

**APPENDIX VIII – PART IV**

**OAA APPLICATION FOR FUNDS**

**TITLE III-E**

**(NATIONAL FAMILY CAREGIVER SERVICES)**

## OAA APPLICATION FOR FUNDS TITLE III-E

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## II.A. General Requirements

### 1. Consumer Projections, Profile and Targeting

Complete Table 1. The projections requested are your best estimates. The profile of your Consumers to be served should be in keeping with the intent of the Older Americans Act which mandates that services be targeted to those 60 years of age and older in greatest social and economic need, especially low income minority individuals or individuals socially or geographically isolated. Table 2, provides the countywide ratios of these targeted groups. The total number of consumers served is an unduplicated count. The sum of each of the categories could be larger than this total.

**Table 1. Projected Consumer Profile Summary Under Title III-E OAA**

	Projected Consumers Served
Total Number of Consumers Served (proposed)	
60+ At Poverty Level (\$8,590) or below	
Low Income Minority <125 % of Poverty (\$10,337)	
60+ With Mobility & Self Care Limitation	
60+ living in rural areas	
Able to Attend Senior Center	

**Table 2. County Level Data – 2008 Estimates**

County	Population 60+	60+ In Poverty	Low Income Minority <125% of Poverty Level	60+ With Mobility & Self Care Limitation	60+ Living in Rural Areas
Miami-Dade	462,236	17.8%	28.0%	8.2%	0.5%
Monroe	19,719	9.2%	19.3%	3.6%	10.0%
PSA-11	481,955	17.5%	28.0%	8.0%	1.0%

2. Service Catchment Area/Geographic Profile

Place a checkmark in each non-grayed box in the “Plan to Serve” column if your agency plans to serve the zip code with OAA Title III-B services under this RFP. Enter the number of clients your agency would serve with OAA Title III-B services under this RFP in non-grayed boxes in the “Projected Clients” column.

Checkmarks indicate “High Concentration of Low Income and Minority Elders,” and “High Concentration of Elders,” respectively, for Monroe and Miami-Dade Counties.

**Table 3. Catchment Area**

Service Area (Zip Code)	High Concentration of Low Income and Minority Elders	High Concentration of Elders	Under Served or Not Served at All	Plan to Serve	Projected Clients
<b>Monroe County</b>					
33036					
33037	J	J			
33040	J	J			
33042					
33043					
33050					
33070					
<b>Miami-Dade County</b>					
<b>The Beaches</b>					
33109					
33139	J	J			
33140					
33141					
33149					
33154					
33160	J		Target		

Service Area (Zip Code)	High Concentration of Low Income and Minority Elders	High Concentration of Elders	Under Served or Not Served at All	Plan to Serve	Projected Clients
<b>North Dade</b>					
33010	J	J	Target		
33012	J	J			
33013	J	J			
33014					
33015			High Target		
33016					
33018					
33054			High Target		
33055			High Target		
33056			High Target		
33138					
33147		J			
33150					
33161					
33162					
33167					
33168					
33169					
33178					
33179			Target		
33180					
33181					

Service Area (Zip Code) Central Dade	High Concentration of Low Income and Minority Elders	High Concentration of Elders	Under Served or Not Served at All	Plan to Serve	Projected Clients
33122					
33125	J	J			
33126	J	J			
33127		J			
33128					
33129					
33130		J			
33131					
33132					
33133					
33134	J				
33135	J	J			
33136					
33137					
33142	J	J			
33143					
33144		J			
33145	J	J			
33146					
33155	J				
33165	J	J			
33172					
33173					
33174		J			
33175	J				
33182					
33183					
33184					
33185					
33192					
33193					
33194					

Service Area (Zip Code)	High Concentration of Low Income and Minority Elders	High Concentration of Elders	Under Served or Not Served at All	Plan to Serve	Projected Clients
<b>South Dade</b>					
33030					
33031					
33032					
33033			Target		
33034			Target		
33035					
33039			Target		
33156					
33157	J				
33158					
33170					
33176					
33177					
33186					
33187					
33189					
33190					
33196					

### 3. Older Americans Act Service Delivery System:

Discuss each of the following—to guide your discussion, review the list of objectives listed in section III of this application and Chapter 4 sections 3 and 9 of the July 2009 DOEA Program and Services Handbook. The discussion on the topics detailed below in this section shall not exceed eight (8) double-spaced pages, which are to be attached.

