
| ☐ Adult Day Care (1 hour) |  |  |
| ☐ Pest Control |  |  |

Attachment 1 (cont’d)

**PROVISION OF SERVICE**

1. SERVICE AVAILABILITY:

|  |
| --- |
| Days of Service Availability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hours of Service Availability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If the applicant agency has multiple offices, please attach a list to the application |

1. NAME OF SUB-CONTRACTOR (if any):

|  |  |
| --- | --- |
| Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**(For each additional sub-contractor, attach listing with above information)**

1. QUALITY OF SERVICE:

The Provider shall ensure that quality services are provided to eligible consumers. The determination of quality must be based on an established quality assurance process.

1. TRAINING:

The Provider will attend meetings or workshops sponsored by the Agency and the Tennessee Commission on Aging and Disability, where appropriate and indicated.

1. SPECIAL CONTRACT CONDITIONS:
2. Attach a schedule of approved holiday closings.
3. Caregiver Training Only: Attach a training curriculum that includes class/session objectives along with a copy of the proposed training schedule for the twelve-month period.

Note: The scope of work for delivery of agreed upon services is a part of the contract and must be attached to both the Provider and the AAAD copy of the contract.

Attachment 1 (cont’d)

**SERVICE DELIVERY AREA(S)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **South Central Tennessee AAAD** | | | **First Tennessee AAAD** | **Upper Cumberland AAAD** | | |
| Bedford | | Lincoln | Carter | Cannon | Overton | |
| Coffee | | Marshall | Greene | Clay | Pickett | |
| Franklin | | Maury | Hancock | Cumberland | Putnam | |
| Giles | | Moore | Hawkins | DeKalb | Smith | |
| Hickman | | Perry | Johnson | Fentress | VanBuren | |
| Lawrence | | Wayne | Sullivan | Jackson | Warren | |
| Lewis | |  | Unicoi | Macon | White | |
|  | | | Washington |  | | |
|  | | |  |  | | |
| **East Tennessee AAAD** | | | **Southwest AAAD** | **Greater Nashville AAAD** | | |
| Anderson | Knox | | Chester | Cheatham | | Rutherford |
| Blount | London | | Decatur | Davidson | | Stewart |
| Campbell | Monroe | | Hardeman | Dickson | | Sumner |
| Claiborne | Morgan | | Hardin | Houston | | Trousdale |
| Cocke | Roane | | Haywood | Humphreys | | Williamson |
| Grainger | Scott | | Henderson | Montgomery | | Wilson |
| Hamblen | Sevier | | Madison | Robertson | |  |
| Jefferson | Union | | McNairy |  | |  |
|  |  | |  |  | |  |
| **Southeast Tennessee AAAD** | | | **MID-SOUTH AAAD** | **Northwest Tennessee AAAD** | | |
| Bledsoe | McMinn | | Fayette | Benton | | Henry |
| Bradley | Meigs | | Lauderdale | Carroll | | Lake |
| Grundy | Polk | | Shelby | Crockett | | Obion |
| Hamilton | Rhea | | Tipton | Dyer | | Weakley |
| Marion | Sequatchie | |  | Gibson | |  |
|  |  | |  |  | |  |

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attachment 2

By signing below, the Organization agrees:

To certify that your organization has supplied the Area Agency on Aging and Disability with the reasonable, usual and customary charges that your organization would charge other persons regardless of whether the person is enrolled in services authorized through the Tennessee Commission on Aging and Disability’s Home and Community Based Services.

To certify the unit cost rates charged to the Area Agency on Aging and Disability do not exceed those usual and customary charges applied to persons not served under services authorized through the Tennessee Commission on Aging and Disability.

To certify that your organization shall notify the Area Agency on Aging and Disability of any changes to the usual and customary charges and that those usual and customary charges will be provided on request.

To certify that your organization acknowledges that OAA and Title III services require a 10% provider match.

**The Organizations Usual and Customary Rates**

|  |  |  |  |
| --- | --- | --- | --- |
| Individual Counseling | $\_\_\_\_\_\_\_\_ | Personal Care | $\_\_\_\_\_\_\_\_ |
| Homemaker | $\_\_\_\_\_\_\_\_ | Adult Day Care | $\_\_\_\_\_\_\_\_ |
| Institutional Respite | $\_\_\_\_\_\_\_\_ | PERS, Installation | $\_\_\_\_\_\_\_\_ |
| PERS, Monthly Fee | $\_\_\_\_\_\_\_\_ | Pest Control | $\_\_\_\_\_\_\_\_ |
| In-home Adult Care | $\_\_\_\_\_\_\_\_ |  |  |

