CENTRAL SAVANNAH RIVER AREA
REGIONAL COMMISSION

REQUEST FOR PROPOSALS

AGING SERVICES

DUE DATE: April 5, 2024
DUE TIME: 3:00 P.M.

ALL BIDS MUST BE SUBMITTED BY THE DUE DATE AND DUE TIME NOTED ABOVE.

SUBMIT BIDS TO: squattlebaum@csrarc.ga.gov

CSRA Regional Commission
3626 WALTON WAY EXT., SUITE 300
AUGUSTA, GA 30909
Phone: 706.210.2000
Fax: 706.210.2006
Email: acrosson@csrarc.ga.gov

RFP Due Date: April 5, 2024 **Deadline for Questions:** March 29, 2024

The Central Savannah River Area Regional Commission is seeking responses as noted below. If you are interested in responding to our Request for Proposals, please do so by the date noted in this RFP and in the manner so described.

The CSRA Regional Commission (hereinafter referred to by name or "CSRA RC"), as the CSRA Area Agency on Aging, 3626 Walton Way Ext., Suite 1, Augusta, GA 30909, will receive responses (hereinafter referred to as "Response" or "Responses" or "Bid" or "Bids") to this Request for Proposals (RFP) until 3:00 PM on April 5, 2024, for the Scope of Services outlined in the RFP.

No responses will be accepted after 3:00 PM on April 5, 2024. The CSRA RC reserves the right to request additional information from any Responder submitting a response to this RFP if the CSRA RC, in its sole discretion, deems such information necessary to further evaluate the responses to this RFP. The CSRA RC reserves the right, in its sole discretion, to interview any Responder responding to this RFP. The CSRA RC reserves the right to waive informalities and minor irregularities in submittals and reserves the sole right to determine what constitutes informalities or minor irregularities. Responder shall be responsible for all costs associated with responding to this RFP.
Any questions concerning this RFP or requests for additional information must be directed in writing to:

acrosson@csrarc.ga.gov or
Andy Crosson, Executive Director
CSRA Regional Commission
3626 Walton Way Ext., Suite 300
Augusta, GA 30909
by 12:00 p.m. on March 29, 2023

Answers/responses from the CSRA RC to questions or requests for additional information will be in writing and will be provided to all persons who have received a copy of this RFP and/or requested to be included on the mailing list for potential addendums as noted above.

The CSRA RC will evaluate each Response, choosing the one(s) that, in the CSRA RC's sole discretion, is/are the most responsive (not necessarily the lowest in cost) for the particular contract, best addresses the work to be performed, taking into consideration factors such as price, potential ability to perform successfully under the terms and conditions of the contract, relevant past project experience/qualifications, organizational capacity, budget/financial capacity, and responses to the scope of work and performance overview sections of this response.

The CSRA RC also reserves the right, in its sole discretion, to contact any and/or all Responders after receiving the Responder's submittal to seek clarification of any portion thereof. The CSRA RC reserves the right to request additional information from any and/or all Responder if the CSRA RC deems, in its sole discretion, such information necessary to further evaluate the Responder's qualifications and/or capacity to perform.

The CSRA Regional Commission reserves the right, in its sole discretion, to cancel the RFP at any time, to amend the RFP before the due date for responses, to alter the time tables for procurement as set forth in the RFP prior to the due date, to reject any or all Responses submitted, and/or to waive any technicalities or formalities

Awarding of any contracts and any subsequent periodic payments during the grant period is contingent upon receipt of local, state and federal funds during the contract period. **EOE / ADA / M/F/H/O**

APPEALS PROCESS

Responders not selected may appeal the CSRA Regional Commission's decision to award a competitively solicited contract/agreement to another Responder by submitting a written appeal to the Executive Director within ten (10) calendar days of being notified that they were not selected. The written appeal must be sent via certified mail, return receipt requested to: Attn: Appeal of Procurement Award, CSRA Regional Commission, 3626 Walton Way Ext., Suite 300, Augusta, GA 30909.

For procurements resulting in awards of less than $125,000, the Executive Director will schedule a time within ten (10) business days to hear the Responder's appeal. The Executive Director will consider the information presented and submit to the appealing Responder his/her decision within ten (10) business days after hearing the appeal.

For procurements resulting in awards equal to or greater than $125,000, the CSRA Regional Commission's Council will hear any such appeal at the Council's next regularly scheduled meeting (where the Responder may present an argument on its behalf, and the Executive Director, or his/her designee, may submit the Regional Commission's counterargument(s)). The Council will consider the information presented and submit to the Responder its decision within ten (10) business days after hearing the appeal. The decision of the CSRA Regional Commission's Council shall be final and binding.

After the Regional Commission's Council or the Executive Director issues an appeal decision, any dispute that shall arise as to the procurement process shall be referred to a(n) arbitrator(s) selected in accordance with the rules of the American Arbitration Association, and such dispute shall be settled by arbitration in accordance with the rules prescribed by the CSRA Regional Commission, and judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction. The party requesting arbitration and the CSRA Regional Commission shall share equally the cost of the arbitration process.

Once the arbitrator(s)'s judgment has been rendered, the decision will be presented to the CSRA Regional Commission's Council at its next regularly scheduled meeting for further consideration and/or action, if necessary.

I have read and understand the appeals process as outlined above.

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ________________________ **Date** ________________________

Name (typed) ________________________ **Title** ________________________

Contact Phone: ________________________ **Email:** ________________________

Background

Through this Request for Proposal (RFP), the CSRA Regional Commission, in its capacity as the Area Agency on Aging, is soliciting responses from potential Responders interested in operating certain aging programs in each of the following counties: Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, and Wilkes for the CSRA Area Agency on Aging for the period outlined within the "Period of Performance and Contract Terms" section of this RFP. Responders may limit their request to serve a particular geographical area.

Responders must complete this Request for Proposal in its entirety to be considered. Selected Responders will become a part of the service delivery system detailed in CSRA RC's FY2025-2029 Area Plan on Aging (a planning document for the CSRA). Inclusion in the Area Plan does not guarantee or imply any grant award for subsequent years. This RFP only covers the period outlined in the "Period of Performance and Contract Terms" section of this RFP.

The Georgia Department of Human Services, Division of Aging Services (DAS) has designated the CSRA RC as the Area Agency on Aging (AAA) for the fourteen-county region. As such, the CSRA RC receives funds through the Older Americans Act (Title III B, C1, C2, D & E and Title VII); the Social Services Block Grant; the Community Care Services Program; the State of Georgia for the Long Term Care Ombudsman Program, the Community Based Services Program (a cost share program), Income Tax Check-off, Alzheimer's Grants, and the Georgia Caregiver Resource Center, Aging and Disability Resource Connection, and, other fund sources to ensure that a comprehensive and coordinated service delivery system for older persons and their caregivers is available.

The CSRA Area Agency on Aging was designated in October 1974, to oversee the provision of and to coordinate programs for older adults in the Central Savannah River Area, located in east central Georgia and headquartered in Augusta, Georgia. From the beginning, the goal of the Agency has been to assure maximum independence and enhance the quality of life for older persons through home- and community-based services.

The CSRA Area Agency on Aging oversees the provision of a variety of services and support to improve the lives of senior citizens in all 14 counties of the CSRA. The Area Agency on Aging's primary activities are:

- identifying and planning for aging-service needs throughout the region,
- connecting senior citizens and caregivers with needed aging services and information, providing staff support and leadership to outside agencies that address aging issues, and
- administering grants and contracts to quality organizations that provide services to older CSRA residents.

