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Nursing Home Diversion Modernization Grants

Including

A Special Funding Opportunity to Serve Veterans

Program Announcement and Grant Application Instructions

U.S. Administration on Aging
2008

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OVERVIEW INFORMATION

Department of Health and Human Services (HHS)

Administration on Aging (AoA) http://www.aoa.gov

AoA Office for Planning and Policy Development

Funding Opportunity Title: Nursing Home Diversion Modernization Cooperative Agreement

Announcement Type: Initial

Funding Opportunity Number: HHS-2008-AoA-CD-0814

Catalog of Federal Domestic Assistance (CFDA) Number: 93.048

Key Dates: The deadline for submission of applications is August 14, 2008. The deadline for submission of letter of intent is July 18, 2008. An open information teleconference for applicants of this solicitation will be held July 10, 2008 at 2:00 p.m., EST. The toll-free teleconference phone number will be 888-396-9185, pass code: 2043392.

Overview: This Program Announcement provides an opportunity for the Aging Services Network to modernize its approach to helping individuals who are at imminent risk of nursing home placement but not eligible for Medicaid to avoid nursing home placement and spend-down to Medicaid, consistent with the long-term care provisions that were included in the 2006 Amendments to the Older Americans Act. The Announcement also includes a special funding opportunity—being made available by the Veterans Health Administration—for the Aging Services network to provide home and community-based services to veterans and their family caregivers.

Under this Announcement, applications will be accepted from State Units on Aging (SUA). A successful applicant will propose to implement projects in partnership with Area Agencies on Aging (AAA), aging services provider organizations, Single-Entry-Point programs, and other long-term care stakeholders including the Single State Medicaid Agency.

The total amount of AoA funds available for this new funding opportunity is expected to be up to $10,000,000. AoA plans to fund up to 10 to 15 states for a period of 18 months. The average grant amount is anticipated to be approximately $800,000 with a range of awards between $600,000 to $1,000,000 each. Because the nature and scope of the proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. Projects will be funded for an 18-month Project Period. Successful applicants will propose a project that will be implemented in one or more Planning and Service Areas (PSA). States with a single Planning and Service Area (PSA) may propose a project that will be implemented in one or more counties or regions of the state.

Grants under this Announcement are to be used to advance **long-term care program changes** at the state and community level that will:

- Enable the Aging Services Network to make better use of single-entry-point programs to efficiently and effectively identify individuals who are not Medicaid eligible but are at imminent risk of nursing home placement and spend-down;

- Strengthen the Aging Services Network's capacity to rapidly authorize and provide services and supports to help high-risk individuals avoid nursing home placement and spend-down to Medicaid;

- Enhance the Aging Services Network's capacity to use service delivery models that provide a full range of options and allow the Network to tailor services to the unique and changing needs of high-risk individuals;

- Expand the Aging Services Network's capacity to use consumer-directed models so the Network can give more people the option to control the types of services they receive and the manner in which those services are provided; and,

- Strengthen the Aging Services Network's capacity to track client outcomes and document how the Network can help the high-risk individuals targeted under this Announcement to avoid nursing home placement and spend-down and also reduce the rate of growth in Medicaid long-term care expenditures.

Projects to be funded under this Announcement must:

1.) No later than the end of the 9th month of the project period, have at least one local project up and running and delivering services to the high-risk individuals targeted under this Announcement in a way that:

A. Uses a Single-entry-point (SEP) program to identify individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down to Medicaid,

B. Uses formal protocols and other tools across, and by, key stakeholder organizations (e.g., SEP, aging services providers, AAAs, hospitals, nursing homes, Centers for Independent Living, Veterans Health Administration, etc.) for making client referrals, prioritizing clients, authorizing services, and following-up with clients to ensure that the local project can rapidly provide home and community-based services and supports to the high –risk individuals who are identified by the Single-entry-point program, and that the services for these individuals can be quickly adjusted as necessary as their needs change.

C. Has in place formal SUA and AAA policies which are in effect-at least in the PSA(s) where the local project(s) are operating—that support the investment of some OAA dollars to serve the high-risk individuals who are targeted under this Announcement.

2.) No later than the end of the 15th month of the project period, in addition to the items in #1, be providing a full range of service options to the individuals who are targeted under this Announcement, as well as giving them the option to use consumer-directed models.

Two examples of tools and protocols that a SUA and/or AAA might want to promote in their policies include:

> Contracting – States or Area Agencies that have fixed contracts (e.g. $25,000 to a specific homemaker agency) may consider implementing fee for service contracting or other variations. Based on an established unit rate, the total amount of funds and service hours can then become more consumer driven. When money follows the consumer, a choice of service providers can be made and a greater focus on quality service provision can result.

> Prioritization – The specific aim of the Nursing Home Diversion Modernization Grants is to identify and serve individuals at imminent risk of going into a nursing home and spending down to Medicaid. States and Area Agencies that have served consumers on a "first come, first served" basis may consider implementing assessment and screening tools, as well as care planning and case management processes, that have been proven to identify and serve those individuals in priority order.

Projects funded under this Announcement must be able to monitor and follow-up with the individuals they are serving under this grant to ensure that the necessary services are being provided, that client needs are being met, and that adjustments in the services are being made as necessary.

Projects must also be able to report on client-level data and be able to document the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down, and any associated cost avoidance for the Medicaid program. AoA, along with the Nursing Home Diversion Technical Assistance Center, will work with successful applicants to identify the specific data that will need to be collected.

States may use one or more of the following sources to support the delivery of home and community-based services to the individuals targeted under this Announcement: grant funds made available under this Announcement; the Older Americans Act; Alzheimer's Disease Demonstration Grants to States (ADDGS); and any other public program or source that can be used to serve individuals who are not eligible for Medicaid.

The specific requirements and fundable activities for this opportunity are outlined in Section I.5.

Applications will be scored in part based on the degree of progress a state proposes to make toward achieving the types of long-term care program changes called for in this Announcement (see Page 1), in comparison to the status quo statewide and within the geographic areas covered by the grant project.

The provisions of this section address service funding that is consistent with the provisions of the Older American's Act and the Public Health Services Act (P.L. 78-410; 42 U.S.C. 280c-3), including provisions for targeting services to individuals at greatest social and economic need.

Technical resources to assist applicants for this funding opportunity are available on the [Nursing Home Diversion Modernization Grant Announcement Resource Page](http://www.aoa.gov/doingbus/fundopp/announcements/2007/NHDP_Resource_Page.doc) (http://www.aoa.gov/doingbus/fundopp/announcements/2007/NHDP_Resource_Page.doc).

Special Funding Opportunity to Serve Veterans

As part of this Program Announcement, The Veterans Health Administration plans to invest approximately $3,000,000 in up to 12 Veterans Integrated Service Networks (VISNs) to successful AoA NHDM grantees that submit a complete application for the Veterans Directed Home and Community Based Service Program (VDHCBS) along with their AoA NHDM grant application. States seeking to apply for this option should see Attachment I for information about the program and application instructions.

SECTION I. FUNDING OPPORTUNITY DESCRIPTION

1. Statutory Authority

The statutory authority for grants under this program announcement is contained in Title IV of the Older Americans Act (OAA) (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365 (Catalog of Federal Domestic Assistance 93.048, Title IV Discretionary Projects).

2. Purpose

The Administration on Aging (AoA) is providing this competitive grants opportunity to assist State Units on Aging (SUA), in partnership with Area Agencies on Aging (AAAs), community-based aging service providers, and other key long-term care stakeholders including the Single State Medicaid Agency, to make system changes at the state and community level that will strengthen the Aging Services Network's role in helping at-risk individuals who are not Medicaid eligible to avoid unnecessary nursing home placement and spend-down, consistent with the long-term care provisions that were included in the 2006 Amendments to the Older Americans Act.

Because Nursing Home Diversion projects include activities and services currently provided under the Older Americans Act (e.g. Title IIIb), the ADDGS program, as well as other public programs delivered to individuals who are not eligible for Medicaid, AoA expects that over the course of the 18-month project period, funding for the home and community-based services provided by the diversion projects under this Announcement will come from a variety of sources, including: the grant funds made available under this Announcement, The Older Americans Act, the Alzheimer's Disease Demonstration Grants to States (ADDGS) program, other public programs, and other sources that can be used to cover the cost of services for individuals who are not eligible for Medicaid. If the ADDGS funds will be used, successful applicants should consult with AoA to assure that funds will be used for their statutory purpose. The Nursing Home Diversion Modernization NHDM grant seeks system change to prioritize home and community based services funded under these programs to ensure that their activities/projects successfully target the at risk population.