**Rates Charged to the Area Agency on Aging and Disability**

|  |  |  |  |
| --- | --- | --- | --- |
| Individual Counseling | $\_\_\_\_\_\_\_\_ | Personal Care | $\_\_\_\_\_\_\_\_ |
| Homemaker | $\_\_\_\_\_\_\_\_ | Adult Day Care | $\_\_\_\_\_\_\_\_ |
| Institutional Respite | $\_\_\_\_\_\_\_\_ | PERS, Installation | $\_\_\_\_\_\_\_\_ |
| PERS, Monthly Fee | $\_\_\_\_\_\_\_\_ | Pest Control | $\_\_\_\_\_\_\_\_ |
| In-home Adult Care | $\_\_\_\_\_\_\_\_ |  |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Applicant Organization**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Title of Authorized Signature Date**

Attachment 1

**SERVICE DESCRIPTIONS**

*Adult Day Care* – 1 hour – Provision of personal care for dependent adults in a supervised, protective congregate setting during some portion of a twenty-four hour day. Services sites may include intermediate and skilled care facilities, hospitals, churches, community centers, senior centers, and other appropriate, accessible facilities. Services offered in conjunction with adult day care includes social and recreational activities, training, and counseling, meals for adult day care; and/or services such as rehabilitation, medications assistance, and home health aide services for adult day health.

*Assistive Technology* –– Programs that pay all or a portion of the cost associated with purchasing assistive technology products and/or services which are used to increase, maintain, or improve functional capabilities of individuals with disabilities. This can include cognitive/learning devices, control and signaling aids, daily living aids, hearing augmentation aids, mobility aids, prosthetic/orthotic/seating devices, recreational aids, speech aids and visual/reading aids.

*Caregiver Training* – 1 hour – Programs that provide training for family members and other unpaid caregivers which focuses on care-related activities such as medication management, personal care and making the home environment safe and barrier-free as well as on stress management and other techniques to help the caregiver take care of him or herself.

*Chore* – 1 hour – Programs that offer the services of domestic workers who go into people’s homes and help with heavy house cleaning chores. Activities include providing assistance to persons having difficulty with one or more of the following instrumental activities of daily living: heavy housework, yard work, or sidewalk maintenance.

*Home Modifications/Repairs* – Programs that provide assistance in the form of labor and supplies for people who need to make essential repairs in order to eliminate health or safety hazards, such as weatherization, installing safety or accessibility features such as ramps, hand rails, grab bars or repairing or replacing steps, repair of heating, plumbing, or electrical systems.

*Homemaker* – 1 hour – Providing assistance to persons having difficulty with one or more of the following instrumental activities of daily living: preparing meals, shopping for personal items, managing money, using the telephone, and doing light housework. Activities include routine household management tasks such as menu planning, budgeting, shopping, meal preparation, and light housekeeping

*Individual Counseling* – 1 hour – Programs that offer personal therapeutic sessions in which the therapist works on a one-to-one basis with clients to help them resolve their mental, emotional or social problems. Provided by a Licensed Professional Counselor, Licensed Clinical Social Worker, or a Licensed Clinical Psychologist.

*Institutional Respite* – Overnight, up to 24 hours – Respite provided in assisted living, intermediate or skilled nursing care facility

*Medical Equipment/Supplies* – Programs that provide necessary sickroom equipment, medical bandages, respiratory aids and other medical supplies that are required by people who are convalescing following surgery or illness. The amount of funding determines purchase(s).

*Personal Care* – 1 hour – Providing personal assistance, supervision or cues for a person having difficulties with one or more of the following five activities of daily living: eating, dressing, bathing, toileting, and transferring in and out of bed

*Personal Emergency Response System* – Installation, Monthly Fee – Programs that provide electronic equipment which connects frail elderly individuals or people who have disabilities with participating hospitals, paramedics or other sources of emergency assistance.

*Pest Control* – Programs that abate established infestations of insects, rodents and other pest which may endanger the health of the family or cause damage to homes.

*Support Groups* – 1 session – Programs that offer sessions in which unrelated groups of seniors and/or their families discuss their attitudes, feelings and problems and, with input from other members in the group, attempt to achieve greater understanding and adjustment and explore solutions to their problem.

RFPA CHECKLIST

* Cover Letter
* W-9
* Current PSSA License
* PSSA licensing or other entity monitoring reports and POC acceptance letters
* Audited financial statement or other requested financial information
* Business License/Business Status
* Valid certificate of liability insurance
* Service Delivery explanation**,** & Attachment 1 – Scope of Work**,** Timeline for implementation
* Policy for conducting/maintaining background checks
* Attached schedule of holidays, (HDM only – procedures for prioritizing Emergency meals; Caregiver Training only – training curriculum, training schedule for 12 month period)
* History, Governing Body, Organizational Chart, Experience
* Mission Statement, Values/Guiding Principles
* Personnel – supervisory structure, qualifications/job descriptions, proposed training and curriculum
* Verification of Workers Compensation Insurance
* Customer Satisfaction Survey Results
* Completed Attachment 2: Assurance and Certification of Usual and Customary Charges
* Signed Authorization for submission