

Section Six:

Forms and Reference Materials

Note:

Forms are posted on www.cvadd.org If you have difficulty downloading these. A request for a printed and/or electronic copy should be sent to the following contact person:

Leigh Powell, CVAAIL Director
Cumberland Valley Area Development District
PO Box 1740
342 Old Whitley Road
London, KY 40743-1740
(606) 864-7391
Fax: (606) 878-7361
Email: lpowell@cvadd.org

FORM 1 Nutrition Services
 Bid Proposal to
 Cumberland Valley Area Development District
Nutrition Services

Agency Making Proposal	
Proposed Service Delivery Area	
Mailing Address	

Bid Price Information (Unit Price)

Services Bid	FY 18	
Meal Prep		

FORM 2
Bid Proposal to
Cumberland Valley Area Development District

Agency Name	
Doing Business As (if applicable):	
Administrative Office Mailing Address:	
Administrative Office Physical Address:	

Telephone Numbers of Administrative Office

Office	
Fax	
Other	

Type of Agency (Check One)

<input type="checkbox"/>	profit
<input type="checkbox"/>	non-profit
<input type="checkbox"/>	partnership
<input type="checkbox"/>	public
<input type="checkbox"/>	minority owned

Executive Director:	
Email Address:	

Board Chairperson	
Address	
Telephone	

FORM 3
Bid Proposal to
Cumberland Valley Area Development District

Site Information

Site Name	
Mailing Address	
Physical Address	
Telephone Number	
Fax Number	
Email Address	
Contact Person	

Site Name	
Mailing Address	
Physical Address	
Telephone Number	
Fax Number	
Email Address	
Contact Person	

FORM 4 Title III
 Bid Proposal to
 Cumberland Valley Area Development District
Title III

Staffing Plan

Include a staffing plan for each site being proposed.

Agency Making Proposal	
Site Proposed	

List ONLY staff persons who will be regularly employed to provide direct services (generating units) to clients in Title III Services and the number of hours per week they will be doing that service -- do not include other duties. Include only the hours the staff member provides direct services at this site. (If staff positions have not been filled, list each position as "To Be Hired 1", "To Be Hired 2", etc.) Do not include administrative positions, janitors, cooks, etc., unless the person provides direct service to the client.

Employee Name	Hours Worked Per Week	Duties Performed	Years of Experience	Check If	
				Paid Staff Member	Volunteer or Non-Traditional

FORM 4 Nutrition Service
 Bid Proposal to
 Cumberland Valley Area Development District
Nutrition

Staffing Plan

Include a staffing plan for each site being proposed.

Agency Making Proposal	
Site Proposed	

If staff positions have not been filled, list each position as "To Be Hired 1", "To Be Hired 2", etc.

Employee Name	Hours Worked Per Week	Duties Performed	Years of Experience	Check If	
				Paid Staff Member	Volunteer or Non-Traditional

#REF!
Calculation of Costs and Unit Prices

PROVIDER NAME

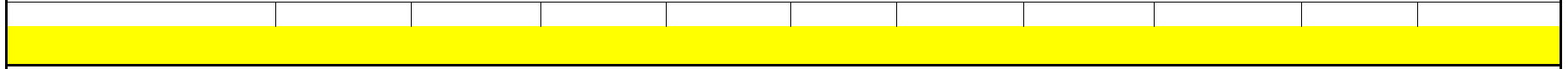
NUTRITION

	Total Congregate Cost	Meal Prep Cost	Home Delivered Meals		
			Total Cost	Title III Cost	Homecare Cost
Total Expenses	-	-	-	-	-
Personnel	-				
Travel	-				
Equipment	-				
Equipment Maint					
Supplies	-				
Contracts	-				
Consultants	-				
Rent	-				
Utilities	-				
Insurance & Bonding	-				
Building Maint.	-				
Vehicle Operation	-				
Raw Food Expense	-				
Training	-				
Miscellaneous	-				
Total Expenses	-	-	-	-	-
Number of Units	-				
Unit Cost					

Note:
Determine the total cost to deliver all Home Delivered Meals.
Next, enter the Title III costs.
The Homecare column will calculate automatically.
This should result in identical unit costs.