The CSRA Area Agency on Aging has the responsibility for developing an Area Plan for aging services and programs which describes this service delivery system in detail and the impact the Plan has on older residents in the planning and service area. The Area Plan is implemented through contracts, subgrant agreements, and cooperative agreements negotiated with various providers and local jurisdictions to implement services for the benefit of older residents and their families/caregivers in the Central Savannah River Area. **The Area Plan planning period should not be confused with the period of contracts, subgrant agreements, or cooperative agreements awarded under this RFP.**

RESPONDER INFORMATION SHEET

Name of Organization: ______________________________

Physical Address:

Street: ______________________________

City: ____________ **State:** ________ **Zip:** ____________

Phone Number: ____________ **Fax Number:** ____________

E-Mail: ______________________________

Mailing Address:

Street and/or P.O. Box: ______________________________

City: ____________ **State:** ________ **Zip:** ____________

Type of Organization: ______**Public** ______**Private Non-Profit**

(check all that apply) ______**Private Proprietary** ______**Minority owned**

(for informational/statistical purposes only) ______**Female owned** ______**Less than 500 employees**

Primary Contact Person: **Name:**______________________________

Title:______________________________

Services to be Provided (check all that apply):

- ☐ Elderly Legal Assistance Program
- ☐ Kinship Care Program
- ☐ Health Promotion and Disease Prevention
- ☐ Homemaker Services
- ☐ Senior Center Activities
- ☐ Supportive Service

Counties to be served (check all that apply):

- ☐ Burke
- ☐ Columbia
- ☐ Glascock
- ☐ Hancock
- ☐ Jefferson
- ☐ Jenkins
- ☐ Lincoln
- ☐ McDuffie
- ☐ Richmond
- ☐ Screven
- ☐ Taliaferro
- ☐ Warren
- ☐ Washington
- ☐ Wilkes

Total Funds Requested: ____________ **Unit Cost** **(if applicable)**: ____________

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________ **Date** ______________

Name (typed) ______________________ **Title** ______________

Contact Phone: ______________________ **Email:** ______________________

REQUEST FOR QUALIFICATIONS

All information requested is required prior to consideration of any response.
The undersigned certifies under oath to factual truth of all information presented.

Name of Firm/Individual:____

Form of Legal Entity (if applicable):_______________________________________

Address:____

Phone:____

Name and Title of Respondent:____

E-Verify Number: ________________________________

Are You or Affiliate Rated by Dun and Bradstreet? ☐ YES ☐ NO

If yes, D&B Number: ____________________

Have you or your firm defaulted on a contract or failed to complete any work awarded, or been involved in work related to litigation (if yes, please describe)?

List up to ten (10) projects which demonstrate skills to be used on a similar project. Note project name, location, owner, year, and nature of firm/individual's responsibility:

List key personnel and qualifications likely to be involved on this type of project and explain their specific role in the work to be done:

List professional references for the firm/individual:

Certifying that all answers to the foregoing questions and all statements therein contained are true and correct, I acknowledge that I am authorized to submit this response and that, if this response is accepted, I or my organization, will perform the duties as described.

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________________ **Date** ______________________

Name (typed) ______________________________ **Title** __________________________

Contact Phone: __________________________ **Email:** ____________________________________

Scopes of Work

ELDERLY LEGAL ASSISTANCE PROGRAM

The Georgia Elderly Legal Assistance Program is funded under Title IIIB [42 U.S.C. Section 302(a)(2)]. As such, the funding of legal assistance by each Area Agency on Aging is mandatory, and services shall be accessible and available throughout each of the 12 planning and service areas in Georgia.

Program Purpose

The broad purposes of legal assistance services are to assist older individuals in:

- Understanding their rights;
- Exercising choice
- Benefiting from services, opportunities and entitlements, and maintaining rights promised and protected by law;
- Providing access to the system of justice by offering advocacy, advice and representation to person 60 and older;

Programs are to:

- Serve particularly those who are the most socially or economically needy, low-income minorities and rural elders including long term care residents, personal care home residents, elders with chronic health problems, elders with particular problems of access to health care, homeless elders, institutionalized or de-institutionalized mentally ill or developmentally disabled, elders with language barriers, elders proposed for or under guardianship, victims of elder abuse, neglect or exploitation and physically isolated elders;
- Address accessibility to the target population groups identified by the Area Agency on Aging and the legal assistance provider, as specified in the Title III B grant application of the provider. These services are to be available and accessible to the target population groups throughout the planning and service area;
- Address outreach efforts through the use of specific techniques which will help to make potential clients aware of their services. The techniques will be tailored to the groups which have been targeted;
- Address the provision of community legal education such as speeches, presentations, radio or television shows;
- Foster cost-effective, high quality services, having maximum impact on the following priority areas – income, health care, long-term care, nutrition, housing and utilities, defense of guardianship, abuse/neglect/exploitation and age discrimination;
- Be accessible through the planning and service area;
- Develop and maximize the use of other resources to expand the provision of legal assistance to older people, including alternate dispute resolution where appropriate

The successful Responder will describe in detail the plan for providing Elderly Legal Assistance to each county in the planning and service area. The plan will indicate any county for which intake, legal advice, representation, community education and or information and referral cannot or will not be provided by Title III B legal services paid staff. In addition, the plan will indicate specifically who will provide intake, legal advice, representation, community education and or information and referral.

HEALTH PROMOTION AND DISEASE PREVENTION

The Georgia Department of Human Services' Division of Aging Services provides the following definitions for Wellness:

Health Promotion and Disease Prevention - Group: The provision of program activities promoting wellness, nutrition, and physical activity, disease prevention and risk management, healthy lifestyle and safety in a group setting.

Staff activities will include:

- Lifestyle Management - The provision of activities and/or education sessions to promote overall health and improve quality of life.
- Nutrition Education - The provision of information about foods and nutrients, diets, lifestyle factors, community nutrition resources and services to people to improve nutrition status.
- Physical Activity - The provision of a variety of leisure time, fun activities to improve balance, strength and flexibility.
- Program Awareness/Prevention - The provision of activities and/or education sessions related to medications management group sessions; prevention of flu; pneumonia; preventing chronic disease and managing risk associated with chronic diseases.

The successful Responder will work with the Health and Wellness program coordinator and will be able to:

- attend local and state trainings
- facilitate health screening for grant projects including, blood pressure checks, range of motion testing, endurance testing, and written pre/post tests
- lead exercise classes
- lead health and nutrition education programs

HOMEMAKER SERVICES

The Georgia Department of Human Services' Division of Aging Services provides the following definitions for Homemaker, Personal Care, and Respite Services:

- **Homemaker:** Provision of assistance to individuals with the inability to perform one or more of the following Activities Daily Living (ADLs) preparing meals, shopping for personal items, managing money, telephoning and light housework.
- **Personal Care**: Providing personal assistance, stand-by assistance, supervision or cues for persons with the inability to perform one or more of following ADLs: eating, dressing bathing and toileting, transferring in/out of bed/chair or walking.
- **Respite Care** – In home: Provision of temporary substitute supports or living arrangements for older persons in order to provide a brief period of rest or relief for family members or other caregivers.

Homemaker, Personal Care, and Respite care providers must comply with regulations for Private Homecare Providers, Chapter 290-5-54, (Office of Regulatory Services) in addition to the GA DHS-DoAS general and HCBS service specific manuals. (HCBS manuals are located at http://www.aging.DHS.georgia.gov) Service providers are expected to be proactive on behalf of HCBS members and maintain active dialogue with the case manager (notify the case manager regarding hospitalizations, emergency room visits, or other change in the member's status).

Documentation for RN supervisory visits for clients receiving personal care must include the following:

- An evaluation of the member's health status and needs, noting changes in health/care.
- An evaluation of the quality of care and client's statement of the level of satisfaction.
- Results of care being rendered.
- Planned interventions and follow-up for any problems identified.
- Any needed revisions to the client's care plan.