- A. Service access, delivery and reporting process
  - 1. Explain how your program will target, identify and serve eligible OAA Consumers in the identified service areas.
  - 2. Describe the process followed to assess, prioritize access, coordinate and deliver OAA services to targeted Consumers (family caregivers and grandparents or older individuals, 55 years of age or older, who are relative caregivers of children not more than 8 years old or individuals with disabilities of any age).
  - 3. Detail how your agency's system will interface successfully with the system operated by the Aging Resource Center for resource listing, referral, wait list management and service reporting.
  - 4. Discuss:
    - a. Coordination with the Community Care for the Elderly (CCE) program,
    - b. Coordination with local community mental health agencies,
    - c. How you will cooperatively respond to requests for assistance for referrals from the Adult Protective System (APS), and
    - d. Coordination with other agencies to ensure there are no overlapping services.
- B. Ability to increase provider capacity by supplementing OAA funds under this RFP
  - 1. Detail other sources of funding or resources such as local government or philanthropic grants, in-kind contributions or volunteers that you will use to supplement/match the funding under this RFP.
  - 2. Describe plans to further develop your agency's financial capacity.
- C. New approaches/models of service delivery
  - 1. Discuss any novel approaches to service delivery that your agency plans to implement. If these are evidence-based provide citation.
- D. Staff Development
  - 1. Detail your plans for staff recruitment, development and training, to ensure you have a pool of staff qualified by experience, education and training with proper and sufficient program and fiscal accountability. Indicate the pre-service, orientation, and in-service training to be provided and how these activities are funded.
- E. Leadership and Advocacy
  - 1. Discuss your leadership and advocacy role for elder issues within the area that you intend to serve.

#### 4. Quality Assurance

Discussion of the following shall not exceed two (2) double spaced pages (not including requested copies of training plans), which are to be attached.

##### A. External Quality Assurance

1. Consumer Satisfaction --Describe process and methods followed to determine Consumer satisfaction, address consumer concerns and implement needed changes.
2. Describe the tools you will use to assess the level of consumer participation and satisfaction with services delivered.

##### B. Internal Quality Assurance

1. Internal methods--Describe internal methods to assure delivery of quality services by the applicant's staff. Attach a copy of the most recent pre-service and in-service training plans for your staff, subcontractors and volunteers.
2. Unusual Incidents--Describe your methods to respond, document and report unusual incidents.

5. Title III-E Service Grid

- A. Place a check in the box to the left of each National Family Caregiver service that you intend to offer under this RFP.

**Table 4. OAA Title III-E Services**

Service Offered	Service Offered
<b>Support Services</b>	
<input type="checkbox"/> Adult Day Care	<input type="checkbox"/> Respite
<input type="checkbox"/> Caregiver Training/ Support	<input type="checkbox"/> Respite in Facility
<input type="checkbox"/> Counseling	<input type="checkbox"/> Screening and Assessment
<b>Grandparent Support Services</b>	
<input type="checkbox"/> Caregiver Training/ Support	<input type="checkbox"/> Sitter
<b>Supplemental Services</b>	
<input type="checkbox"/> Chore	<input type="checkbox"/> Material Aid
<input type="checkbox"/> Housing Improvements	

- B. Assessed Need: Provide a detailed description, in narrative form, about the Consumers you intend to serve and their needs. Specific attention should be given to any unmet needs of the community or target area(s) you intend to serve. This additional information will help the review team understand the population that your organization serves or intends to serve, and how you make its services accessible to all Consumers in the catchment area. Justify the services requested in terms of your Consumer profile and the geographic catchment area. Explain the rationale for selecting the services to be offered.

Please use up to two double-spaced pages.

### **III.A. Outcome Measures and Standards**

The next pages list outcome measures and standards that the Alliance has identified for funding under this RFP. Using the format provided in the next pages, please describe in sufficient detail the implementation strategies, action steps and/or processes that your agency will follow to achieve or exceed the standards listed. Also, demonstrate, through direct experience or through a literature review, how the strategy would lead to the desired outcome. Provide an estimate of the standard that your agency expects to achieve.