FY 2017

Calculation of Costs and Unit Prices



PROVIDER NAME

DATE

SUMMARY

	III-B	CONG.	HOME DEL.	MEAL PREP	III-D	HOME CARE			LOCAL	TOTALS
Total Expenses	-	-	-	-	-	-	-	-	-	
Personnel										-
Travel										-
Equipment										-
Equipment Maint										-
Supplies										-
Contracts										-
Consultants										-
Rent										-
Utilities										-
Insurance & Bonding										-
Building Maint.										-
Vehicle Operation										-
Raw Food Expense										-
Training										-
Miscellaneous										-
Total Expenses	-	-	-	-	-	-	-	-	-	-

#REF!
Calculation of Costs and Unit Prices



PROVIDER NAME

NUTRITION

	Total Congregate Cost	Meal Prep Cost	Home Delivered Meals		
			Total Cost	Title III Cost	Homecare Cost
Total Expenses	-	-	-	-	-
Personnel	-				
Travel	-				
Equipment	-				
Equipment Maint	-				
Supplies	-				
Contracts	-				
Consultants	-				
Rent	-				
Utilities	-				
Insurance & Bonding	-				
Building Maint.	-				
Vehicle Operation	-				
Raw Food Expense	-				
Training	-				
Miscellaneous	-				
Total Expenses	-	-	-	-	-

Number of Units	-				
Unit Cost					

Note:
Determine the total cost to deliver all Home Delivered Meals.
Next, enter the Title III costs.
The Homecare column will calculate automatically.

Section Seven:

Assurance Forms

Establishing Kentucky Resident Bidder

Name of Contact for Agency: _____

Name of Agency: _____

Address of Agency: _____

Per KRS 45A.494 definitions of resident bidder and non-resident bidder:

1. A resident bidder is an individual, partnership, association, corporation, or other business entity that, on the date the contract is first advertised or announced as available for bidding:
 - A) is authorized to transact business in the Commonwealth; and
 - B) Has for one (1) year prior to and through the date of the advertisement, filed Kentucky corporate income taxes, made payments to the Kentucky unemployment insurance fund established in KRS 341.490, and maintained a Kentucky workers' compensation policy in effect.

2. A non resident bidder is an individual, partnership, association, corporation, or other business entity that does not meet the requirements as stated above.

I certify that my agency is a resident bidder

I certify that my agency is a non-resident bidder

Signature of Agency Contact Person: _____

**APPLICANT ASSURANCE
CUMBERLAND VALLEY AREA DEVELOPMENT DISTRICT
REQUEST FOR PROPOSAL
FY 2018**

The applicant provides assurance of compliance with all State (Kentucky Administrative Regulations and Kentucky Revised Statutes) and Federal regulations, CVADD, Area Agency on Aging and Independent Living policies and procedures and the requirements and assurances of the RFP for the Title III, Nutrition and Homecare.

The applicant assures that they have read and will comply with the Title III & Title IV of the Older Americans Act of 1965, as amended, and the regulations promulgated there under.

Date _____

By _____
Signature

Title

Applicant

Street Address or PO Box

City, State, Zip Code

TERMS AND CONDITIONS FOR OFFICIAL APPLICATION

Terms and Conditions - It is understood and agreed by the undersigned that:

1. Funds contracted as a result of this request are to be expended for the purpose set forth herein and in accordance with all applicable laws, regulations, policies and procedures of this state and the Administration on Aging of the U.S. Department of Health and Human Services.

2. Any revisions in this proposal must be submitted in writing by that applicant and after approval by the Cumberland Valley Area Development District / Area Agency on Aging shall be deemed incorporated into and becomes a part of this agreement.

3. The assurance of civil rights compliance (Form HHS-441) applies to this proposal when approved.

4. Funds awarded by the Cumberland Valley Area Development District / Area Agency on Aging may be terminated at any time for violations of any terms and requirements of this agreement.

Name and title of individual authorized to commit applicant organization on this agreement:

Signature _____ Title _____ Date _____

ATTEST _____ Title _____ Date _____

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE
REHABILITATION ACT OF 1973 AS AMENDED**

The undersigned (hereinafter called the "recipient") HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulations (45 C.F.R. Part 84), all guidelines and interpretations issued pursuant thereto.

Pursuant to s84.5(a) of the regulations (45 C.F.R. 84.5(a)), the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance, including payments of other assistance made after such date on application for federal financial assistance were approved before such date. The recipient recognizes and agrees such federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signature appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal financial assistance is extended to it by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in the s84.5(b) of the regulation (45C.F.R 84.5(b)).

The recipient: Check (a) or (b)

- a. employs fewer than fifteen persons;
- b. employs fifteen or more persons and, pursuant to s84.7 (a) of the regulation (45 C.F.R. 84.7 (a)), has designated the following person(s) to coordinate its efforts to comply with the HHS regulation.

Name of Designee(s) - Type or Print

Name of Recipient - Type or Print

Street Address or PO Box

(IRS) Employer ID Number

City

State

Zip Code

I certify that the above information is complete and to the best of my knowledge.

Date

Signature and Title Authorized

If there has been a change in name or ownership within the last year, print the former name below.