Other requirements include, but are not necessarily limited to the following:

- Before a provider implements changes in frequency and type of service, the provider must discuss care plan revisions with the case manager.
- The provider must employ a sufficient number of qualified and experienced staff to render services in their approved areas.
- At least annually, the provider RN, or LPN completes and documents an in-home supervisory visit to observe and monitor in-home performance of the homemaker and personal care aide.
- The aide must document service provided to each client, each time service is delivered. At least once per month, the aide submits service forms to the agency's supervisory. The provider maintains copies of service forms in the provider's files as record of services rendered to the client.
- Providers must have Service Plans for clients that are clearly written with the tasks that the personal care/ homemaker aide is supposed to be doing ("Housekeeping" is not sufficient). Service Plans contain: Functional limitations of client, types of services required, expected times, frequency and duration of services, number of visits per week, approximate time of day and duration, goals and objectives, and discharge plans.
- Providers must maintain documentation of personal care aide's initial and annual training requirements:
- Personal care aides are to receive 40 hours of training (20 before serving clients) or passed the NLN or GAHCA test.
- Each employee must have at least 8 hours of training each year after the first year of employment, and the training must be related to the duties they perform.
- The successful Responder will be required to attend quarterly trainings and meetings.

KINSHIP CARE

The aging programs solicited through this RFP will be operated to develop a Kinship Care Center (KCC) to assist in the provision of Information and Assistance Services, Counseling, Advocacy, Respite and Community/Public Education.

Minimum Program Services to be Provided:

The core services which must be provided under this grant are as follows: First, the successful applicant(s) will provide a space designated as the Kinship Care Center where Information and Assistance Services, Counseling Services, and Community/Public Education Services can occur. Secondly, the successful applicant(s), once awarded a contract, will be required to offer the following two services as part of this contract agreement:

- **Counseling Services:** Counseling to caregivers to assist them in making decisions and solving problems relating to their caregiver roles. This includes counseling to individuals, support groups and caregiver training (of individual caregivers and families). Providing individual guidance and assistance with problem resolution by professionally qualified paid or volunteer staff to older persons or grandparents raising grandchildren. Primary reasons for counseling include, but are not limited to, depression, grief, family problems and lifestyle changes.
- **Case Management:** Assistance either in the form of access or care coordination in circumstances where the older person is experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by a formal service provider or family caregivers.

Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as

The CSRA Regional Commission Area Agency on Aging Gateway will offer information and referral services and technical assistance to support all kinship care projects in the region as part of its ongoing Gateway Connection.

Optional Program Services:

In addition to the minimum program services required, each contractor has the option of providing any of the services listed below.

1. **Kinship Care – Group:** Kinship Caregiver group activities provided on behalf of kinship caregivers and kinship care receivers to support their continued independence and well-being.
2. **Respite Care – Out of Home:** Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite Care for Kinship Care (grandparents caring for children) includes summer camps, child care or after school care. While these services are optional, the inclusion of any or all in the applicant's proposal will be weighed during the review process.

The successful Responder will work with the CSRA RC's Kinship Care Coordinator to ensure adequate service outreach and delivery within the service area(s) awarded.

SENIOR CENTER ACTIVITIES

The Georgia Department of Human Services' Division of Aging Services provides the following definitions for Senior Center Activities/ Recreation/ Health Promotion:

- **Exercise/Physical Fitness:** Provision of activities which promote health, wellness, mobility, and flexibility, including specialized exercises/workouts for persons with disabilities or mobility limitations.

- **Senior Recreation – Group:** Nutritional related activities; activities that promote socialization, physical and mental enrichment; clubs; education sessions and programming for other leisure activities (i.e., sports, performing arts, games, crafts, travel, volunteering; community gardening; environmental activities; and intergenerational activities, etc.) offered to eligible persons sponsored by and/or at an approved senior center facility which are facilitated by an instructor or provider.

Responder must clearly identify the services to be performed and outline how those services meet the criteria for Recreation and/or Health Promotion/Wellness as outlined above.

The Area Agency on Aging prefers to utilize funding for these activities within the region's existing Senior Center locations to maximize participation by clients of those centers. Consideration will be given for projects that target eligible recipients who do not otherwise attend a local Senior Center. In responding, please indicate where the services you propose will be provided and the target population you plan on reaching.

Responder who will be providing services to a Senior Center(s) but does not otherwise operate the Center(s) must include written approval from the operator of the Center acknowledging that the Responder, if successful, will be authorized to provide the service at the local Center.

SUPPORTIVE SERVICES

The Georgia Department of Human Services' Division of Aging Services provides the following definitions for Supportive Services:

- Community/Public Education: Contacts with several current or potential clients/caregivers, or the general public, to inform them of service availability or provide general program information.
- Adult Day Care/Health: Provision of personal care for dependent adults in a supervised, protective, congregate setting during some portion of a twenty-four hour day. Services offered in conjunction with Adult Day Care or Adult Day Health typically include social and recreational activities, trainings, counseling, meals for adult day care and services such rehabilitation, medications assistance, and personal care services for Adult Day Health. Mobile daycare services are provided by staff that travels from a central location on a daily basis, to various sites, primarily rural areas.
- Counseling: Providing guidance and assistance with the problem resolution by professionally qualified paid or volunteer staff to older persons or caregivers, including grandparents raising grandchildren. Counseling may be provided individually or group settings, such as support groups or open forums to encourage sharing and questions. Primary reasons for counseling include, but are not limited to, depression, grief, family problems, and lifestyle changes, education about prevention, detection, and treatment of mental disorders and age-related dementia and neurological and organic brain dysfunction.
- Emergency Response: Installation of an in-home electronic support system which provides two-way communication to geographically and socially isolated individuals, enabling them to remain in their own homes. The electronic system provides 24-hour-a-day access to medical control center on a daily basis.
- Material Aid: Payments to or on behalf of an older person for housing/shelter, utilities, food/meals or groceries, clothing, eyeglasses, dental care, etc.
- Home Modification: Provision of housing improvement services designed to promote the safety and wellbeing of adults in their residence, to improve internal and external accessibility, to reduce the risk of injury, and to facilitate in general the ability of older individuals to live at home. May also include the purchase and installation of assistive devices and security devices, such as locks, smoke detectors, tub rails, improved lighting, etc.

Responder must clearly delineate in their application the services to be provided. All such services must achieve the activities outlined within the definition above. Additionally, each application must identify the target service area (i.e. one or more counties by name, the CSRA region as a whole, etc…)

In responding, the Responder must fully describe the activities to be undertaken and outline how those activities aid the target population.

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put SEE ATTACHED" in the space provided for each answer.

Applicant Narrative Questions

Capacity:

1. Describe how the Bidder will interface with the Area Agency on Aging to resolve issues effectively related to service delivery and clients.

2. Discuss the qualifications and capability to provide effective services that will meet all program standards.

3. How does the organizational chart demonstrate effective lines of communication and program responsibility, and detail percent of staff time assigned to each service or program? (attach Org Chart)

4. State when (days and hours of operation) and where services will be provided, and if alternate delivery sites are used, identify each site and days and hours of operation.

5. Upload a copy of your Organizational Chart.

UPLOAD ORG CHART

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put SEE ATTACHED" in the space provided for each answer.

Information and Referral

1. Describe how Bidder will interface with the Area Agency on Aging (AAA) Gateway/ADRC Information and Assistance and their management of the waiting list.

Special Initiatives or Collaborations:

1. Describe any special initiatives, innovations that will enhance Bidder's program in the community.

2. Describe any new or on-going plans to obtain additional financial support or resources for this program.

3. Describe any partnerships or collaborations with other community organizations or private businesses that will strengthen the services provided by Bidder.

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put SEE ATTACHED" in the space provided for each answer.

Outreach or Marketing Plan

1. Describe the program awareness activities or marketing plan for agency.

2. Describe the methods Bidder will use to provide outreach to persons in the community as well as minorities, homebound or otherwise isolated individuals.

3. Describe any special materials or techniques Bidder has developed to reach special populations.

4. Describe any specific populations Bidder will target, if any.

5. Describe methods to be used to provide services to Limited English Proficiency/Sensory Impaired (LEP/SI) clients.

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put SEE ATTACHED" in the space provided for each answer.

Professional Staff Development

1. Describe how Bidder will provide new staff orientation and training and provide an outline of the orientation schedule and topics.

2. Describe Bidder's plan for conducting on-going staff training including topics and number of training sessions to be held.