In 2007, AoA published the NHDM grant opportunity for the first time. From that solicitation, twelve (12) states were awarded approximately $500,000 each to develop nursing home diversion programs that target those at greatest risk of institutionalization and spend-down to Medicaid through Single-Entry-Point systems. Grantees were required, using existing non-Medicaid funding, to provide targeted individuals with flexible services to assist them in remaining at home and in the community. AoA saw the initial NHDM grant as an opportunity to learn about how State and Area Agencies on Aging, with their community partners, could most effectively approach nursing home diversion activities that met AoA standards. This 2008 NHDM Program Announcement draws from the experiences and lessons learned by the 2007 grantees.

These competitive grants offer community-based aging services provider organizations the opportunity to partner with their Area Agencies on Aging and Single-entry-point programs to modernize the way they deliver home and community-based services. There also has been considerable progress over the past decades in developing models to deliver flexible services and per capita budgeting techniques that allow programs to manage their resources in a way that enables them to better respond to the unique and changing needs of individual consumers while simultaneously tracking service dollars to statutory funding streams. The project will also allow aging services providers to participate in consumer-directed programs that give clients greater control over the types of services they receive and the manner in which those services are provided. As a result of their involvement in this project, aging services provider organizations should be better positioned in the changing long-term care environment, and have a better capacity to serve the growing number of individuals who will be at risk of nursing home placement.

3. Background on the Policy Context for this Program Announcement

The Older Americans Act has always authorized the Aging Services Network at all levels to promote the development of comprehensive and coordinated systems of services and supports that enable seniors to remain in their own homes and communities for as long as possible. Consistent with the flexibility provided under the Act, the Network has carried out this statutory responsibility in a variety of ways, using different strategies and approaches that reflect varying state and local conditions, policies and practices. Additionally, the state-of-the-art in helping seniors to remain at home has evolved over time, with the development of new approaches and techniques for identifying and serving people who are at risk of nursing home placement, including the use of nursing home preadmission screening programs. Most nursing home diversion strategies and programs have focused on Medicaid-eligible individuals, but at least eight states have supplemented their OAA programs with state revenue funds to establish nursing home diversion programs specifically targeted at helping individuals who are not Medicaid eligible.

The new long-term care provisions that were incorporated into the Older Americans Act in 2006 create an opportunity for the Aging Services Network to modernize its approach to providing services to at-risk individuals and to strengthen its overall role in long-term care.

The new OAA provisions complement the changes occurring in Medicaid, in particular the "Money Follows the Person Initiative" by strengthening the Network's capacity to help states reach people before they enter a nursing home and spend-down to Medicaid. The 2006 Amendments authorize all levels of the Network to actively promote and participate in the development of consumer-centered systems of long-term care. The Amendments also emphasize the Network's use of a three-pronged strategy for advancing needed changes in our long-term care programs at the Federal, state and local level that will make them more responsive to the needs and preferences of consumers. These three strategies include:

- Empowering individuals to make informed decisions about their care options through Aging and Disability Resource Centers (ADRCs);

- Enabling older people to live healthier lives through the use of Evidence-Based Disease and Disability Prevention Programs; and,

- Helping seniors who are not Medicaid eligible to avoid unnecessary nursing home placement and spend-down through targeted home and community based services and supports and the use of flexible, consumer-directed models of care.

AoA, in collaboration with a variety of Federal partners and several private foundations, has been rolling out projects since 2003 to support the first two components of the strategy (i.e., ADRCs and Evidence-Based Prevention Programs). This grant opportunity, like the 2007 Nursing Home Diversion grant opportunity, is designed to support the implementation of the third component of the long-term care strategy that is now embedded in the OAA.

4. Relevant Sections of the Older Americans Act

As a result of the 2006 Amendments, Title II Section 202b of the Older Americans Act authorizes the Assistant Secretary for Aging to "promote the development and implementation of comprehensive, coordinated systems at the Federal, state, and local levels that enable older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals."

Title II Section 202 b(4) goes on to authorize the Assistant Secretary to: "facilitate, in coordination with the Administrator of the Centers for Medicare and Medicaid Services, and other heads of Federal entities as appropriate, the provision of long-term care in home and community-based settings, including the provision of such care through self-directed models that:
(A) provide for the assessment of the needs and preferences of an individual at risk for institutional placement to help such individual avoid unnecessary institutional placement and depletion of income and assets to qualify for benefits under the Medicaid program under title XIX of the Social Security Act (42 U.S.C et seq.);
(B) respond to the needs and preference of such individual and provide the option-
(i) for the individual to direct and control the receipt of support services provided; or
(ii) as appropriate, for a person who was appointed by an individual, or is legally acting on the individual's behalf, in order to represent or advise the individual in financial or service

coordination matters (referred to in this paragraph as a 'representative' of the individual), to direct and control the receipt of those services; and
(C) assist an older individual (or, as appropriate, a representative of the individual) to develop a plan for long-term support, including selecting, budgeting for, and purchasing home and community-based long-term care and supportive services."

To complement this new authority, the 2006 Amendments also included a new definition in Title I Section 102(a)(46) to support the use of consumer-directed models:

"The term **'self-directed care'** means an approach to providing services (including programs, benefits, supports, and technology) under this Act intended to assist an individual with activities of daily living, in which:
(A) such services (including the amount, duration, scope, provider, and location of such services) are planned, budgeted, and purchased under the direction and control of such individual;
(B) such individual is provided with such information and assistance as are necessary and appropriate to enable such individual to make informed decisions about the individual's care options;
(C) the needs, capabilities, and preferences of such individual with respect to such services, and such individual's ability to direct and control the individual's receipt of such services, are assessed by the area agency on aging (or other agency designated by the area a agency on aging) involved;
(D) based on the assessment made under subparagraph (C), the area agency on aging (or other agency designated by the area agency on aging) develops together with such individual and the individual's family caregiver (as defined in paragraph (18)(B)), or legal representative:
(i) a plan of services for such individual that specifies which services such individual will be responsible for directing;
(ii) a determination of the role of family members (and others whose participation is sought by such individual) in providing services under such plan; and
(iii) a budget for such services; and
(E) the area agency on aging or State agency provides for oversight of such individual's self-directed receipt of services, including steps to ensure the quality of services provided and the appropriate use of funds under this Act."

5. Description of FY 2008 Funding Opportunity

Under this Announcement, AoA will award Cooperative Agreements to assist State Units on Aging (SUA). SUAs will work in partnership with one or more Area Agencies on Aging (AAA), aging service provider organizations, and other long-term care stakeholders including the Single State Medicaid Agency, to strengthen the capacity of the Aging Services Network to help individuals who are not eligible for Medicaid but at imminent risk of nursing home placement and spend-down to remain at home and in the community.

Projects will be funded for an 18-month Project Period. A State Unit on Aging may propose a project within one or more Planning and Service Areas (PSA). States with a single Planning and Service Area (PSA) may propose a project targeted to one or more counties or regions of the state. Other than States where there is a single PSA, the SUA is encouraged to look to the Area Agency on Aging to lead the local implementation of any project within its PSA that is supported under this Announcement.

No later than the end of the 9th month after receiving the grant award, projects funded under this Announcement must have at least one local project up and running and delivering services to the high-risk individuals targeted under this Announcement in a way that:

A. Uses a Single-entry-point (SEP) program to identify individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down to Medicaid,

B. Uses formal protocols and other tools across, and by, key stakeholder organizations (e.g., SEP, aging services providers, AAAs, hospitals, nursing homes, Centers for Independent Living, VHA, etc.) for making client referrals, prioritizing clients, authorizing services, and following-up with clients to ensure that the local project can rapidly provide home and community-based services and supports to the high –risk individuals who are identified by the Single-entry-point program, and that the services for these individuals can be quickly adjusted as necessary as their needs change.

C. Has in place formal SUA and AAA policies which are in effect-at least in the PSA(s) where the local project(s) are operating—that support the investment of OAA dollars to serve the high-risk individuals who are targeted under this Announcement.

For purposes of this Announcement, a "Single-Entry-Point" (SEP) program must have the operational capacity to:

A. Effectively and efficiently identify individuals who are at imminent risk of nursing home placement but not eligible for Medicaid and who, without some type of intervention, will in fact go into – or stay in – a nursing home facility and spend-down to Medicaid (consistent with Standards I.B and I.D in Appendix A);

B. Assess the needs of such individuals; provide them with options counseling; and, as needed, work with them to develop care plans and arrange for services, including linking them to services provided by aging network provider organizations (consistent with Standard II. A in Attachment A);

C. Provide streamlined processes for determining an individual's eligibility for publicly supported long-term care services and supports. This means the Single-Entry-Point programs used for projects under this Announcement need to be integrated, in some manner, with the process that is used by the state to determine a person's eligibility for Medicaid long-term care (both their programmatic eligibility and their financial eligibility for Medicaid). To the extent feasible it would be beneficial that individuals who are deemed by Medicaid to be ineligible for Medicaid long-term care and who are at imminent risk of nursing home placement have the opportunity to be referred to the diversion program supported under this Announcement (consistent with Standard II.A. in Attachment A).

At the discretion of a state, the three (3) functions described above may be performed by separate entities that are coordinated to create a seamless program for consumers.

