Application for Proposal

for the selection of Providers to provide

Transportation Services

for the period

July 1, 2021 through June 30, 2025

Area Agency on Aging *Serving North Central Idaho*

a division of
Community Action Partnership
124 New 6th Street
Lewiston, Idaho 83501
208-798-4201

Completed applications must be physically in the possession of the Area Agency on Aging by 3:00 p.m., June 4, 2021.

Instructions for Application:

- All organizations bidding for service please complete the entire application package in its entirety.
- Be clear and concise in your describing and answering the questions.
- Describe your organization as you would to someone that is unfamiliar with your agency and its operations. *Individuals reviewing these applications may NOT be familiar with your agency.
- Type in the grey boxes below each question. They will expand as you type.
- To checkmark boxes, double click on the box, under default value choose the box that says checked.
- Absolutely no handwritten explanations.

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Applicant Information

Legal Name of Provider: _____
Business Name: (if different from above): _____

Contact Person: _____ Title: _____

Physical Address: _____
Mailing Address (if different): _____
City: _____ County: _____
State: _____ Zip: _____

Telephone number: _____ Fax: _____ Email of business: _____

1. IRS Employer ID #: _____
2. Legal status of Provider: ☐ Private Non-Profit ☐ Public Non-Profit ☐ For-Profit ☐ Other, describe: _____

- If you are a **Non-Profit Provider** –
  - A. Attach copies of the Provider's:
    - a. Article of Incorporation, (**Label Attachment #1**)
    - b. Bylaws, (**Label Attachment #2**)
    - c. 501(c)(3) status. (**Label Attachment #3**)
  - B. If Provider's receive over $300,000 of Federal funding in past year?
    - ☐ No
    - ☐ Yes – please attach the most recent audit. (**Label Attachment #4**)
- If you are a **For-Profit Provider** –
  - A. What type of For-Profit Provider is your organization?
    - ☐ Incorporated ☐ Sole Proprietorship ☐ LLC ☐ Partnership
    - ☐ Other: _____

3. Business Types: (Check all that apply **and attach documentation**): (**Label Attachment #5**)
   - ☐ Small business Owned
   - ☐ Woman-Owned, 51% or more owned by 1 or more women
   - ☐ Veteran-Owned, 51% or more owned by a Veteran
   - ☐ Disabled Veteran-Owned, 51% or more owned by a Disabled Veteran
   - ☐ Javits-Wagner-O'Day (JWOD)
   - ☐ Historically Black College & University Minority Institution
   - ☐ Hubzone Small Business Concern, Historically Underutilized Business Zones as Certified with SBA
   - ☐ Disadvantaged, 51% or more owned by one or more socially or economically disadvantaged Individuals, including Black Americans, Hispanic Americans, Native Americans, Asian-Pacific Americans

4. Provide **ONE** of the following documents to this application which demonstrates the Provider's financial soundness: (**Label Attachment #6**)
   - ☐ Audit Report, within the past 12 months
   - ☐ Better Business Bureau report
   - ☐ Credit Report
   - ☐ Income Tax Statements

5. What governing body will be responsible for the oversight of the program? Complete chart below:

Position Title	Paid/Volunteer	Major Responsibilities

6. Provider submits the application to provide in the following location(s):

Transportation	Service Area
	Clearwater Co.
	Elk River
	Orofino
	Peirce
	Weippe

Transportation	Service Area
	Idaho Co.
	Cottonwood
	Elk City
	Ferdinand
	Grangeville
	Riggins
	Stites
	White Bird

Transportation	Service Area
	Latah Co.
	Bovill
	Deary
	Genesee
	Juliaetta
	Moscow
	Potlatch
	Princeton
	Troy

Transportation	Service Area
	Lewis Co.
	Nezperce
	Craigmont
	Kamiah

Transportation	Service Area
	Nez Perce Co.
	Cavendish
	Culdesac
	Lapwai
	Spalding

If Provider chooses a specific city or locale, will transportation service have service boundaries?
☐ Yes ☐ No

Explain Boundaries: _____

7. Attach job descriptions, by title, for **all** personnel, paid and volunteer, including administrative personnel who will support the Transportation program. (**Label Attachment #7**)

8. Attach a current list of member's names, addresses, telephone numbers, office positions, year elected, and terms of office. (**Label Attachment #8**)

9. What is the mission of the Provider?

   _____

10. Summarize the history of your organization, describing the programs and clients you serve

    _____

11. Attach copies of the Provider's current insurance policies: (**Label Attachment #9**)

12. Does the Provider ☐ Own **or** ☐ Lease any facilities needed to deliver the proposed service? (**Label Attachment #10 – Leased Facilities only**)

Assurances.