3. Describe method Bidder will use to determine the training needs of staff.

4. Describe the agency's staff recruiting practices and retention strategies. Indicate the annual staff turnover rate from the most recent fiscal year.

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put SEE ATTACHED" in the space provided for each answer.

Client Confidentiality

1. Describe the annual Health Insurance Portability and Accountability Act (HIPAA) training for all staff and volunteers.

2. Describe policy or procedures concerning client confidentiality

Technology and Ability to Meet Reporting Requirements

1. Describe agency's capacity for and use of technology, both in agency administration and delivering services.

2. Describe agency's strategic plan for maintaining adequate stock including hardware, software and voice/data services.

3. Indicate capacity or plan to interface with the Division of Aging Services Aging Information Management System (AIMS) for reporting.

4. Detail person(s) responsible for data validation, data entry and reporting.

Quality Assurance Program or Plan:

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put SEE ATTACHED" in the space provided for each answer.

1. Describe how Bidder will ensure the quality of the program or services to clients.

2. Describe how Bidder will measure the effectiveness of your program.

3. Describe how Bidder will determine if the program had an impact on the clients.

4. Describe how Bidder will determine the client’s satisfaction with services.

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put "SEE ATTACHED" in the space provided for each answer.

Subcontracting

Describe, for each service, any proposed subcontract agreements and clearly identify the general scope of work to be performed by the subcontractor. If subcontracting for a service, include documentation of the bidding process to secure such subcontractors. Describe subcontractor qualifications, subcontractor requirements and how the subcontractor will be monitored. Any required reporting forms, with due dates, for subcontractors should be included in the response.

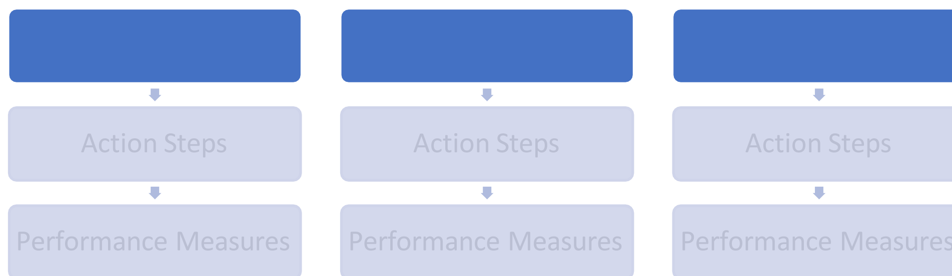
Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put SEE ATTACHED" in the space provided for each answer.

OUTCOME MEASUREMENTS

List the outcome(s) proposed to measure for this service and how you will measure them. Identify the specific staff position responsible for determining and measuring outcomes for this service. In identifying outcome measurements, develop the following:

- Objectives: What results are intended? Objectives should have a definite time frame and should always be measurable. List as many objectives as needed.
- Action Steps: State what tasks or activities must be completed to achieve the objective; who is responsible for them; and when they will be completed.
- List as many action steps as needed to accomplish the objective.
- Performance Measure: What results will indicate that the objective has been achieved? How will success be measured?

Example:



Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put "SEE ATTACHED" in the space provided for each answer.

Budget Narrative

In addition to the Uniform Cost Methodology (if required), please upload supporting financial documentation, in order of preference, 1) the most recent Comprehensive Annual Financial Report (CAFR); 2) financial statements (FS) that have been reviewed by an independent public accountant (IPA) with accompanying notes; 3) FS compiled by and IPA; 4) federal tax returns; and 5) last internally prepared FS's signed by the owner or an individual familiar with finances of the entity.)

UPLOAD FINANCIAL DOCUMENTS

The budget narrative must address the following elements

1. EMPLOYEE COSTS:

A. Wages

Identify the name, title, and FTE of each employee that will charge this program. For any employee with an FTE of <1, please provide a list other programs charged.

Example:

John Smith, Program Director ($50,000)

Cost Code	Full Time Equivalent (FTE)	Salary Per Cost Code
Meal Program	.50	$25,000
Rec Program	.25	$12,500
General Agency Programs	.25	$12,500
Amount budgeted for contract = $25,000	1.0	$50,000

B. Fringe Benefits

Identify each payroll related expense included in the budget and the formula used.

Example:

Social Security – Total Wage Budget = $100,000 x 7.65% = $7,650

Any payroll related expenses over and above Social Security, Worker's Compensation, and Unemployment Insurance must have a company policy attached.

B. Other Payroll Expenses

Identify any payroll expenses not included in Wages or Fringe Benefits (i.e.. payroll administration costs, etc…)

C. Employee Travel

Employee travel must be supported through mileage logs or supervisor approved mileage reimbursement forms. We will not reimburse for gas purchases. In order to be reimbursed for employee travel, you must submit a copy of a travel reimbursement policy identifying the mileage reimbursement rate

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put SEE ATTACHED" in the space provided for each answer.

2. OPERATIONAL COSTS:

A. Consumable Supplies Expenses

Consumable supplies include supplies and materials that relate to the program that cannot be used for future programs. Please identify the supplies and materials that you plan on buying in detail (i.e. do not just include a "per participant" cost).

B. Insurance Costs

You may only include insurance costs if they are specifically provided for this program. If you are including direct insurance costs, please provide support as to the premium amount that relates specifically to this program.

3. OTHER EXPENSES

Please list and give a detailed description of all other costs that need to be reimbursed by this program. Please keep in mind the federal allowable costs principals.

A. Supportive Services Paid to Participants

Some participants may require supportive services. If supportive services are planned, please provide a description and estimate of each cost. Case Management providers are required to provide supportive services, as needed, to participants. No participant may receive more than $3,000 for supportive services per calendar year.

B. Small Equipment

Please provide the detail of planned purchases of equipment less than $500.00. Equipment is any item that will be used for the program, but has the potential of continuing use beyond the duration of this contract.

C. Equipment

Please provide the detail of planned purchases of equipment over $500.00. Equipment is any item that will be used for the program, but has the potential of continuing use beyond the duration of this contract.

UPLOAD BUDGET

Budget Form

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put "SEE ATTACHED" in the space provided for each answer.

BUDGET PROPOSAL

FY2025 AAA RFP

Full-Time Employees:	
Part-Time Employees	
Fringe Benefit Rate:	

	TOTAL
EMPLOYEE EXPENSES	
Salaries/Wages	
Fringe Benefits	
Other Payroll Expenses	
Employee Travel	
SUBTOTAL:	$ 0
OPERATIONAL COSTS	
Supplies and Materials	
Rental (Real Estate)	
Rental (Equipment)	
Postage and Freight	
Consumable Supplies	
Insurance Costs	
SUBTOTAL:	$ 0
OTHER EXPENSES	
Telecommunications	
Advertising	
Memberships and Subscriptions	
Conference/Seminar Costs	
Facilities Cost	
Small Equipment	
Equipment	
SUBTOTAL:	$ 0
TOTAL:	$ 0

EVALUATION CRITERIA AND REVIEW CONSIDERATIONS

It is essential that the Responder address each requirement set forth in this Request for Proposals. The response must contain all requested information. If a response is materially incomplete, in the sole judgment of the CSRA RC, it may be declared technically unresponsive and may be eliminated from further consideration.

For all procurements that are expected to result in an award/contract greater than $50,000 in aggregate[1], a review committee assembled by the CSRA RC (at its sole discretion) may be used to objectively review responses received. The review committee may or may not include or be solely limited to staff members of the CSRA RC.

By responding to this RFP, you also explicitly acknowledge that your response may be reviewed by a review committee as noted above and that any notes and/or discussions generated during the review of this RFP by the review committee are private and will not be shared with any Responder. A compilation of each Responder's average score (generated by averaging the score assigned by each reviewer for that Responder) may be made available only at the end of the award of this RFP.