**If your organization is proposing to provide ANY of the following services: adult day care, counseling, chore, escort, homemaker, or personal care, you must address all six outcome measure items, If it is not proposing to provide any of these services, only respond to Outcome Measure 1 and write “N/A” in the remaining five outcome measure items.**











<p><b>Outcome Measure 6:</b> Percent of caregivers whose ability to provide care is maintained or improved after one year of service intervention, as determined by the caregiver.</p> <p><b>Standard:</b> 90 percent (refers to caregivers whose ability to continue to provide care is maintained or improved in the own caregiver’s opinion as per DOEA 701B form.)</p>
<p><b>Strategy:</b> Describe your strategies for meeting this outcome measure with the services you are proposing. Demonstrate if you plan to exceed the standard.</p>
<p><b>Action Steps:</b> Describe the steps you plan to use to implement your strategy.</p>

### IV.A. Applicant’s Qualifications and Prior Experience

The applicant shall indicate their experience and performance record by selecting one item from the following list of categories. Include a copy of all monitoring reports for the past three years if you have not been an Alliance for Aging provider for at any time in the past 3 years. All applications will be verified.

If you have been an Alliance for Aging provider at any time in the past 3 years (as of August 31, 2009), you must select one of the Alliance for Aging Provider categories (current or former, as applicable).

<b>Current Alliance for Aging provider for at least 3 years</b>	
<b>Currently an Alliance For Aging provider for all services applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (70 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (60 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (20 points)	<input type="checkbox"/>
<b>Currently an Alliance For Aging provider for at least one service applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (65 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (55 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (15 points)	<input type="checkbox"/>
<b>Currently an Alliance For Aging provider, but not providing any services applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (60 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (50 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (10 points)	<input type="checkbox"/>

<b>Current Alliance for Aging provider for less than 3 years</b>	
<b>Currently an Alliance For Aging provider for all services applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (60 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (50 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (10 points)	<input type="checkbox"/>
<b>Currently an Alliance For Aging provider for at least one service applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (55 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (45 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (5 points)	<input type="checkbox"/>
<b>Currently an Alliance For Aging provider, but not providing any services applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (50 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (40 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>

<b>Former Alliance for Aging provider within the past 3 years</b>	
<b>Former provider for all services applied for under this Title</b>	
Was not under Corrective Action Plan in past 3 years (60 points)	<input type="checkbox"/>
All Corrective Action Plans were resolved (50 points)	<input type="checkbox"/>
Corrective Action Plan is unresolved (10 points)	<input type="checkbox"/>
<b>Former Alliance For Aging provider for at least one service applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (55 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (45 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (5 points)	<input type="checkbox"/>
<b>Former Alliance For Aging provider, but not providing any services applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (50 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (40 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>

<b>Current provider for at least 3 years- Not an Alliance for Aging provider during the last 3 years</b>	
<b>Currently provider to elders for all services applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (60 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (50 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (10 points)	<input type="checkbox"/>
<b>Currently provider to elders for at least one service applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (55 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (45 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (5 points)	<input type="checkbox"/>
<b>Currently provider for all services applied for under this Title, but not to elders</b>	
Not under Corrective Action Plan in past 3 years (50 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (40 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>
<b>Currently provider for at least one service applied for under this Title, but not to elders</b>	
Not under Corrective Action Plan in past 3 years (45 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (35 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>
<b>Currently a provider, but not providing any services applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (40 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (30 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>

<b>Current provider for more than 1 year but less than 3 years- Not an Alliance for Aging Provider during the last 3 years</b>	
<b>Currently a provider to elders for all services applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (40 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (30 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>
<b>Currently a provider to elders for at least one service applied for under this Title</b>	
Not under Corrective Action Plan in past 3 years (35 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (25 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>
<b>Currently a provider for all services applied for under this Title, but not to elders</b>	
Not under Corrective Action Plan in past 3 years (35 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (25 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>
<b>Currently a provider for at least one service applied for under this Title, but not to elders</b>	
Not under Corrective Action Plan in past 3 years (30 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (20 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>
<b>Currently not providing any services applied for under this Title as a provider</b>	
Not under Corrective Action Plan in past 3 years (25 points)	<input type="checkbox"/>
All Corrective Action Plans are resolved (15 points)	<input type="checkbox"/>
Currently under a Corrective Action Plan (0 points)	<input type="checkbox"/>

<b>Less than 12 months experience as a provider</b>	
<b>Currently a provider to elders for at least one service applied for under this Title</b>	
Not under Corrective Action Plan (15 points)	
All Corrective Action Plans are resolved (10 points)	
Currently under a Corrective Action Plan (0 points)	
<b>New Provider (5 points)</b>	