13. The Provider will ensure access to the Transportation Services will be equally available to all eligible seniors (individuals aged over 60 years).
    ☐ Yes ☐ No

14. The Provider has read, understands in full, and will follow the AAA's Transportation Scope of Work – as outlined in the Guide to Request for Proposals.
    ☐ Yes ☐ No

15. The Provider owns or leases the vehicles to be used in the Transportation service **OR** participates in an established vehicle sharing program.
    ☐ Yes ☐ No

16. The Provider will ensure the geographically difficult areas of the locale are served.
    ☐ Yes ☐ No

17. The Provider will accommodate for cultural differences and take them into account when delivering services.
    ☐ Yes ☐ No

18. The Provider will make accommodations to work with persons who have various types of disabilities, including but not limited to, vision and hearing impairments.
    ☐ Yes ☐ No

19. The Provider will make accommodations to work with persons who speak a language other than English.
    ☐ Yes ☐ No

20. The Provider is an equal opportunity employer and has an affirmative action policy, if applicable.
    ☐ Yes ☐ No

21. The Provider will electronically report accurate fiscal and program data, on time, as required in the General Terms and Conditions of the AAA Contract, or as requested.

☐ Yes ☐ No

Required Activities and Application Narrative

22. The Provider will provide Outreach to locate persons in the community who are not participating in available senior programs or receiving senior services for which they qualify. Provider will identify their service needs; provide information about aging program and services available; and assist them in accessing services they need or want to participate in.
    Describe in detail how you plan to provide outreach.

23. Describe in detail any plans for expansion of this service.
    _____

24. Describe in detail how maintaining confidentiality of client information will be handled.
    _____

25. Describe in detail the plan to maintain confidentiality of client donations.
    _____

26. Describe in detail the Emergency Procedures in the event transportation services are not operational.
    _____

27. Describe in detail how client satisfaction of services will be assessed and completed on an annual basis.
    _____

28. Describe in detail the procedures for handling injuries to clients, staff, and volunteers.
    _____

29. Describe in detail the procedures for handling, reporting, and documenting client complaints.
    _____

30. Describe in detail the Transportation service(s) that the Provider has provided to individuals aged 60 years and older (seniors) and others within the last 12 months. If none, describe the Transportation service for seniors the Provider is planning to undertake. Include funding sources in addition to the funding structure.
    _____

31. Describe in detail what strengths uniquely qualify the Provider to provide Transportation Services for seniors?
    ______

32. Describe in detail the minimum qualifications of your drivers, including volunteer drivers.
    _____

33. Describe in detail the Provider's system to **prioritize** transportation destinations? (Approved types of service include: social services, health care services, meal programs, senior centers, shopping)

    _____

34. Describe in detail the **process** for a participant to receive Transportation services? (e.g. 24 hour notice, reservations, day of service, etc)

    _____

35. Describe in detail how the Provider will track Transportation participants (ensuring that the AAA is billed only for seniors) and the types of Transportation services provided to participants for purposes of reporting to the AAA. (**Label Attachment #10 – if form is used**)

    _____

Partnership, Collaboration and Fund leveraging.

36. Describe in detail how the Provider has sufficient financial and in-kind resources to fulfill the AAA's 15% minimum match requirement and to preclude total dependency on AAA funds.

    _____

37. Describe the Provider's networking and coordinating strategies for the following:
    a. Home Health Agencies

       _____
    b. Hospital and Physicians

       _____
    c. Local Government

       _____
    d. Long Term Care Facilities

       _____
    e. Senior Housing Complexes

       _____
    f. Other Senior Service Providers

       _____
    g. Businesses

       _____
    h. Other

       _____

38. Describe any partnerships the Provider has or anticipates ensuring that services are delivered. Include partnering organizations' names, funding sources, partners' cash contributions, in-kind, etc.

    _____

Cost Effectiveness

39. Describe in detail the various activities and methods the Provider employs that are designed to increase community involvement, participation, and donations for Transportation services.

_____

40. Describe in detail the Provider's utilization of volunteers. (Explain how are they recruited, trained, evaluated, supervised; are they reimbursed for any of their volunteer expenses)

_____

41. How will the Provider assure services are provided throughout the contract within the confines of funding? (i.e. Provider budgeted for 10,000 units January through December, served 15,000 units by October, how will this affect the program).