By responding to this RFP, you also acknowledge that the CSRA RC, in its sole discretion, may make any award(s) to the Responder whose Response is the most responsive Response for the particular contract, best addresses the work to be performed, taking into consideration factors such as price, potential ability to perform successfully under the terms and conditions of the contract, analysis of the applicable Unit Cost Methodology or other cost analysis, relevant past project experience/qualifications, organizational capacity, budget/financial capacity, and responses to the scope of work and performance overview sections of this response.

The review committee's recommendation scoring will be submitted to the CSRA RC's management for consideration. The CSRA RC's Council will make a final decision related to the award of responses taking into consideration the RC's management's recommendation and the criteria for responsiveness. The CSRA RC Board's decision may differ from the review committee's recommendations.

Acknowledgement of Appeals Process

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________________ **Date** ______________________

Name (typed) ______________________________ **Title** __________________________

Contact Phone: __________________________ **Email:** ______________________________________

[1] For procurements that are expected to result in an award/contract amount that is less than $50,000, the CSRA RC may, at its sole discretion determine the best method to ascertain the responsible Responder who possess, at the Commission's sole discretion, the potential ability to perform successfully under the terms and conditions of a proposed procurement.

Contractual and Administrative Assurances

The following assurances must be signed and included with the response.

- General Financial Requirements and Assurances
- Contractual and Standard Program Assurances
- Assurance of Compliance with Title VI of the Civil Rights Act of 1964, As Amended
- Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, As Amended and the Americans' with Disabilities Act of 1990, As Amended
- Certification Regarding Debarment, Suspension, and Other Responsibility Matters
- Disclosure of Lobbying Activities
- Health Insurance Portability Protection Act (HIPPA) Business Associate Agreement
- Certification of Non-Collusion
- Conflict of Interest Disclosures
- E-Verify Certification
- Clean Air Act Certification

RESPONDER CERTIFICATIONS

All Responders are required to affirm the following statements.

Yes	No	Certification – Affirm or Deny each of the following
☐	☐	The Responder is registered and in good standing with the Georgia Secretary of State to do business in the State of Georgia.
☐	☐	The person signing the response is the person in the Responder's organization responsible for, or authorized to make, decisions as to the prices quoted.
☐	☐	The price(s) proposed has been arrived at independently without collusion, communication, or agreement relating to such prices with any other Responder or competitor(s).
☐	☐	The response does not deviate from the detailed requirements of this RFP and I acknowledge that the CSRA RC, at its sole discretion, reserves the right to reject any response containing deviations and/or to require modifications before accepting any such deviations, and/or to immediately terminate any subgrant agreement and/or contract entered into when deviations that have not been duly noted are subsequently discovered.
☐	☐	I am not using any subcontractor(s) to do work on this project. If "NO" is selected, the general scope of work to be performed by the subcontractor/subgrantee, the subcontractor's/subgrantee's willingness to perform the work indicated; and guarantees that the subcontractor/subgrantee does not discriminate in its employment practices with regard to race, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or disability is attached.
☐	☐	The Responder and any applicable subcontractor(s) will comply with the Georgia Security and Immigration Compliance Act, which requires the verification of the work eligibility for all newly hired employees thorough an electronic federal work authorization program (Employment Eligibility Verification (EEV)/Basic Pilot Program). ***(Note: For more information about the Georgia Security and Immigration Compliance Act, visit the Georgia Department of Labor's website at: http://www.dol.state.ga.us) The EEV/Basic Pilot Program can be accessed at https://e-verify.uscis.gov/enroll/).***
☐	☐	The organization and its subcontractors/subgrantees, if any, will be compliant with the Health Insurance Portability and Accountability Act (Public Law No.104-191,110 Stat. 1936), including its Privacy, Security and Electronic Data Interchange standards and regulations, and any and all signed business associate or other agreements for the CSRA RC's Area Agency on Aging and the Department of Human Resources.
☐	☐	My agency has the solvency to meet performance requirements of this project and detailed financial data that gives a clear indication of the Respondent(s)' fiscal ability to perform the scope of services is attached. ***(Note: Preferred documentation includes, in order of preference, 1) the most recent Comprehensive Annual Financial Report (CAFR); 2) financial statements (FS) that have been reviewed by an independent public accountant (IPA) with accompanying notes; 3) FS compiled by and IPA; 4) federal tax returns; and 5) last internally prepared FS's signed by the owner or an individual familiar with finances of the entity.)***

Yes	No	Certification – Affirm or Deny each of the following
☐	☐	The name, address, and telephone number of the individual(s) who can be contacted from 8:00 am to 5:00 pm during business days for questions regarding this proposal is included in this response.
☐	☐	I understand that all responses become the property of the CSRA RC and will not be returned to the Responder and the CSRA RC will have the right to use all ideas or adaptations of ideas contained in any response received and that selection or rejection of the Responder response will not affect this right.
☐	☐	There was no contact specifically related to this solicitation, direct or otherwise, with any employee of the CSRA RC or any Georgia Department of Human Services (DHS) staff with direct involvement with this RFP process, except as permitted by the RFP and that any subcontractor(s)/subgrantee(s) listed in this response also complied with this restriction on communications as well.
☐	☐	No undisclosed conflict of interest relationship exists nor will exist during the contract/subgrant period should the Responder enter into a subgrant agreement and/or contract with the CSRA RC that interferes with fair competition or is a conflict of interest. ***(Note, disclosures of potential conflicts of interest are done on the Conflict of Interest Disclosure form contained in this RFP and do not necessarily prevent the Responder from successfully contracting with the CSRA RC.)***
☐	☐	No relationship exists between the Responder and another person or organization that constitutes an undisclosed conflict of interest with respect to an existing subgrant agreement and/or contract with the AAA. ***(Note, disclosures of potential conflicts of interest are done on the Conflict of Interest Disclosure form contained in this RFP and do not necessarily prevent the Responder from successfully contracting with the CSRA RC.)***
☐	☐	The Responder assume(s) all costs associated with the preparation and submission of all documents related to this RFP and no claim will be made for payment to cover costs incurred in the preparation or submission of this response or any other costs associated with responding to any portion of this RFP.
☐	☐	I understand that prior to award, the apparent winning Responder will enter into discussions with the CSRA RC to resolve any subgrant agreement and/or contractual differences before an award is made and that these discussions are to be finalized and all exceptions resolved within two (2) weeks of notification, unless mutually agreed otherwise in writing, and if they are not resolved in that time, this could lead to rejection of the Responder's response and discussions initiated with the Responder deemed by the CSRA RC, in its sole discretion, to be the next most responsive Responder.
☐	☐	I understand the CSRA RC, in its sole discretion, may make any award(s) to the Responder whose Response is the most responsive for the particular contract, best addresses the work to be performed, taking into consideration factors such as price, potential ability to perform successfully under the terms and conditions of the contract, analysis of the applicable Unit Cost Methodology or other cost analysis, relevant past project experience/qualifications, organizational capacity, budget/financial capacity, and responses to the scope of work and performance overview sections of this response.