For purposes of this Announcement, an “aging services provider organization” is an organization that is currently operating a program that serves older adults and is funded (at least in part) through the Older Americans Act. A Native American Tribal Organization funded under Title VI of the Older Americans Act may be included as an aging services provider under this grant announcement.

For purposes of this Announcement, “models to deliver flexible services” includes service authorization and service delivery. The service authorization process should include the authority to utilize funds that can support a wide variety of service options so that services can be tailored to the unique and changing needs of individual clients. Models should also include the capacity of many provider organizations to provide and coordinate a complete array of services for elderly individuals and foster greater utilization of these types of providers. This approach to flexible services will foster greater efficiency and reduce per capita costs of services. Models to deliver flexible services should recognize full service providers and foster utilization of their services. “Consumer-directed models” are methods of delivering services that give the individuals being served the option to determine the specific types of services they receive as well as the manner in which those services are provided. (See Standards I.A and I.C in Attachment A)

Projects funded under this Announcement must be able to monitor and follow-up with the individuals they are serving to ensure that the necessary services are being rapidly authorized and initiated, that client and family needs are being met, and that necessary adjustments in services are rapidly being made as the needs of the client and/or family caregiver change.

Projects must also be able to track individual clients and be able to document and report on the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down.

No later than the end of the 15 month, the projects supported under this Announcement in addition to the items required by the end of the 9th month, must be providing a full range of service options to the individuals who are targeted under this Announcement, as well as giving them the option to use consumer-directed models. (See Attachment A for more information on flexible services models and consumer-directed models.)

Two examples of tools and protocols that a SUA and/or AAA might want to promote in their policies include:

> Contracting – States or Area Agencies that have fixed contracts (e.g. $25,000 to a specific homemaker agency) may consider implementing fee for service contracting or other variations. Based on an established unit rate, the total amount of funds and service hours can then become more consumer driven. When money follows the

consumer, a choice of service providers can be made and a greater focus on quality service provision can result.

Prioritization – The specific aim of the Nursing Home Diversion Modernization Grants is to identify and serve individuals at imminent risk of going into a nursing home and spending down to Medicaid. States and Area Agencies that have served consumers on a "first come, first served" basis may consider implementing assessment and screening tools, as well as care planning and case management processes, that have been proven to identify and serve those individuals in priority order.

States may, where appropriate, use one or more of the following sources to support the delivery of home and community-based services to the individuals targeted under this program: grant funds made available under this Announcement; The Older Americans Act; Alzheimer's Disease Demonstration Grants to States (ADDGS); any other public program, and private pay or other sources that can be used to serve individuals who are not eligible for Medicaid.

Priority will be given to states with project proposals that demonstrate real potential to:

- No later than the end of the 9th month after receiving the grant award,

    - Applicants must commit that they will identify the amount and source(s) of funding to be used for home and community-based services and supports that will be provided to clients under their proposed project no later than the end of the 9th month, as well as during the rest of the grant's 18 month project period.

    - Have the capacity in place and be using formal protocols and other tools to rapidly provide home and community-based services and supports to individuals who are identified by a Single-entry-point program as being at imminent risk of nursing home placement and spend-down to Medicaid; and

    - Implement SUA policies and AAA policies (at a minimum in the PSAs where the grant project is being implemented) that:

      1.) support the Aging Services Network's use of Single-Entry-Point programs as a vehicle for identifying individuals who are not Medicaid eligible but are at imminent risk of nursing home placement and spend-down;

      2.) support the use of protocols and tools that will enable these targeted individuals to rapidly receive home and community-based services from the Aging Services Network, including aging services provider organizations;

      3.) prioritize the use of OAA resources and services to be targeted at individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down, and

4.) support the use of flexible services and consumer-directed models in OAA programs.

- By the end of the 15th month of the project period, have the capacity in place to provide a full range of service options to the individuals who are targeted under this Announcement as well as giving them the option to use consumer-directed models that give people control over the types of services they receive and the manner in which they are provided.

- Fully coordinate the project(s) with other state-administered long-term care programs and rebalancing efforts; and,

- Provide home and community-based services to significant numbers of clients in the target population in one or more geographic areas of the state over the 18 months of the grant period. Applications must indicate the anticipated number of targeted individuals that will be diverted from nursing home placement and spend-down to Medicaid during the 18 month grant period. (Attachment H includes a chart that estimates the total number of people within each state that may be at risk of nursing home placement and spend down to Medicaid. Applicants should project the percentage of the estimated population they anticipate to divert from nursing home placement and spend down to Medicaid.)

- Achieve a significant degree of progress toward achieving the types of system changes describe in this Announcement (see Page 1), in comparison to the status quo statewide and within the geographic areas covered by the grant project, and the likelihood that such changes will be sustained beyond the project period.

Grant funds under this announcement can be used for the following activities:

- The provision of home and community-based services and supports to individuals. These services can include, but are not limited to, personal care, homemaker/chore services, transportation, meal preparation, home-delivered meals, home modifications, respite, assistive devices, and other good and services that support the individual's ability to remain at home or the families ability to continue to provide support.

- Supporting nursing home diversion operations of a SEP to help ensure it is capable of effectively performing, directly or through a seamless system, the functions of client screening, assessment, options counseling, care planning, and streamlined access to all publicly supported long-term care services and supports, including Medicaid HCBS and nursing home care, for the population targeted under this Announcement. Among other things, this can include: developing or refining a SEP program's targeting criteria and tools to ensure that those at-risk of imminent nursing home placement and spend-down to Medicaid are effectively and efficiently targeted by the SEP;

- Training and technical assistance activities designed to assist the state and its partners in understanding and achieving project goals and objectives. AoA is funding a Nursing Home Diversion Technical Assistance Center that will provide technical assistance to successful grantees. and;

- Designing and implementing evaluation and quality assurance systems and protocols.

- Project administration.

As part of its diversion program, states may propose to direct a portion of its diversion activities on transitioning individuals who are not eligible for Medicaid out of acute care and other facility settings, including hospitals and nursing homes, into the community if such individuals otherwise would have remained in, or have been sent to, a nursing facility for a long-term stay and spent down to Medicaid.

Applicants should note in their Project Narrative if activities developed under this funding opportunity are supported with other funding and if so, how the multiple funding sources will support, and not duplicate, efforts. In addition, applicants for this opportunity should indicate if they are currently applying for:

- The 2008 CMS Real Choices Systems Change grant and how activities proposed under that opportunity support and do not duplicate efforts proposed in the NHDM application.

- The Veterans Health Administration Option (Veteran Directed Home and Community Based Service Program) described in Attachment I of this announcement. The Veteran Directed Home and Community Based Service Program (VDHCBS) is designed to serve Veterans of any age at risk of nursing home placement. Veterans Health Administration funds will be used to assess veterans for eligibility for the VDHCBS program, using consumer directed methods provide assistance in the development of a service plan, and to arrange, deliver and purchase services for veterans eligible for the Veteran Directed Home and Community Based Service Program.   The AoA application shall include a statement regarding how the Veteran Directed Home and Community Based Service Program will be implemented in conjunction with the Nursing Home Diversion Modernization Grant Program. **States interested in applying for this option must complete a separate application as described in Attachment I and submit it with their AoA grant application.**

NOTE: Additional information important in the development of proposals for this grant opportunity can be found in Section IV.2.C Project Narrative and in Section V.1. Application Review Criteria.

SECTION II. AWARD INFORMATION

The total amount of AoA funds available for this new funding opportunity is expected to be up to $10,000,000. AoA plans to fund up to 10 to 15 states for a period of 18 months. The average grant amount is anticipated to be approximately $800,000 with a range of awards between $600,000 to $1,000,000 each. Because the nature and scope of the proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. This may include funding for capacity development grants (approximately $50,000 per award) to complement potential participation in the VDHCBS program. AoA reserves the right to offer a funding level that differs from the requested amount. Funding will be allocated in total at the time of the award. Grantees are required to provide a 25% match of the total project cost**.**

All funds will be awarded by September 30, 2008. Applicants are required to submit one project budget (SF424A) and one budget justification for the AoA funds.

These grants will be issued as Cooperative Agreements because AoA anticipates having substantial involvement with the recipients during performance of funded activities. AoA's involvement may include:

- Assisting the project leadership in understanding the strategic goals and objectives, policy perspectives, and priorities of the AoA by sharing such information on an ongoing basis via e-mail, conference calls, briefings, and other consultations;
- Providing technical assistance and support on nursing home diversion methodologies and long term care systems change strategies, grant management and implementation issues, including execution of the cooperative agreement;
- Identifying specific data that will need to be collected,
- Defining project performance criteria and expectations; and,
- Monitoring, evaluating and supporting the projects' efforts in achieving performance goals.
- Training and contact with the State agency, Area Agency on Aging, and the aging services provider organizations that receive and administer service funds through the grant, and other partners that are participating substantially in the nursing home diversion modernization program.