_____

Budget

Provide a prospective budget to establish Provider's cost per unit (unit being a meal) rate of service and reflect what funding will be used to cover any per unit costs exceeding the AAA's per-meal reimbursement rate.

The AAA's SFY 2021 per-unit standard reimbursement rate is $7.00 per Transportation Boarding and its minimum match requirement is 15%.

Provider's Budget is as follows:

REVENUE	Amount	Comments
AAA Funds (**not to exceed $7.00 per Transportation boarding**)		
County Funds		
City Funds		
Other Federal/State Funds		
Client donations		
Fundraisers		
Other: (Describe)		
Total Revenue		

EXPENSES	Amount	Comments
Admin Staff Wages w/ fringe		
Program Staff Wages w/ fringe		
Travel Costs		
Training Costs		
Space		
Utilities		
Supplies		
Marketing		
Printing/Postage		
Insurance		
Food Costs		
Other: (Describe)		
Total Expenses		

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<u>Transportation Units</u> (1 unit = 1 boarding **<u>onto</u>** the bus)

Maximum number of units to be served (at AAA's per unit price)	
Per unit price	$7.00
Total AAA Funding Application	**$**

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Application Submission Letter

In submitting this application, Provider certifies and acknowledges that:

1. The RFP and all attached documents have been read and understood and that all information provided is true, complete, and accurate to the best of Provider's knowledge. Should an investigation at any time disclose any misrepresentation or falsification information provided by Provider to the Area Agency on Aging Serving North Central (AAA) hereunder, this application may be rejected and contracts entered may be terminated.

2. Enclosed, at a minimum, is **all** information requested in this RFP.

3. **One original and attachments** are being submitted in a sealed envelope as instructed within this RFP.

4. Any RFP amendments received regarding the Provider's original RFP are signed and submitted with this application.

5. Provider agrees to provide services to eligible individuals regardless of the source of funding.

6. Provider certifies that the assurances contained in this application have been met by the Provider.

7. Provider certifies that the submission of this application did not involve collusion or other anti-competitive practices.

8. Provider certifies as to Non-Debarment.

9. Provider agrees to comply with all applicable Idaho Commission on Aging and Area Agency on Aging Serving North Central Idaho service specifications, contract terms, manuals, policies and directives, and all applicable federal, state and local laws.

10. Provider agrees to provide services to eligible individuals regardless of the source of funding.

11. Provider certifies, upon award of contract, to maintain liability insurance as specified in the General Terms and Conditions of the AAA's Contract.

12. The person signing on behalf of the Provider is legally authorized to submit this application and to make this certification.

____ ____________________

Signature of Provider Official **Date**

____

Title of Provider Official

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Debarment Certification

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, 29 CFR Part 98, Section 98-5 1 0, Participant's Responsibilities. The regulations were published as Part VII of the May 28, 1988 Federal Register (pages 19160-19211).

Before Completing Certification, Read Instructions for Certification:

1. The recipient of federal assistance funds certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

2. Where the recipient of federal assistance funds in unable to certify to any of the statements in this certification, such participant shall attach an explanation to this proposal.

3. By signing below, I acknowledge that I have read and comply with the Instructions of Debarment.

Agency Name: ______________________________

Address: ______________________________

City: ____________________ **State:** __________ **Zip:** _____

Signature: ______________________________

Print Name: ______________________________

Title of Authorized Representative: ______________________________

Application Submittal Checklist

Before printing and submitting this application, please review all answers for accuracy and completeness.

Make sure all attachments are labeled correctly, an example: Attachment #1

- ☐ Print completed application – Include labeled attachments in correct order as follows:
  - ☐ Attachment 1 – Articles of Incorporation - (not applicable if provider is a for profit agency)
  - ☐ Attachment 2 – Bylaws – (not applicable if provider is a for profit agency)
  - ☐ Attachment 3 – 501(c)(3) status – (not applicable if provider is a for profit agency)
  - ☐ Attachment 4 – Audit – (if applicable)
  - ☐ Attachment 5 – Proof of Business Type – (if applicable)
  - ☐ Attachment 6 – Financial Soundness
  - ☐ Attachment 7 – All job descriptions
  - ☐ Attachment 8 – Governing Body – Membership Information List
  - ☐ Attachment 9 – All Insurance Coverages
  - ☐ Attachment 10 – Lease Documentation – (if applicable)