Yes	No	**Certification – Affirm or Deny each of the following**
☐	☐	I understand that the CSRA RC reserves the right, in its sole discretion, to contact any and/or all Responder after receiving the Responder's response to this RFP to seek clarification of any portion thereof and that the CSRA RC reserves the right to request additional information from any and/or all Responder if the CSRA RC deems, in its sole discretion, such information necessary to further evaluate the Responder's qualifications and/or capacity to perform.
☐	☐	I understand that by responding to this RFP, that my response may be reviewed by a review committee assembled by the CSRA RC, at its sole discretion, which may or may not include staff of the CSRA RC and/or independent individual(s), and that any notes and/or discussions generated during the review by the review committee are private and will not be shared with any Responder and only a compilation of each Responder's average score (generated by averaging the score assigned by each reviewer for that Responder) may be made available only at the end of the award of this RFP.
☐	☐	I understand this RFP will result in a twelve (12) month contract/subgrant award for service(s) and that the contract/subgrant award document will outline methods of termination of the award. ***This RFP covers the CSRA RC's fiscal year running from July 1, 2024 to June 30, 2025.***
☐	☐	I understand that inclusion in the CSRA RC's Area Agency on Aging's Area Plan does not guarantee or imply any grant award/contract for the immediate or any subsequent year.
☐	☐	I acknowledge that any/all contract(s)/subgrant agreement(s) resulting from this Request for Proposal process are contingent on the availability of funds from the Georgia Department of Human Services (DHS) and that the terms and conditions of the CSRA RC's contract with DHS and any subsequent policy decisions, laws or regulations shall be applied to the contractor(s)/subgrantee(s) chosen through this process.
☐	☐	I understand that subgrant agreements, contracts, and cooperative agreements issued as a result of this RFP may be amended, by mutual agreement, from time-to-time whenever adjustments are needed because of changes in the CSRA RC's funding sources, and that any such agreement(s)/contract(s) may be immediately terminated by the CSRA RC if mutual agreement cannot be reached.
☐	☐	I understand that, notwithstanding any other certifications to the contrary, the CSRA RC may terminate any contract(s)/subgrant agreement(s) issued as a result of this RFP due to non-availability of funds, due to default, or for cause, or for convenience, at any time by giving thirty (30) days written notice.
☐	☐	I know that the CSRA Regional Commission reserves the right to reject any or all Responses, to cancel the RFP, and/or to waive any technicalities or formalities at its sole discretion and that awarding of any and/or all contracts and periodic payments during the grant period is contingent upon receipt of local, state and federal funds during the contract period.

Yes	No	Certification – Affirm or Deny each of the following
☐	☐	I am aware of the appeal process of this RFP and that the appeal decision of the RC's Council is final and binding.
☐	☐	I understand that after the RC's Executive Director or Council (as applicable) issues its appeal decision, any dispute that shall arise as to the RFP process shall be referred to a(n) arbitrator(s) selected in accordance with the rules of the American Arbitration Association, and such dispute shall be settled by arbitration in accordance with the rules prescribed by the CSRA RC, and judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction, and that the party requesting arbitration and the CSRA RC shall share the cost of the arbitration process equally.
☐	☐	If the Responder has had prior subgrant agreements, contracts, or cooperative agreements with the CSRA Regional Commission, I acknowledge that the obligations set forth under the previous agreement(s)/contract(s) were successfully met.
☐	☐	I acknowledge that the CSRA RC reserves the right, in its sole discretion, to cancel the RFP at any time, to amend the RFP before the due date for responses, to alter the time tables for procurement as set forth in the RFP prior to the due date, to reject any and all responses submitted, and/or to waive any and/or all technicalities or formalities.
☐	☐	I am aware that awarding of any contracts and any subsequent periodic payments during the grant period is contingent upon receipt of local, state and federal funds during the contract period.
☐	☐	I certify that I have read, understand, and accept all other terms, conditions, criteria, and requirements set forth in this RFP.

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ____________________________________ **Date** __________________________

Name (typed) ____________________________________ **Title** ________________________________

Contact Phone: ________________________________ **Email:** ____

GENERAL FINANCIAL REQUIREMENTS AND ASSURANCES

The Responder/provider assures that the following general financial conditions are understood and will be met as a requirement for entering into a contract with the CSRA Regional Commission (CSRA RC) for Aging services:

1. I understand that the CSRA Regional Commission shall have the right to suspend/withhold payment if conditions of the contract are not met.

2. I understand that CSRA RC shall not be liable for non-payment or late payment for services rendered if funds are not available or have not been received from the Georgia Department of Community Health.

3. I understand that federal, state, and program income are restricted funds and must be spent during this fiscal year. Minimum required match is the minimum non-federal funds necessary to earn the federal and state funds for the program.

4. I understand that program income is funds voluntarily donated by the participants of the program to increase or maintain services. Included in the budget is an estimate of the funds to be collected during this next fiscal year and is based on past history of such collections of program income from participants of the program.

5. I understand this budget is for a period that runs from July 1, 2019 to June 30, 2020.

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________________ **Date** ______________________

Name (typed) ______________________________ **Title** ______________________

Contact Phone: ______________________________ **Email:** ______________________________

Please note that there is an attachment page at the end of this document. If you wish to attach additional information, please use those buttons and put "SEE ATTACHED" in the space provided for each answer.

CONTRACTUAL AND STANDARD PROGRAM ASSURANCES

The Vendor assures the following general conditions will be met as a requirement for entering a contract with for aging services:

1. Assures compliance with the Older Americans Act (Public Law 89-73, Stat. 218) and any other funding sources as well as all federal, state laws, standards, policies and procedures.
2. Assures the provision of training to staff and volunteers as needed and/or required.
3. Assures that services will not be denied to any person because they cannot or will not contribute toward the cost of the service.
4. Assures that funds received through voluntary contributions from program participants will not be used to replace funds from other non-federal sources but will be used to maintain or expand aging services provided under this contract.
5. Assures that any required criminal record checks are performed for all employees.
6. Assures that it will supply an annual audit in accordance with the provisions of the 1359 Audit Law. Copies of all reports resulting from said audits shall be furnished to the CSRA Regional Commission no later than 180 days after the contract period has expired.
7. Assures records relating to the funded programs are kept on file at least six (6) years after the end of the contract.
8. Assures all services provided under this program will meet current state and local licensure safety and insurance requirements for the provision of those services.
9. Assures compliance with existing regulations and all relevant and current circulars from the Office of Planning an Budget for determination and allowableness of costs in connection with federal/state contracts and grants.
10. Assures the accurate and timely reporting of programmatic and financial information to the CSRA RC, state and federal government as required.
11. Assures access to all program and agency records by the CSRA RC, GADCH, and other federal or state officials or auditors as needed.
12. Assures cooperation in the transition of any service subsequently contracted to another vendor/contractor.

I HAVE REVIEWED, UNDERSTAND, AND AGREE TO ABIDE BY ALL CONDITIONS AS STATED.

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________________ **Date** ______________________

Name (typed) ______________________________ **Title** ___________________________

Contact Phone: __________________________ **Email:** ____________________________________

CONTRACTUAL AND STANDARD PROGRAM ASSURANCES OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, AS AMENDED

The responder hereby agrees that it will comply with Title VI of the Civil Rights Act of 1964, as amended, 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 and the Act and the Regulation, no person in the United States shall, on the ground of political affiliation, religion, race, color, sex, handicap, age, or national origin, be excluded from participation in, be denied the benefits of or be otherwise subjected to discrimination under any program or activity financed in whole or in part by federal funds, which the RESPONDER provides or participates directly through a contractual or other arrangement.

The RESPONDER agrees to make no distinction on the ground of political affiliation, religion, race, color, sex, handicap, age, or national origin with respect to admission policy or procedure or in the provision of any aid, care, service or other benefits to individuals admitted or seeking admission to the RESPONDER.
This assurance is given in consideration of and for the purpose of receiving any and all payments from state agencies receiving federal grants. The RESPONDER recognizes and agrees that state agency financial payments will be extended in reliance on the presentations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance.

The assurance is binding on the RESPONDER, its successors, transferees, and assignees, and the persons whose signatures appear below are authorized to sign this assurance on behalf of the RESPONDER.

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________________ **Date** ____________________

Name (typed) ______________________________ **Title** __________________________

Contact Phone: __________________________ **Email:** ____________________________________

ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED, AND THE AMERICANS WITH DISABILITIES ACT OF 1990, AS AMENDED

The RESPONDER HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act of 1990, as amended, and all requirements imposed by the applicable DHHS regulation (45 CFR Part 84) and all guidelines and interpretations issued pursuant thereto.

Pursuant to sub-section 84.5(a) of the regulation (45 CFR 84.5(a)), the RESPONDER 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 or other assistance made after such date on Responses for federal financial assistance that were approved before such date.

The RESPONDER recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the RESPONDER, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal assistance is extended by it to the Department of Health and Human Services or, where the assistance is in the form of real property, for the period provided for in sub-section 84.5(b) of the regulation (45 CFR 84.5(b)).