Grantees will be expected to maintain regular contact with their Federal project officer and to cooperate with the AoA Resource Center that will be providing technical assistance. Grantees will also be expected to share with AoA all significant products from their NHDM program.

Award Size

As noted above, AoA plans to award up to 10 to 15 grants with a maximum award of up to $1,000,000. A key consideration for AoA is how the award correlates with the significance of proposed endeavors, rather than the size of the State. Significance will be measured in terms of

1. the likelihood of a state being able to, no later than the end of the ninth (9^{th}) month after receiving the grant award, rapidly provide home and community-based services to individuals who are identified by a Single-Entry-Point program as being at imminent risk of nursing home placement and spend-down, and have SUA and AAA policies in place – at a minimum in the PSA(s) where any of the grant project(s) are being implemented – that :

1.) support the Aging Services Network's use of Single-Entry-Point programs as a vehicle for identifying individuals who are not Medicaid eligible but are at imminent risk of nursing home placement and spend-down;

2.) support the use of protocols and tools that will enable these targeted individuals to rapidly receive home and community-based services from the Aging Services Network, including aging services provider organizations;
3.) prioritize the use of some OAA dollars to be targeted at individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down, and
4.) support the use of models to deliver flexible services and consumer-directed models in OAA programs; and,

2. the extent to which a state will be likely to, by the end of the 15th month of the project period, be providing a full range of service options to the individuals who are targeted under this Announcement, as well as giving them the option to use consumer-directed models that give people control over the types of services they receive and the manner in which they are provided.

Special Opportunity to Serve Veterans--VDHCBS Option Award:

The Veterans Health Administration is seeking to offer the Veteran's Directed Home and Community Based Service Program (VDHCBS) in up to 12 Veteran Integrated Service Networks (VISN's) and plans to invest approximately $3 million to serve veterans at risk of institutionalization. **.** **States seeking to apply for this option must complete the form in Attachment I and submit it as part of their AoA grant application.**

The Veterans Health Administration does not require match for the VDHCBS program.

The Veterans Health Administration will directly purchase services from State Units on Aging and/or local Area Agencies on Aging for the VDHCBS program. Service funding will be provided by the local VA Medical Centers to State Units on Aging or their selected AAA pilot sites based on the number of veterans that will be enrolled in the VDHCBS and the estimated monthly budget for services for each enrolled veteran.

Applicant's eligibility and receipt of funding from the VHA for this option is dependent upon approval of their AoA NHDM grant application. The VDHCBS Option selection of participating states will be made no later than September 30, 2008. At the time a Notice of Award is made by AoA for a NHDM grant to an NHDM applicant that also applies for this option, the VHA in partnership with AoA will make contact with all committed parties as demonstrated by the letters of support, to discuss and negotiate the details of their proposal for partnership and to enable them to finalize the arrangement between the local VA Medical Center(s) and the State Unit on Aging or local AAA pilot site(s).

SECTION III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Only a State Unit on Aging (SUA) may apply for a Nursing Home Diversion Modernization Grant. As State Units on Aging are both the State agency and Aging Services Network entity designated with directing the planning and provision of OAA funds and services within their State for the targeted population, they are the only organization positioned to collaborate with all the necessary partners in the State (including: the State Medicaid agency, Area Agencies on Aging, and Aging Service Providers), and to coordinate the development of and implementation of State nursing home diversion programs. State Units on Aging are uniquely positioned in their states to manage and implement the primary goal of this grant: to develop and implement, or expand an existing, nursing home diversion program that helps individuals and families avoid unnecessary institutionalization and spend down to Medicaid.

2. Cost Sharing or Matching

Under this Older Americans Act (OAA) program, AoA will fund no more than 75% of the project's total cost, which means the applicant must cover at least 25% of the project's total cost with non-federal resources. In other words, for every three (3) dollars received in federal funding, the applicant must contribute at least one (1) dollar in non-federal resources toward the project's total cost. This "three-to-one" ratio is reflected in the formula included under Item 18 in Attachment A. You can use this formula to calculate your minimum required match. A common error applicants make is to match 25% of the federal share, rather than 25% of the project's total cost. Please note, applications with a match greater than the minimum required will **<u>not</u>** receive additional consideration under the review. Match is not one of the responsiveness criteria as noted in Section III.3, *Application Screening Criteria*.

3. Application Screening Criteria

All applications will be screened to assure a level playing field for all applicants. Applications that fail to meet the three screening criteria described below will **<u>not</u>** be reviewed and will receive **<u>no</u>** further consideration.

In order for an application to be reviewed, it must meet the following screening requirements:

- **A.** Applications must be submitted electronically via www.grants.gov by 11:59 pm of **August 14, 2008**.

- **B.** The Project Narrative section of the Application must be double-spaced, on "8 ½ x 11" plain white paper, with 1" margins on both sides, and a font size of not less than 11.

- **C.** The Project Narrative must <u>not</u> exceed 20 pages. NOTE: The Project Work Plan, Letters of Commitment, and Vitae of Key Project Personnel and Attachment I--the response to apply for the Veteran's Directed Home and Community Based Service Program **<u>are not counted</u>** as part of the Project Narrative for purposes of the 20-page limit.

4. Responsiveness Criteria

The successful applicant will be an organization that meets the following criteria:

1. Provides letters of commitment from relevant partners related to their defined role in the project including for example the Single State Medicaid Agency, Area Agencies on Aging responsible for leading projects within their respective PSAs, participating Single-Entry-Point entity, and participating community-based service provider organizations, including aging services provider organizations.

2. Commitment to utilizing a "Single-Entry-Point" program to identify individuals who are at imminent risk of nursing home placement and spend-down to Medicaid.

3. Commitment to developing and implementing SUA and AAA polices that support the type of system changes called for in this Program Announcement (see Page 1).

4. Commitment to designing and implementing evaluation activities that measure, monitor and report success in diverting individuals from nursing home placement and spend-down to Medicaid.

SECTION IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

Application materials can be obtained from http://www.grants.gov or http://www.aoa.gov/doingbus/fundopp/fundopp.asp.

Application materials are also available by writing to:

U.S. Department of Health and Human Services
Administration on Aging
Richard Nicholls
Center for Planning and Policy Development
Washington, D.C. 20201

Or by calling: 202-357-0152
Or e-mailing: richard.nicholls@aoa.hhs.gov

Please note, AoA is requiring applications for this announcement to be submitted electronically through www.grants.gov. The Grants.gov registration process can take several days. If your organization is not currently registered with www.grants.gov, please begin this process immediately. **For assistance with www.grants.gov, please contact them at support@grants.gov or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time.** At www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website.

How to apply for this opportunity via www.grants.gov:

- You may access the electronic application for this program on www.Grants.gov. You must search the downloadable application page by the CFDA number 93.048**.** At the www.grants.gov website, you will find information about submitting an

application electronically through the site, including the hours of operation. AoA strongly recommends that you do not wait until the application due date to begin the application process through www.grants.gov because of the time delay.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System number and register in the Central Contractor Registry (CCR). You should allow a minimum of **five days** to complete the CCR registration.
- You may submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the Grants.gov compatibility information and submission instructions provided at www.grants.gov (click on "**Vista and Microsoft Office 2007 Compatibility Information**").
- Your application must comply with any page limitation requirements described in this program announcement.
- After you electronically submit your application, you will receive an automatic acknowledgement from www.grants.gov that contains a Grants.gov tracking number. The Administration on Aging will retrieve your application form from Grants.gov.
- We may request that you provide original signatures on forms at a later date.
- Each year organizations registered to apply for federal grants through www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online and it will take about 30 minutes (www.grants.gov/CCRRegister). You should receive your CCR registration within 7–10 business days.

2. Content and Form of Application Submission

A. Letter of Intent

Applicants are requested, but not required, to submit a letter of intent to apply for this funding opportunity to assist AoA in planning for the application independent review process. The deadline for submission of the letter of intent is July 18, 2008.

B. DUNS Number

The Office of Management and Budget requires applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements on or after October 1, 2003. It is entered on the SF 424. It is a unique, **nine-digit identification number**, which provides unique identifiers of single business entities. The DUNS number is *free and easy* to obtain.

Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link: https://www.whitehouse.gov/omb/grants/duns_num_guide.pdf.

C. Project Narrative

The Project Narrative must be double-spaced, on 8 ½" x 11" paper with 1" margins on both sides, and a font size of not less than 11. You can use smaller font sizes to fill in the Standard Forms and Sample Formats. AoA will not accept applications with a Project

Narrative that exceeds 20 pages. The Project Work Plan, Letters of Commitment, Vitae of Key Personnel, and Attachment I--the response to apply for the Veteran's Directed Home and Community Based Service Program are not counted as part of the Project Narrative for purposes of the 20-page limit, but all of the other sections noted below are included in the limit.