## **V.A. Organizational Capability Pull-Out Package**

The documents listed below are meant to be submitted in such a way that they may be pulled out of the RFP proposal packet and reviewed separately. Please provide the listed items in the order specified below:

1. A copy of the most recent, board approved, organizational chart illustrating the structure and relationship of all paid staff positions related to the program in question.
2. Copies of job descriptions for all staff involved in the management of this contract.
3. A copy of the most recent audited financial statements and compliance reporting package. Include any letters to management submitted by the independent auditor under separate cover as well as any response stating management's position and plan of action.
4. A full roster of all current members of your Board of Directors.
5. A copy of your corporate bylaws.
6. A certificate of insurance from your agent detailing the types of coverage you currently hold, the maximum dollar amount for each, and the dates when coverage became effective and is scheduled to terminate. Applicant is required to demonstrate adequate liability and worker's compensation insurance coverage.
7. A copy of your continuing operations plan (COOP)
8. Commitment to CIRT reporting
9. Commitment to ARC reporting
10. Agreement to comply with handbook requirements

**B. CONTRACT MODULE FORMAT****I.B. Unit Cost Grid**

Complete the rows for each service that you are applying for.

For the “Proposed OAA Funded” column (B), include the total funds requested by OAA Title III-E by service. (Do NOT include match.)

For the “Anticipated All Other Sources” column (C), include all match funding for OAA as well as any other funding for these services, for example, CCE, Medicaid, United Way, etc.

Enter the number of units you are applying for in the “Proposed OAA Units” column (D).

Enter the adjusted unit rate in the “Proposed OAA Adjusted Unit Rate” column (E). See Paragraph C. 1. f. for details.

The value in column (E) should not be higher than the amount in the “Maximum Allowed Adjusted Rate” column (F).

The value in the column (B) should equal the number in column (D) times the rate in column (E).

Make sure that each service with a value in the “Proposed OAA Funded” column is checked in Table 4.

Due to the heterogeneity of their units of service, services with an asterisk in column (F) do not have a maximum unit rate. Screening and assessment is required from all selected providers.

**SCREENING AND ASSESSMENT:** The allocation of funds for this service is determined using a formula described in the RFP solicitation--Section A.3.d.iv. Enter a proposed adjusted rate not to exceed \$25, but do not enter units or funding requested.

(A) Service Offered	(B) Proposed OAA Funded (Total \$)	(C) Anticipated All Other Sources (Total \$)	(D) Proposed Adjusted OAA Units	(E) Proposed OAA Unit Adjusted Rate	(F) Maximum Allowed Rate
<b>Support Services:</b>					
Adult Day Care					\$8.00
Caregiver Training/ Support					\$8.00
Counseling					\$60.00
Respite					\$18.00
Respite in Facility					\$11.00
Screening & Assessment					\$25.00
<b>Grandparent Support Services:</b>					
Caregiver Training/ Support					\$8.00
Sitter					\$11.00
<b>Supplemental Services:</b>					
Chore					\$18.00
Housing Improvements					*
Material Aid					*

**II.B**

Use form included in Appendix VI (Acceptance of Contract Terms and Conditions)

**III.B**

Use form included in Appendix VII (Statement of No Involvement)

### IV.B. Match Commitment of Cash Donation

Agency Name: \_\_\_\_\_

Donor Identification:

Name:  
Street:  
City:  
State:  
Zip:  
Phone:

Authorized Representative: \_\_\_\_\_

Total Amount: \$

# Payments

Amount/Payment: \$

Contribution Period:

\_\_\_\_\_

Special Conditions:

\_\_\_\_\_

Donor Certification:

I hereby certify intent to make the cash donation set forth above for use in the specified program during the program's upcoming funding period. This cash is not included as match for any other State or Federally assisted program or contract and is not borne by the federal government directly under any federal grant or contract.

\_\_\_\_\_  
Signature of Donor or Representative

\_\_\_\_\_  
Date

### V.B. Match Commitment for Donation of Building Space

Agency Name: \_\_\_\_\_

Donor Identification:

- Name:
- Street:
- City:
- State:
- Zip:
- Phone:

Authorized Representative:

\_\_\_\_\_

Description of Space:  Office       Site  Other

\_\_\_\_\_

Provider Owned Space:

- 1. Number of square footage used by project:      sq/ft
- 2. Appraised rental value per square foot:      \$
- 3. Total value of space used by project (1x2):      \$

\_\_\_\_\_

Donor Owned Space:

- 1. Established monthly rental value:      \$
- 2. Number of months rent to be paid by donor:
- 3. Value of donated space (1x2):      \$

\_\_\_\_\_

Special Conditions:

\_\_\_\_\_

Donor Certification:

I hereby certify intent to donate use of the space set forth above for the program specified above during the program's upcoming funding period. This space is not being used as match for any other State or Federal program or contract.