The responder
Employs fifteen (15) or more persons and, pursuant to sub-section 84.7(a) of the regulation (45 CFR 84.7(a)), has designated the following person(s) to coordinate its efforts to comply with the DHHS regulation.

Name of Compliance Person

Employer Identification # (IRS#)

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

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________________ **Date** ______________________

Name (typed) ______________________________ **Title** ___________________________

Contact Phone: __________________________ **Email:** ____________________________________

COMPLIANCE WITH CLEAN AIR AND WATER ACTS

The grantee certifies that:

This contract is subject to the requirements of the Clean Air Act, as amended, 42 USC 1857 et. seq., and the regulations of the Environmental Protection Agency with respect thereto, at 40 CFR Part 15, as amended from time to time.

In compliance with said regulations:

1. The Contractor shall require of subcontractors that any facility to be utilized in the performance of any nonexempt contract or subcontract is not listed on the List of Violating Facilities issued by the Environmental Protection Agency (EPA) pursuant to 4C CFR 15.20.
2. The Contractor will comply with all the requirements of Section 114 of the Clean Air Act, as amended, (42 USC 1857c-8) and section 308 of the Federal Water Pollution Control Act as amended, (330 USC 1318) relating to inspection, monitoring, entry, reports, and information, as well as all other requirements specified in said section 114 and section 308, and all regulations and guidelines issued thereunder.
3. The Contractor will provide prompt notice of any notification received from the Director, Office of Federal Activities, EPA, indicating that a facility utilized or to be utilized for the contract is under consideration to be listed on the EPA List of Violating Facilities.
4. The Contract will include or cause to be included the criteria and requirements to paragraph (1) through (4) of this section in every nonexempt subcontract and take such action as the Government will direct as a means of enforcing such provisions.

Signature of Legally Authorized Person

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ________________________ **Date** ____________________

Name (typed) ________________________ **Title** ____________________

Contact Phone: ____________________ **Email:** ____________________________

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS AND GRANTS

Federal Executive Order 12549 requires the CSRA RC to screen each covered potential contractor/grantee to determine whether each has a right to obtain a contract/grant in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor/grantee must also screen each of its covered subcontractors/providers.

In this certification "contractor/grantee" refers to both contractor/grantee and subcontractor/sub-grantee: "contract/grant" refers to both contract/grant and subcontract/subgrant. By signing and submitting this certification the potential contractor/grantee accepts the following terms:

1. The certification herein below is a material representation of fact upon which reliance was placed when this contract/grant was entered into. If it is later determined that the potential contractor/grantee knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, the Technical College System of Georgia, or the CSRA Regional Commission may pursue available remedies, including suspension and/or debarment.
2. The potential contractor/grantee shall provide immediate written notice to the person to which this certification is submitted if at any time the potential contractor/grantee learns that the certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
3. The words "covered contract," "debarred," "suspended," "ineligible," "participant," "person," "principal", "response," and "voluntarily excluded," as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549. Usage is as defined in the attachment.
4. The potential contractor/grantee agrees by submitting this certification that, should the proposed covered contract/grant be entered into, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, the Technical College System of Georgia and/or the CSRA Regional Commission as applicable.
5. The potential contractor/grantee further agrees by submitting this certification that it will include this certification titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts and Grants" without modification, in all covered subcontracts and in solicitations for all covered subcontracts.
6. A contractor/grantee may rely upon a certification of a potential subcontractor/subgrantee that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered contract/grant, unless it knows that the certification is erroneous. A contractor/grantee must, at a minimum, obtain certifications from its covered subcontractors/subgrantees upon each subcontract's/subgrant's initiation and upon each renewal.
7. Nothing contained in all the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this certification document. The knowledge and information of a contractor/grantee is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for contracts/grants authorized under paragraph 4 of these terms, if a contractor/grantee in a covered contract/grant knowingly enters into a covered subcontract/subgrant with a person who is

suspended, debarred, ineligible, or voluntarily excluded from participation in the transaction, in addition to other remedies available to the federal government, Department of Health and Human Services, United States Department of Agriculture, or other federal department or agency, as applicable, the Technical College System of Georgia, or other state department or agency, as applicable, and/or the CSRA Regional Commission may pursue available remedies, including suspension and or debarment.

Debarment Certification Statement

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS (Executive Order 12549, Debarment and Suspension,34 CFR Part 85)

Organization/Individual certifies to the best of its knowledge and belief, that it and its principals:

(a) ☐ Are ☐ are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(b) ☐ Have ☐ have not within a three-year period preceding award of this consulting agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or Local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) ☐ Are ☐ are not presently indicted for or otherwise criminally charged by a governmental entity (Federal, State or Local) with commission of any of the offenses enumerated in Paragraph (b) above; and

(d) ☐ Have ☐ have not within a three-year period preceding award of this consulting agreement had one or more public transactions (Federal, State or Local) terminated for cause or default.

Signature of Legally Authorized Person

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________________ **Date** ______________________

Name (typed) ______________________________ **Title** __________________________

Contact Phone: __________________________ **Email:** ____________________________________

CHECK HERE IF NOT APPLICABLE

Disclosure of Lobbying Activity Form

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	a. bid/offer/response b. Initial award c. post-award	a. initial filing b. material change For Material Change Only: year _______quarter ________ date of last report_________

4. Name and Address of Reporting Entity: ____Prime ____Subawardee Tier______, if known: Congressional District, if known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime Congressional District, if known:
6. Federal Department/Agency:	7. Federal Program Name/Description CFDA Number, if applicable: ___________________
8. Federal Action Number, if known:	9. Award Amount, if known:$
10. a. Name and Address of Lobbying Entity (if individual, last name, first name, MI): (attach Continuation Sheet(s)	b. Individual Performing Services (including address if different from No. 10a) (last name, first name, MI) SF-LLL-A, if necessary)
11. Amount of Payment (check all that apply): $___________ ____ actual ____planned 12. Form of Payment (check all that apply): ____ a. cash ____ b. in-kind; specify: nature______________ value___________	13. Type of Payment (check all that apply): ____ a. retainer ____ b. one-time fee ____ c. commission ____ d. contingent fee ____ e. deferred ____ f. other; specify: ________________________

14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employee(s), or Member(s) contacted, for payment indicated in Item 11:
(attach Continuation Sheet(s) SF-LLL-A, if necessary)

15. Continuation Sheet(s) SF-LLL-A attached: Yes No

16. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each failure.	Signature:_______________________________ Print Name:____________________________________ Title:___________________________________ Telephone No.:________________Date:_____________
Federal Use Only	Authorized for Local Reproduction Standard Form--LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee of prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing of attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract, grant, or loan award number, the response/response control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.
    (b) Enter the full names of the individual(s) performing services and include full address if different from 10(a); Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material charge report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D.C. 20503.

Health Insurance Portability Protection Act (HIPPA)
Business Associate Agreement

The contractor, ____, satisfactorily assures the Central Savannah River Area Regional Commission Area Agency on Aging (CSRA RC AAA) that it is in compliance with Health Insurance Portability and Accountability Act (HIPAA), Public Law No. 104-19 1, 110 Stat. 1936. (Kassenbaum, Kennedy), 45 CFR 160, et seq. (HIPAA Privacy Regulations) and its regulations, including but not limited to the Privacy rule promulgated in 45 CFR 160 and Part 164 subparts A and E, that pursuant to HIPAA became effective April 14, 2003. The contractor (provider) understands and acknowledges that the Georgia Department of Human Services is a covered entity as defined by HIPAA and is required to adopt and implement standards and procedures for the handling of protected health information by April 14, 2003. Further, as the CSRA RC Area Agency on Aging is for purposes of HIPAA, a business associate of the Georgia Department of Human Services and Georgia Department of Community Health (collectively "DEPARTMENTS"); its contractors that provide aging related services and handle protected health information are business associates of both the CSRA RC AAA and the DEPARTMENTS. The contractor (provider) further understands and acknowledges that upon entering a contract with the CSRA RC AAA, it is a business associate of the Georgia Department of Human Services and the Georgia Department of Community Health and the CSRA RC Area Agency on Aging as defined by HIPAA and is required to agree to comply with and abide by the Department's and the CSRA RC Area Agency on Aging's privacy standards and procedures. The contractor (provider) therefore agrees that any use of protected health information pursuant to this contract will comply with all HIPAA and DEPARTMENTS and CSRA RC AAA requirements and privacy standards and procedures.