The components counted as part of the 20 page limit include:

- Summary/Abstract
- Current Status of State's Nursing Home Diversion Efforts
- Goal(s) and Objective(s)
- Proposed Approach
- Project Outcomes
- Project Management
- Organizational Capability

The Project Narrative is the most important part of the application, since it will be used as the primary basis to determine whether or not your project meets the minimum requirements for grants under Title IV of the Older Americans Act. The Project Narrative should provide a **clear and concise** description of your project. AoA recommends that your project narrative include the following components:

Summary/Abstract. This section should include a brief - no more than 265 words maximum - description of the proposed project, including: the goal(s) and objectives, and a description of the specific types of changes that will be made to existing programs as a result of the proposed project. Detailed instructions for completing the summary/abstract are included in Attachment F of this document.

Current Status of Aging Network's Role in Nursing Home Diversion Efforts in the State. Applicants should provide a description of the current efforts, or planned activities, in the State (and in the PSA(s) where local project(s) will be implemented) to divert both Medicaid and non-Medicaid individuals from institutions, and the specific role that the SUA, AAAs, "single-entry-point" programs, and community-based aging services provider organizations, and other stakeholders currently play in these existing efforts. Explain how these existing diversion activities fit into the state's overall long-term care system, including current system reform efforts.

Goals and Objectives. This section should describe the proposed project's goals and objectives.

Proposed Approach. Describe the overall approach you plan to use to make each of the system changes described in this Program Announcement (see Page 1), including how you plan to change the way services will be provided to the individuals targeted under this Announcement, and why you think your approach will be successful. This **must** include a description of how funds are currently being used statewide and in the geographic areas to be covered by the proposed project, and how their use will be changed as a result of the project.

Applicants are encouraged to provide as much detail – and to be as precise as possible -- in describing both the "status quo" and the specific changes that will be made in the way existing programs, organizations and funds are being deployed in order to achieve the long term care program changes described in this grant Announcement (see Page 1). This includes identifying the specific funds to be used, exactly how their use will change to improve the way the Aging Services Network diverts individuals in the target group from unnecessary nursing home placement and Medicaid spend-down, as well as to provide flexible service models and consumer-directed models like Cash and Counseling. Applicants should provide a detailed description of the involvement of the State Medicaid Agency, Area Agencies on Aging, Single-Entry-Point programs, and community providers, including aging services provider organizations, agencies serving people with disabilities, and other key stakeholders in the process.

A successful application will include a description of how this project will actively engage aging services provider organizations in diversion activities. Such activities might include assisting providers in receiving referrals from a Single-entry-point program, developing the capacity to rapidly respond to the unique and changing needs and preferences of the individuals targeted under this program, and helping providers to set up models to deliver flexible services as well as helping them to participate in consumer-directed models such as Cash and Counseling.

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Applicants must describe the elements of the targeting criteria they either already have in place, and/or plan to develop and implement. The description of the targeting criteria should also include the relationship of the targeting criteria to the State Medicaid Agency's definition of nursing home level of care. This section shall also include a detailed description of how the targeting criteria will be used through the SEP, to effectively and efficiently identify individuals who are in fact at imminent risk of nursing home placement and spend-down to Medicaid, consistent with the targeting standards described in I.B. and I.D. contained in Attachment A.

Ideally, the SEP will be performing nursing home preadmission screening and will be using its preadmission screening program to identify individuals to be served under this grant program. Applicants must document the manner in which the SEP is integrated with, the process used by the state Medicaid long-term care program to determine a person's eligibility (both programmatic and financial) for Medicaid long-term care. Applicants should also include a description of the methods by which people who are found to be ineligible for Medicaid will be referred immediately and seamlessly to the diversion program supported under this Announcement.

Projects must be able to report on client-level data and be able to document the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down, and any associated cost avoidance for the Medicaid program. Projects must be able to report unduplicated and aggregated data on the number of clients receiving home and community-based services under this project, and also be able to report on the total and per capita amounts expended from all public sources on home and community based services and supports provided to the clients being served under this program, as well as the total amounts being expended on home and community-based services and supports from each public source, including the grant funds under this project. AoA, along with the Nursing Home Diversion Technical Assistance

Center, will work with successful applicants to identify the common data that will need to be collected.

Applicants should specify and provide a rationale for selecting the geographic location(s) where grant efforts will be carried-out in their state. State Units on Aging, at a minimum, may implement program elements in one or more Planning and Service Areas (PSAs) of their state (or one or more counties or regions in a state with a single PSA).

Applicants must specify the names and role of, and provide a rationale for selecting, the various key partners who will be involved in the project, including Area Agencies on Aging, community-based aging services provider organizations, the SEP, the Single State Medicaid Agency, and other key partners. The role and makeup of any strategic partnerships to be involved in implementing the intervention, including other organizations, funders, and/or consumers should also be described.

Applications should also include a projection of the total amount of grant and any matching funds that will be used to provide home and community-based services and supports to consumers no later than the end of the 9^{th} month of the project period, and by the end of the 15^{th} month of the project period. By the 18^{th} month or end of the grant, 100% of the match should be used.

Proposals should include a description of the Information Technology (IT) that will be used to support a Nursing Home Diversion Modernization Grant project.

Applicants should demonstrate how their proposal fits with other state nursing home diversion activities, including those targeted at Medicaid eligible individuals.

Proposals should include any major barriers anticipated in trying to achieve the systems changes called for in the Announcement (see Page 1), and how the project will be able to overcome those barriers. Applicants may wish to refer to the *State Readiness Assessment & Gap Analysis for a Nursing Home Diversion Program* located on the Nursing Home Diversion Modernization Grant Announcement Resource Page for assistance in preparing for this funding opportunity.

Project Outcomes. This section of the project narrative must clearly identify the project outcomes to be accomplished by the end of the 18-month project period, based on the priority activities outlined in Section I.5, 'Description of Funding Opportunity' and the standards described in Attachment A. The state's project must at a minimum:

- No later than the end of the 9th month of the project period, have at least one local project up and running and delivering services to the high-risk individuals targeted under this Announcement in a way that:

    A. Uses a Single-entry-point (SEP) program to identify individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down to Medicaid,

    B. Uses formal protocols and other tools across, and by, key stakeholder organizations (e.g., SEP, aging services providers, AAAs, hospitals, nursing homes, Centers for Independent Living, VHA, etc.) for making client referrals, prioritizing clients, authorizing services, and following-up with clients to ensure that the local project can rapidly provide home and community-based services and supports to the high –risk individuals who are identified by the Single-entry-point program, and that the services for these individuals can be quickly adjusted as necessary as their needs change.

C. Has in place formal SUA and AAA policies which are in effect-at least in the PSA(s) where the local project(s) are operating—that support the investment of some OAA dollars to serve the high-risk individuals who are targeted under this Announcement.

- No later than the end of the ninth (9^{th}) month project period, the project must have in place SUA policies and AAA policies (at a minimum in the PSAs where the grant project is being implemented) that:
  1.) support the Aging Services Network's use of Single-Entry-Point programs as a vehicle for identifying individuals who are not Medicaid eligible but are at imminent risk of nursing home placement and spend-down;
  2.) support the use of protocols and tools that will enable these targeted individuals to rapidly receive home and community-based services from the Aging Services Network, including aging services provider organizations;
  3.) prioritize the use of some OAA dollars to be targeted at individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down, and
  4.) support the use of flexible service models and consumer-directed models in OAA programs. (See Attachment A for more information on models to deliver flexible services and consumer-directed models.)

- No later than the end of the 15^{th} month of the project period, in addition to the items required by the 9^{th} month, be Providing a full range of service options to individuals who are targeted under this Announcement, as well as giving them the option to use consumer-directed models that give people control over the types of services they receive and the manner in which they are provided.

- Projects funded under this Announcement must be able to monitor and follow-up with the individuals they are serving to ensure that the necessary services are being provided, that client and family needs are met, and that adjustments in services are made as necessary. At the discretion of the state, this "on-gong monitoring and follow-up" function can be performed by either the "Single-Entry-Point" or by another entity.

- Projects must be able to report on client-level data and be able to document the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down, and any associated cost avoidance for the Medicaid program. Projects must be able to report unduplicated and aggregated data on the number of clients receiving home and community-based services under this project, and also be able to report on the total and per capita amounts expended from all public sources on home and community based services and supports provided to the clients being served under this program, as well as the total amounts being expended on home and community-based services and supports from each public source, including the grant funds under this project. AoA, along with the Nursing Home Diversion Technical Assistance Center, will work with successful applicants to identify the common data that will need to be collected.

- This section should include a projected number of clients that will be served, the proportion of the estimated state eligible population that will be served, and a projected enrollment strategy that reflects the projected ramp up of the program. Consider the information provided in Attachment H which includes the estimated number of people throughout the state likely to be at risk of nursing home placement and spend down to Medicaid.

This section should also describe how, and to what extent, the system changes brought about by the project will be sustained beyond the grant period, as well as the extent to which the changes will be incorporated into the state's overall system of long-term care.