\_\_\_\_\_  
Signature of Donor or Representative

\_\_\_\_\_  
Date

AUGUST 2009

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**VI. B. Match Commitment of Supplies**

Agency Name: \_\_\_\_\_

Donor Identification:

- Name:
- Street:
- City:
- State:
- Zip:
- Phone:

Authorized Representative:

\_\_\_\_\_

The below described supplies are committed for use by the project for the period of:

\_\_\_\_\_

Description of Supplies:

\_\_\_\_\_

Computation of value method:

Value to be claimed by project:        \$

\_\_\_\_\_

Donor Certification:

These supplies are not included as contributions for any other State or Federally assisted program or contract and are not borne by the Federal Government directly or indirectly under any Federal grant or contract except as provided for under (cite the authorizing Federal regulation or law if applicable.)

\_\_\_\_\_  
Signature of Donor or Representative

\_\_\_\_\_  
Date

## VII. B. Match Commitment of Equipment

Agency Name: \_\_\_\_\_

Donor Identification:

Name:

Street:

City:

State:

Zip:

Phone:

Authorized Representative:

\_\_\_\_\_

The equipment described below is committed for use by the project for the period of:

ITEM DESCRIPTION	NUMBER COST	ACQUISITION VALUE	VALUE TO PROJECT*
1.			
2.			
3			
4			
5			
TOTAL VALUE CLAIMED:			\$

\*Items that are currently owned by the Grantee or are loaned or donated to the project are valued at an annual rate of 6 $\frac{2}{3}$ % of the acquisition value.

Donor Certification:

This equipment is not included as match for any other State or Federally assisted program or contract and is not borne by the Federal Government directly or indirectly under any Federal grant or contract except as provided for under (cite the authorizing Federal regulation or law if applicable.)

\_\_\_\_\_  
Signature of Donor or Representative

\_\_\_\_\_  
Date

### **VIII. B. Match Commitment of In-Kind Contribution of Services by Staff of Service Provider or Staff of Other Organizations**

Agency Name: \_\_\_\_\_

Donor Identification:

Name:

Street:

City:

State:

Zip:

Phone:

Authorized Representative: \_\_\_\_\_

The personal services described below are committed for use by the project for the period of:

Description of Positions:

POSITION TITLE	SERVICE	HOURLY RATE OR ANNUAL SALARY	HOURS WORKED	VALUE TO PROJECT*
1.				
2.				
3.				
4.				
5.				
			TOTAL	\$

\*Value to project = (hours worked) x (hourly rate of annual salary).

Donor Certification: It is certified that the time devoted to the project will be performed during normal working hours.

These services are not included as match for any other State or Federally assisted program or contract and are not borne by the Federal Government directly or indirectly under any Federal grant or contract except as provided for under (cite the authorizing Federal regulation or law if applicable.)

\_\_\_\_\_  
Signature of Donor or Representative

\_\_\_\_\_  
Date

**IX. B. Match Commitment of In-Kind Volunteer Personnel and Travel**

Agency Name: \_\_\_\_\_

Donor Identification: The volunteer staff positions identified below will be filled by local volunteers who will be recruited, trained and supervised as an ongoing activity of our agency. We will maintain volunteer records to document individual volunteer activity.

Describe Volunteer Effort: \_\_\_\_\_

POSITION TITLE	EQUIVALENT HOURLY RATE(S)	HOURS WORKED	VALUE TO PROJECT
1.			
2.			
3.			
4.			
5.			
TOTAL VALUE TO AGENCY			\$

Equivalent Hourly Rate(s) was/were determined by:

- Rates for comparable positions within own agency.  
 State Employment Service estimate of rates for type of work.  
 Rates for comparable positions within other local agencies.

Estimated Mileage x Rate per mile = Value \_\_\_\_\_

Donor Certification:

I certify that commitments have been received from individual volunteers or groups sufficient to provide the volunteer hours and travel as identified above.

\_\_\_\_\_  
Signature of Agency Official\_\_\_\_\_  
Date