Further, the contractor agrees to provide training for its employees as required by HIPAA. It shall provide the privacy, security, and electronic data interchange safeguards as outlined by federal law and regulations. It shall provide clients' rights, notice of privacy policies, maintain minimum necessary and de-identified information as required by HIPAA and will comply with any policies of the DEPARTMENTS or the CSRA RC Area Agency on Aging. The contractor further acknowledges and agrees that the Georgia Department of Human Services Division of Aging Services, including the Long-Term Care Ombudsman, the Georgia Department of Community Health, and the CSRA RC Area Agency on Aging provide functions that are considered health oversight agencies in their funding, quality improvement and regulatory functions. As health oversight agencies, protected health information **must be shared with them and authorization is not required**, according to HIPAA.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO ABIDE BY ALL CONDITIONS AS STATED HEREIN.

Name of Responder____ Date: _______________
(typed)

____ Title: ____________________________________
Signature of Legally Authorized Person

CERTIFICATE OF NON-COLLUSION

FAILURE TO EXECUTE THIS CERTIFICATE WILL AUTOMATICALLY RESULT IN REJECTION OF RESPONSE

I certify that this bid and/or response is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a response for the same materials, supplies, equipment, and/or services and is in all respects fair and without collusion or fraud. I understand that collusive bidding and/or applying is a violation of State and Federal Law and can result in fines, prison sentences, and civil damage awards. I agree to abide by all conditions of this response and certify that I am authorized to sign this response for the Responder.

I HAVE REVIEWED, UNDERSTAND AND AGREE THAT THIS RESPONSE HAS BEEN DEVELOPED AND SUBMITTED WITHOUT ANY COLLUSION BETWEEN THE RESPONDER AND ANY OTHER RESPONDER.

Signature of legally Authorized Person

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________________ **Date** ______________________

Name (typed) ______________________________ **Title** ___________________________

Contact Phone: __________________________ **Email:** ____

CONFLICT OF INTEREST DISCLOSURES

The Central Savannah River Area Regional Commission is recognized as an Organization of Ethics under the Georgia Municipal Association's ethics designation program. Additionally, the RC has established ethics policies that dictate that potential conflicts of interest be clearly delineated by respondents seeking to do business with the RC or its component units. Such disclosures do not necessarily prevent the Responder/respondent/Responder from being awarded contracts by the RC so long as the disclosures take place in the Request for Proposal/Response/Bid process. This form must be submitted with all responses to Central Savannah River Area Regional Commission Requests for Responses/Responses/Bids.

Name of Firm/Individual: ____

Form of Legal Entity (if applicable): ____

Address: ____

Phone: ______________________________

Name and Title of Respondent: ____

Disclosure Certification:

If the owner(s) and/or any key personnel or immediate family members of all such personnel identified in this response have been employed by the RC or served on any of the following Boards/Authorities/Councils currently or within the past five (5) years, please check the appropriate box(es) below and attach supporting documentation[2] you feel is necessary to address potential conflict of interest questions which may be raised:

- ☐ A former employee of the Central Savannah River Area RC
- ☐ Central Savannah River Area Regional Commission's Council
- ☐ CSRA RC Historic Preservation Advisory Council
- ☐ CSRA RC Area Agency on Aging Advisory Council
- ☐ CSRA Business Lending (to include the following companies):
- ☐ CSRA Local Development Corporation
- ☐ CSRA Rural Lending Authority
- ☐ CSRA Resource Development Agency
- ☐ No owner, key personnel, or immediate family members serve in any capacity on the entities listed above.

By signing below, I acknowledge that the above disclosure is true and accurate as of the date signed.

______________________________________ ______________________

Signature of Certifying Official Date Signed

[2] All Responders applying for funds through the Area Agency on Aging must a) identify the person or persons for whom a potential conflict of interest exists, b) the relationship to any current or former board member, current of former advisory council member, or current of former employee; and c) the nature of the potential conflict. The person or persons for whom the potential conflict of interest exists shall certify that he/she will abide by all rules established by Subsection 102.12 (Conflicts of Interest) of the Georgia Department of Human Services Division of Aging Services Administrative Guidelines.

E-Verify Certification
Affidavit Under O.C.G.A. § 13-10-91(b)(4)

By executing this affidavit, the undersigned sub-subcontractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the individual, firm or corporation which is engaged in the physical performance of services under a contract for the Workforce Development Program on behalf of agencies of the State of Georgia has registered with, is authorized to use and uses the federal work authorization program commonly known as E-Verify, or any subsequent replacement program, in accordance with the applicable provisions and deadlines established in O.C.G.A. § 13-10-91.

Furthermore, the undersigned sub-subcontractor will continue to use the federal work authorization program throughout the contract period and the undersigned sub-subcontractor will contract for the physical performance of services in satisfaction of such contract only with sub-subcontractors who present an affidavit to the sub-subcontractor with the information required by O.C.G.A. § 13-10-91(b). The undersigned sub-subcontractor shall submit, at the time of such contract, this affidavit to (name of subcontractor or sub-subcontractor with whom such sub-subcontractor has privity of contract).

Additionally, the undersigned sub-subcontractor will forward notice of the receipt of any affidavit from a sub-subcontractor to (name of subcontractor or sub-subcontractor with whom such sub-subcontractor has privity of contract). Sub-subcontractor hereby attests that its federal work authorization user identification number and date of authorization are as follows:

Federal Work Authorization User Identification Number ______________________________

Date of Authorization ______________________________

Name of Subcontractor ______________________________

Name of Project ______________________________

Name of Employer ______________________________

I hereby declare under penalty of perjury that the forgoing is true and correct.

I understand that an electronic signature has the same legal effect and can be enforced in the same manner as a written signature.

☐ ***By checking this box and signing my name below, I am electronically signing this form.***

Signature ______________________________ **Date** ______________________________

Name (typed) ______________________________ **Title** ______________________________

Contact Phone: ______________________________ **Email:** ______________________________

FILE ATTACHMENT LIST

(PDF and Word Documents Only)

Attach Files

DOCUMENT **CLICK IF A FILE IS ATTACHED**

Request for Qualifications (Supporting Documents (if applicable))

Applicant Narrative Questions (Capacity) (if applicable)

Organizational Chart (if not uploaded previously)

Information and Referral Questions (if applicable)

Outreach Marketing Plan (if applicable)

Professional Staff Development (if applicable)

Client Confidentiality (if applicable)

Quality Assurance Program or Plan (if applicable)

Subcontracting Supporting Documents (if applicable)

Outcome Measures

Budget Narrative **(REQUIRED)**

Uniform Cost Methodology Forms **(REQUIRED)**

Other 1

Other 2

Other 3

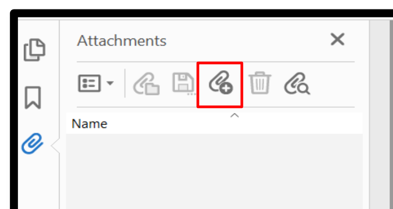
Other 4

Other 5

To attach a file, click the attach button.
The attachment window will open to the left.

DOCUMENT UPLOADS
(PDF and Word Documents Only) ATTACH FILES

Click on the paper clip and then choose the file you wish to attach.



PRINT AND SUBMIT RESPONSE

1. Save your response.

2. Print your response prior to submitting.

3. Submit your response

You will receive an email notification acknowledging receipt of your response. Note that this is an automatic reply and does not necessarily mean your application is complete. You will be notified if any additional documentation is needed or if there are any problems with the attachments. Contact acrosson@csrarc.ga.gov if you have any questions related to the submission of your response.