Project Management. This section should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes, including the systems changes described in this Announcement (see Page 1). It should specify who will have day-to-day responsibility for key tasks such as: leadership of project; monitoring the project's on-going progress, preparation of reports; communications with SUA, AAA and other partners, and AoA. It should describe the approach that will be used to monitor and track progress on the project's tasks and objectives, and how the state plans to measure, monitor, and report success in diverting individuals from institutionalization and spend-down to Medicaid.

Organizational Capability Statement. Each application should include an organizational capability statement, organizational charts, and vitae for key project personnel. The organizational capability statement should describe the organization and capacity of the SUA, AAA (if applicable), community-based services providers, the SEP, and other key participants, and how they will collaborate in this project. Neither vitas nor an organizational chart will count towards the narrative page limit. Also include information about any service provider or contractual organization(s) that will have a significant role(s) in implementing the program and achieving project goals.

Work Plan. Applicants should provide a realistic timetable and work plan that outlines the extent to which they will be able to complete each activity within the 18 month project period as well as a description of how each activity will contribute to the overall goals and objectives of the program and to the system changes described in the Announcement.

The Project Work Plan should reflect and be consistent with the Project Narrative and Budget. It should include a statement of the project's overall goal, anticipated outcome(s), key objectives, and the major tasks / action steps that will be pursued to achieve the goal and outcome(s). For each major task / action step, the work plan should identify the timeframes involved (including start- and end-dates), and the lead person responsible for completing the task. Please use the Sample Work Plan format included in the Attachments.

Letters of Commitment from Key Participating Organizations and Agencies. Include confirmation of the commitments to the project (should it be funded) made by key collaborating organizations and agencies. This should include at a minimum letters of commitment from: 1) the State Medicaid Agency; 2) the collaborating AAA(s); 3) community provider partners; 4) the Single-Entry-Point; and, any other organization that is specifically named to have a significant role in carrying out the project. For applications submitted electronically via www.grants.gov, signed letters of commitment should be scanned and included as attachments. Applicants unable to scan the signed letters of commitment may fax them to the AoA Office of Grants Management at 202-357-3466 no later than the application submission deadline.

3. Submission Dates and Times

Applicants are requested, but not required, to submit a letter of intent to apply for this funding opportunity. The letter of intent assists AoA in planning for the independent review process of the applications. The deadline for submission of letters of intent is July 18, 2008.

The deadline for the submission of completed applications under this program announcement is August 14, 2008. Applications must be submitted electronically at www.grants.gov. Applications that fail to meet the application due date will **not** be reviewed and will receive **no** further consideration.

Grants.gov will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in Grants.gov.

An open information teleconference for applicants of this solicitation will be held July 10, 2008 at 2:00 p.m., EST. The toll-free teleconference phone number will be 888-396-9185, pass code: 2043392.

4. Intergovernmental Review

This funding opportunity announcement is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs."

5. Funding Restrictions

The following activities are not fundable:

- Construction and/or major rehabilitation of buildings;
- Basic research (e.g. scientific or medical experiments); and,
- Continuation of existing projects without expansion or new and innovative approaches.

6. Other Submission Requirements

Electronic submissions must be sent to: http://www.grants.gov.

Applicants submitting their application through www.grants.gov must register in the Central Contractor Registry (CCR) database in order to be able to submit the application. One element of the CCR is the DUNS number (see section IV.2), which must be obtained separately from CCR registration. Information about CCR is available at http://www.grants.gov/CCRRegister. You must also register with a Credential Provider to receive a username and password to securely submit your grant application. Information is available at http://www.grants.gov/CredentialProvider .

SECTION V. APPLICATION REVIEW INFORMATION

The Review Criteria listed below will be used by an Independent Review Panel to score each application for this funding opportunity. In applying for this opportunity, applicants should therefore be sure to adequately address all of the elements noted below.

1. Application Review Criteria

Applications are scored by assigning a maximum of 100 points across five criteria:

I. Current Status of Aging Network's Role in Nursing Home Diversion Efforts in the State (Weight – 5 Points)

5 pts. a. Does the applicant provide a description of the "status quo" including current efforts, or planned activities, statewide and in the PSA where the projects supported under this Announcement will be implemented, related to diverting people, including non-Medicaid individuals, away from nursing home placement and spend-down, and the specific role that the SUA, AAAs, SEPs and community-based aging services provider organizations play in those efforts? Does the applicant explain how these existing diversion activities fit into the state's overall long-term care system, including current system rebalancing/reform efforts. Does the applicant describe the "status quo" statewide and in the relevant PSA(s) on the use of models to deliver flexible services and consumer-directed models like Cash and Counseling?

II. Goals and Objectives, Proposed Approach, Project Outcomes (Weight – 65 Points)

10 pts. a. Does the applicant describe activities, resources, partners and/or the infrastructure which are currently in place, and those that are being planned under the proposed project, that would suggest the project is going to be able to, no later than the end of the ninth (9^{th}) month of the Project Period, be identifying - through a SEP - individuals in the target population and then using formal protocols and tools to link those individuals with provider organizations that can rapidly provide them the home and community-based services they need to avoid nursing home placement and spend-down? Does the

applicant describe the SUA and AAA policies they plan to implement no later than the 9th month of the project period, that support the investment of some OAA dollars to serve the high-risk individuals who are targeted under this Announcement?

10 pts. b. Does the applicant propose in detail how it will provide, and is it likely to succeed at implementing and providing a full range of service options and providing the option to use consumer-directed models to the targeted population by the end of the 15th month in the project period?

5 pts. c. Is the number of clients to be served by the end of the 18 month Project Period a significant number given the population of the state, population of the pilot area(s), the estimated number of people likely to be at risk of nursing home placement and spend down to Medicaid, and other factors described in the application? Does the enrollment strategy and "ramp-up" plan demonstrate growth toward program sustainability?

10 pts. d. Does the applicant either describe their criteria for identifying individuals who are ineligible for Medicaid but at imminent risk of nursing home placement and spend-down, or detail their plans to develop these criteria, in a way that is consistent with targeted standards I.B and I.D. described in Attachment A? Do they indicate how these criteria will be applied through the SEP to identify at-risk individuals to be diverted?

10 pts. e. Does the applicant provide evidence to document that the SEP will also, at a minimum, have the operational capacity, directly or through a seamless system, by the 9th month of the project period to:

1. Assess the needs of individuals in the target group; provide them with options counseling; and, as needed, work with them to develop care plans;
2. Coordinate with community-based service providers, including aging services provider organizations, to assist the targeted individuals who are identified by the SEP to rapidly arrange for and deliver the home and community-based services and supports that are needed to help these individuals avoid nursing home placement and spend-down;
3. Assess targeted individuals potential eligibility for publicly supported long-term care services and supports;
4. Be operationally integrated with – or so closely coordinated with – the Medicaid eligibility determination functions (both programmatic and financial) to ensure that individuals who are determined to be ineligible for Medicaid are immediately and seamlessly referred to the nursing home diversion project supported under this grant Announcement.

5. Be using formal protocols and other tools across and by key stakeholder organizations (e.g., SEP, aging services providers, AAA's, hospitals, nursing homes, Centers for Independent Living, VHA, etc.) for making client referrals; prioritizing clients; authorizing services, and following-up with clients?

5 pts. f Does the applicant emphasize the use of full or multi-service providers to support efforts to meet the full and changing needs of clients served under this project?

5 pts. g Does the applicant describe how the project will monitor and follow-up with the individuals being served to ensure services are provided and needs are being met?

10 pts. h Is there a system proposed for tracking individual clients and for analyzing and reporting the data, including data that can be used to document the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down, and the cost avoidance being achieved for Medicaid? Projects must be able to report on client-level data and be able to document the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down. Does the applicant commit to work with AoA and other successful applicants in the development and use of a common data set?

III. Organizational Capability Statement (Weight – 10 Points)

5 pts a. Did the applicant describe the organizational capacity of the SUA and its partners including the AAAs, community-based aging services providers, SEP, and other stakeholders to implement and administer the NHD grant, and are these partners likely to coordinate as planned and succeed in achieving the project's goals and objectives and in advancing the systems changes called for in the Announcement (see Page 1).

5 pts. b. Are project staff and their roles and responsibilities clearly described? Are the roles of any contract organizations clear and reasonable?

IV. Project Management, Work Plan and Budget (Weight – 10 Points)

5 pts. a. Did the applicants provide a realistic timetable and work plan that outlines the extent to which they will be able to complete each activity as required by the 9th month, 15th month and within the 18 month project period?

5 pts. b. Does the budget realistically reflect the goals, objectives and activities outlined in the work plan?

V. Sustainability *(Weight – 10 Points)*

10 pts. Is there a plan for sustaining the system changes called for in the Announcement (see Page 1) and implemented by the project beyond the 18 month project period? Does the applicant describe key policy and system changes that will be implemented to embed the program in the fabric of the long term care delivery system in the state or pilot area? Does the applicant describe a plan for leveraging other resources to ensure the sustainability of the project? Are there letters of commitment from key partners? Does the applicant describe how this effort will coordinate with other long-term care programs and rebalancing efforts in the state?