**ASSURANCE OF COMPLIANCE WITH THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964**

_____ (hereinafter called the "Applicant" HEREBY
Name of Applicant - Type or Print

AGREES THAT it will comply with the Title VI of the Civil Rights Act of 1964, 42 USC 2000, etc. seq., and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCES THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, This assurance shall obligate the Applicant, on in the case of any transfer of such property, and transferee, for the period during which the real property or structure is used for a purpose for which the federal financial assistance is extended of for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts, or other Federal financial assistance extended after the date hereof the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the applicants, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on the behalf of the Applicant.

This assurance is hereby submitted for the period of _____ through _____.

Date _____ By _____
Signature and Title of Authorized Official

Telephone Number

Applicant (type ot print)

Address or PO Box City State Zip Code

ASSURANCE OF COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT OF 1990

The undersigned (hereinafter referred to as the "recipient") AGREES TO COMPLY with the provision of P.L. 101-336, the Americans with Disabilities Act of 1990.

This assurance obligates the recipient for the period during which federal and state financial assistance is extended to it by the State of Kentucky and/or the Department of Health and Human Services.

This assurance is binding upon the recipient, its successors, transferees, and assignees and the person or persons whose signature appears below are authorized to sign this assurance on behalf of the recipient.

Name of Designees - Type or Print

Name of Recipient

Street Address or PO Box

(IRS) Employer ID Number

City

State

Zip Code

I certify that the above information is complete and correct to the best of my knowledge.

DATE

Signature and Title

If there has been a change in name or ownership within the last year, please print the former name below.

Date: _____

Legal Document Authorization

I hereby authorize the following person(s) to sign legal documents from this agency in accordance with the terms of the contract with the Cabinet for Health and Family Services, Department of Aging and Independent Living.

Typed Name

Signature

Chairman of the Board
Authorized Official's Signature

Agency Name

Address

Date: _____

Invoice Authorization

I hereby authorize the following person(s) to sign legal documents from this agency in accordance with the terms of the contract with the Cabinet for Health and Family Services, Department of Aging and Independent Living.

Typed Name

Signature

Chairman of the Board
Authorized Official's Signature

Agency Name

Address

**Bid Proposal to
Cumberland Valley Area Development District**

Checklist

Provider

Part 1: Administration	yes	no	n/a
The agency is identified			
Proof of incorporation and bylaws submitted			
The agency is in Good Standing as defined by the Secretary of State.			
Organizational chart submitted or addressed in narrative			
List of Board of Directors, Trustees, or Stockholders			
Staffing Plan is submitted			
Personnel Policy addressed			
Job description submitted			
Experience in provision of service is described			
Sub-contracts for services if any, is addressed			
Back-up plan for services is addressed			
Disaster Plan submitted			
Personal Services Certification Documentation			
Grievance Procedures			
General Liability Insurance and Workman's Comp. Documentation			

Part 2: Title III	yes	no	n/a
The proposed service delivery area is described and acceptable			
Description of clients to be served			
Service facility is described			
Use of volunteers is addressed			
Training of staff and volunteers is described			
Proposed schedule of activities and days/hours of operation is described			
Cost per Unit is specified			

Part 3: Meal Prep - Nutrition	yes	no	n/a
The proposed service delivery area is described and acceptable			
Copy of license to operate a nutrition kitchen is enclosed			
Recent health department inspection is included			
Location of prep kitchen is identified			
Start and Finish time for meal prep is identified			
Proposed time and travel routes for delivery to meal service sites is included			
Equipment in prep kitchen is identified			
Vehicles and method to maintain temperatures during transport is identified			
Cost per unit is specified			
Meal cost breakdown is specified			

Date Reviewed: _____

Staff Member's Initials: _____

**Bid Proposal to
Cumberland Valley Area Development District**

Checklist

Provider

Part 4: Forms - Program Information

	yes	no	n/a
Nutrition Bid Price Form			
Bidder Information			
Site Information			
Nutrition Staffing Plan			

Part 5:

	yes	no	n/a
Terms & Condition for Official Application			
Assurance - Compliance with Section 504			
Assurance - Compliance with Regulation under Title VI Of Civil Rights Act of 1964			
Assurance - Compliance with ADA of 1990			
Legal Document Authorization			
Invoice Authorization			
Board Members of Qualified Agency			
Establishing Kentucky Resident Bidder			
Bid Proposal Checklist			
New Bidders only: Transition plan is addressed			

Date Reviewed: _____

Staff Member's Initials: _____

Section Eight:

Menus and Equipment Inventory

Menu Samples are in a separate attachment.

Inventory Form is in a separate attachment.