2. Review and Selection Process

An independent review panel of at least three individuals will evaluate applications that pass the screening. These reviewers are experts in their field, and are drawn from academic institutions, non-profit organizations, State and local government, and federal government agencies. Based on the specific programmatic considerations as outlined under Section I.5, 'Funding Opportunity Description', the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the criteria identified above.

Final award decisions will be made by the Assistant Secretary for Aging (ASA). In making these decisions, the ASA will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; geographic distribution; program diversity; whether the state is receiving funding under the CMS Real Choice Systems Change grant program, and the likelihood that the proposed project will result in the benefits expected.

Applicants have the option of omitting from the application copies (not the original) specific salary rates or amounts for individuals specified in the application budget and Social Security Numbers. The copies may include summary salary information.

SECTION VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive an Approval Letter, and a Notice of Award. The Notice of Award is the authorizing document, and will be signed by the AoA grants management officer, the AoA authorizing official, and the AoA budget office. Unsuccessful applicants are notified within 30 days of the final funding decision and will receive a disapproval letter via U.S. mail.

The Veterans Health Administration will select and make awards for the VDHCBS program. Service funding will be awarded by the Veterans Health Administration and will be provided to State Units on Aging or their selected AAA pilot sites based on the number of veterans that will be enrolled in the VDHCBS and the estimated monthly budget for services for each enrolled veteran.

2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement, located at:
http://www.hhs.gov/grantsnet/adminis/gpd/index.htm.

3. Reporting

The SF-269 (Financial Status Report) is due annually and the AoA program progress report is due semi-annually. Final performance and SF-269 reports are due 90 days after the end of the project period.

SECTION VII. AGENCY CONTACTS

Project Officers:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Richard Nicholls
Telephone: (202) 357-0152, e-mail: richard.nicholls@aoa.hhs.gov

Grants Management Officer:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Alexis Lynady
Telephone: (202) 357-3465, e-mail: alexis.lynady@aoa.hhs.gov

Veterans Health Administration Officers:

U.S. Veterans Health Administration
VA Central Office
Geriatrics & Extended Care
Washington, DC
Attn: Daniel J. Schoeps
Director, Long-Term Care Purchasing

Telephone: (202) 461-6763, e-mail: daniel.schoeps@va.gov

U.S.
Geriatrics & Extended Care
VA Central Office
Washington, DC
Attn: Patrick Brady
Coordinator, Purchased Long-Term Care Reimbursement
Telephone: (202)-461-6787, e-mail: patrick.brady@va.gov

SECTION VIII. OTHER INFORMATION

1. Application Elements

A. SF 424 – Application for Federal Assistance.

B. SF 424A – Budget Information.

C. Separate Budget Narrative/Justification (See Attachments for Sample Format).

D. SF 424B – Assurances. Note: Be sure to complete this form according to instructions and have it signed and dated by the authorized representative (see item 18d on the SF 424).

E. Certifications-Required of the applicant organization regarding lobbying, debarment, suspension, and other responsibility matters; and drug free workplace requirements. (See page A-14 in the Attachment Section)

F. Copy of the applicant's most recent indirect cost agreement, as necessary.

G. Project Narrative with Work Plan (See Attachment for Sample Work Plan Format).

H. Organizational Capability Statement and Vitae for Key Project Personnel.

I. Letters of Commitment from Key Partners.

2. The Paperwork Reduction Act of 1995 (P.L. 104-13)

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.
The project description and budget justification is approved under OMB control number 0985-0018 which expires on 05/31/2010.
Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

ATTACHMENTS

Attachment A:
Standards for a Nursing Home Diversion Program

Attachment B:
Instructions for completing the SF 424, Budget (SF 424A), Budget Narrative and Other Required Forms

Attachment C:
Budget Justification Format – Sample Format with Examples

Attachment D:
Budget Justification – Sample Format

Attachment E:
Project Work Plan - Sample Format

Attachment F:
Instructions for Completing the Summary/Abstract

Attachment G:
"Survey on Ensuring Equal Opportunity for Applicants"

Attachment H:
"Estimated Number of Eligible Individuals for Nursing Home Diversion by State"

Attachment I:
"Veteran's Directed Home and Community Based Service Option"

Attachment J:
"Veterans Integrated Service Networks (VISN) Map"

Attachment K:
NHDM Grant Program Cooperative Agreement

Attachment L:
NHDM Frequently Asked Questions

Attachment A

Standards for Nursing Home Diversion Program

Consistent with the new long-term care provisions in the OAA and the latest research and best practices from the field, AoA has identified standards for a Nursing Home Diversion Program. These standards include nine key elements. These elements are described in this Attachment and include both service elements and systems elements.

The **service elements** are designed to ensure that the program reaches its intended target population, and that the needs and preferences of consumers are fully considered in the design and implementation of the program. The **systems elements** of a Nursing Home Diversion Program are designed to ensure the effective and efficient administration of the program.

Consistent with the principle of local flexibility that has been a hallmark of the Older Americans Act, AoA will allow states to exercise considerable freedom in designing and implementing the service and system elements of a Nursing Home Diversion Program, including how to best phase in the implementation of the various elements over time. We expect and encourage states to demonstrate creativity and ingenuity in using the latest research and best practices to design their diversion programs. We believe this approach will help to advance the state-of-the art by providing states with an opportunity to learn from one another as they develop and/or refine and implement their Nursing Home Diversion Programs.

The following standards describe the key design elements of a state-of-the-art Nursing Home Diversion Program targeted at individuals who are not eligible for Medicaid.

I. Service Elements:

A. Flexible Service Dollars that Follow the Needs of Individuals

Nursing Home Diversion Programs that support the needs of individuals at risk of nursing home placement and spend down to Medicaid need to be responsive to the needs of the consumer. A fully flexible, consumer-responsive program means that the funding is not tied to any particular service, or package of services, nor to any particular type, or types, of providers. Additionally, certain fiscal management techniques, such as per-capita and unit rate budgeting, help support the delivery of flexible service models and consumer-directed approaches. Within the statutory structure of the current Older American's Act which contains separate Title's or funding streams, State Units on Aging (SUAs) and/or Area Agencies on Aging (AAAs) can base client funding decisions on the needs of consumers rather than the source of the funding.

The funding used to support a nursing home diversion program should be flexible, so that it can be fully responsive to the individualized needs and preferences of consumers. This includes the capacity to respond rapidly to the often changing needs and circumstances facing at risk consumers.

Research on systems change efforts, such as those undertaken by CMS Real Choice Systems Change grantees, suggests that the most effective systems change efforts undertaken to-date by states include mechanisms to change long-term service systems from being provider and service driven to systems that are consumer-driven, and that it is critical that states concentrate on efforts and best practices that focus on consumer's needs. (See *Unlocking the Code of Effective Systems Change* located on the Nursing Home Diversion Modernization Grant Resource Page.)

B. Targeting Individuals at High Risk of Nursing Home Placement

Targeting individuals at high risk of nursing home placement is an essential element of any nursing home diversion program. The earliest nursing home diversion programs used targeting criteria that focused on a person's functional status, such as the number of impairments in activities of daily living. Since these early efforts, the state-of-the-art has advanced considerably. Today, the more advanced nursing home diversion programs use multiple targeting criteria that go beyond functional status to include factors that relate to the individual's health and cognitive status and the status of their informal support system.

In addition to the state's functional definition of nursing home level of care, a Nursing Home Diversion Program should use multiple risk factors in its targeting criteria to ensure that the program has a high likelihood of reaching individuals who are, in fact, at high-risk of institutionalization. At a minimum, at least four domains must be addressed by these risk factors:

- ***Functional status*** which includes ability to perform activities of daily living and instrumental activities of daily living.
- ***Health status*** which includes diagnoses (e.g., diabetes, fall-related fractures) and medical/skilled care needs (e.g., nursing, therapies) and can be evidenced by a hospitalization or a prior nursing facility stay and the use of medications.
- ***Cognitive/emotional status,*** which includes cognitive impairments, impairments in decision-making ability, inability to make decisions to avoid injury in emergency situations, etc.
- ***Informal support system status,*** *which may include* the existing capacity of caregivers to assist in the provision of support, as well as the lack of informal support.

Many States are already using some of these risk factors in their existing eligibility criteria for public programs. Additional information is located on the Nursing Home Diversion Modernization Grant Announcement Resource Page.

C. Giving Consumers the Option to Use a Consumer-directed Model

A Nursing Home Diversion Program should give consumers the maximum degree of control possible, or desired, over decisions affecting the types of services and supports they receive, as well as the manner in which the services and supports are provided. AoA believes all consumers receiving long-term care from public programs should be offered – as a matter of choice - the option of controlling their own services through a consumer direction. Obviously, if the consumer does not want, or is not able to participate in, a consumer direction model, then a traditional form of care would be provided. For example under Cash and Counseling, individuals, or their representatives, manage a flexible budget, employ and pay workers, including family and friends, and purchase needed goods and services based on their specific needs and preferences. This model is reflected in the definition of "self-directed care" that was added to Title I of the OAA as a result of the 2006 Amendments.

The Cash and Counseling Demonstration provides clear evidence on the importance of using consumer-directed models of care. The evaluation of this three state demonstration, which was targeted at Medicaid clients who were at high-risk of nursing home placement, found that consumers who self-directed their services had better quality care, greatly improved quality of life, better health outcomes, and decreased utilization of more expensive services such as nursing home care. Additional information can be found at http://www.cashandcounseling.org/index.html and is included on the Nursing Home Diversion Modernization Grant Announcement Resource Page.

D. Targeting Individuals at High Risk of Medicaid Spend-down

In order to effectively target individuals who are at risk of Medicaid spend-down, states will have to develop an approach to understand how an individual's income and assets relate to the state's Medicaid financial eligibility criteria, and then use that information to determine the person's risk of spending down. A number of states have developed different approaches to assess the risk of Medicaid spend-down. Minnesota, for example, in its Alternative Care Program determines how long it may take an individual to spend-down if he/she were to enter a nursing facility, taking into account the combination of income and assets.

Additional information is located on the Nursing Home Diversion Modernization Grant Announcement Resource Page.

E. Complementing Caregiving and Individual Resources

Since its inception, Older Americans Act funding has been designed to fill gaps in services, not to fully fund the cost of all the services and supports needed by older individuals. Consistent with this philosophy and approach, a Nursing Home Diversion Program should complement other resources being deployed to support the consumer's desire to remain at home. Of particular importance here are the personal and financial resources of the individual.

Variations in the amount of publicly supported services and/or supports that an individual receives should in no way preclude states from developing and operating Nursing Home Diversion Programs that serve individuals who are able to pay for their care. AoA strongly encourages states to develop Nursing Home Diversion Programs that not only serve individuals who need some form of public support to cover the cost of their care, but that also serve the growing number of individuals who are able to pay. For example, many states already have programs that can assist such individuals by helping them to assess their needs and then locate and/or help them to arrange for services that they directly purchase with their own resources.

Additional information is located on the Nursing Home Diversion Modernization Grant Announcement Resource Page.

II. System Elements

A. Using Single-Entry-Point Programs to Ensure Streamlined Access for Consumers

Single-Entry-Point systems perform functions that are essential to nursing home diversion activities. For example, integrating access with Medicaid through a Single-Entry-Point system can ensure that those individuals who are screened by the entry point and found not eligible for Medicaid are seamlessly linked to the Nursing Home Diversion Program for non-Medicaid eligible individuals. Accordingly, to be effective, a "Single-Entry-Point" system need to be integrated, in some manner, with the process that is used by the state to determine a person's eligibility for Medicaid long-term care, and perform, at a minimum, the following functions for all those programs:

- Screening individuals to identify those most likely to benefit from the program, including performing preadmission nursing home screening which is a key component of any well developed system of long-term care;
- Assessing the needs of the targeted individuals;
- Working with the individual and their caregivers to develop service plans;
- Linking consumers to needed services.
- Monitor and follow-up with the individuals being served to ensure services are provided and needs are being met.

Single-Entry-Point systems that are integrated, in some manner, with the process to provide streamlined access to all publicly funded long-term care programs can enable policy makers and program administrators to more effectively respond to individual needs, address system problems, and limit the unnecessary use of high-cost services, including institutional care.[1] The AoA/CMS funded Aging and Disability Resource Centers (ADRC) Program includes a "single point of entry" component that covers all publicly supported long-term care programs. For more detailed information on the components of a fully functional single point of entry system, additional information is located on the Nursing Home Diversion Modernization Grant Announcement Resource Page.

B. Infrastructure to Support Consumer-directed Service Approaches

The reauthorized OAA supports the use of consumer directed models as an important element of a Nursing Home Diversion Program. For example, the Cash & Counseling model requires state and local programs to have the capacity to offer consumers the option of managing their own budgets, hiring their own workers, and purchasing necessary goods and services. This includes fiscal management services and specialized care managers or support brokers. Fiscal management services involve payroll functions including paying taxes and insurance for the workers hired by consumers participating in the program. Support brokers are specially trained to counsel and assist consumers in directing their own care. Some of the functions of the support broker and/or fiscal management services include:

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[1] The Lewin Group (2006), The Aging and Disability Resource Center (ADRC) Initiative Interim Outcomes Report. www.adrc-tae.org.

- Training and assisting participants/representatives on recruiting, hiring, training, managing, evaluating and dismissing workers;
- Assisting participant/representative in developing an individual back-up plan;
- Processing payroll for directly hired workers in accordance with Federal, State and local tax, labor and worker compensation laws for domestic service employees and government or vendor fiscal/employer agents operating under Section 3504 of the IRS code[2]; and,
- Processing and making payments for goods and services in accordance with the participant's approved spending plan.

A full description of the operational systems and supports that a state needs to offer Cash and Counseling can be found on the website of the National Program Office for the Cash and Counseling Program at www.cashandcounseling.org. To the extent possible, a Nursing Home Diversion Program that chooses to use a Cash and Counseling program, should build on any existing Cash and Counseling program, including the infrastructures they developed for carrying out the necessary fiscal management and support broker functions.

More information on consumer direction can be found on http://www.hcbs.org and on the Nursing Home Diversion Modernization Grant Announcement Resource Page

C. Quality Assurance

Any effective long-term care program must have a well defined quality assurance program. Nursing Home Diversion Programs should adopt the CMS Quality Framework, or a similar quality assurance program, as the basis for development of the quality assurance component of their Programs. A well developed quality assurance program enhances a state's capacity to determine if its long-term programs are operating as they were designed, and that the critical quality assurance processes of discovery, remediation, and systems improvement occur in a structured and routine manner.

Quality can assume several dimensions in community-based systems. The basic measures included in the CMS Quality Framework are:

- Participant access to services;
- Participant-centered service planning and delivery;
- Provider capacity and capabilities;
- Participant safeguards;
- Participant rights and responsibilities;
- Participant outcomes and satisfaction; and,
- Systems performance.

A system of continuous quality improvement - remediation and systems improvement - results from examining and analyzing data to determine the meaning and significance for the programs operation. This includes sharing information with program administrators

[2] Oregon is the exception to this, for historical reasons.

with responsibility and authority for program quality and interventions necessary to affect program improvements, using the information as a management tool to identify issues that need attention and remediation, and using subsequent measurements to gauge whether their interventions were successful or whether additional changes are necessary.

Quality monitoring, assessment and improvement activities in consumer-directed systems must involve consumer evaluation and must be focused on using data to enhance program quality. Quality monitoring systems might include complaint hotlines and program performance indicators. Quality assessment and improvement activities should involve mechanisms for stakeholder input and program self-assessment.

Information on the CMS Quality Framework can be found at: http://www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf. In addition, "A Guide to Quality in Consumer-directed Services" and other information on quality in consumer-directed systems can be found at http://www.cashandcounseling.org/index.html and on the Nursing Home Diversion Modernization Grant Announcement Resource Page.

D. Performance Measurement and Evaluation

A state's Nursing Home Diversion Program must include a performance measurement program that can be used to continually track and evaluate the program's performance in achieving its goals and objectives. States must identify the relevant outcome and process evaluation factors they plan to use for their nursing home diversion program. At a minimum, states must plan for performance measurement and evaluation that includes the following factors:

- Change in consumer well being and quality of life;
- Numbers of consumers diverted from nursing home care;
- Numbers of consumers diverted from spending down to Medicaid;
- Documentation of cost-savings (or cost-neutrality) to public programs, including Medicaid, as compared to institutional care; and,
- Decrease in State's Medicaid nursing home utilization.

The Performance Indicators being used in the Cash and Counseling replication offer a good model for developing a performance measurement and evaluation program. This can be accessed at www.cashandcounseling.org or on the Nursing Home Diversion Modernization Grant Announcement Resource Page.

Attachment B

Instructions for completing the SF 424, Budget (SF 424A), Budget Narrative, and Other Required Forms

This section provides step-by-step instructions for completing the four (4) standard federal forms required as part of your grant application, including special instructions for completing Standard Budget Forms 424 and 424A. Standard Forms 424 and 424A are used for a wide variety of federal grant programs, and federal agencies have the discretion to require some or all of the information on these forms. AoA does not require all the information on these Standard Forms. Accordingly, please use the instructions below in lieu of the standard instructions attached to SF 424 and 424A to complete these forms. Please note that in FY 2006, a new version of the SF 424 is being used for new grants.

a. Standard Form 424

1. **Type of Submission:** (Required): Select one type of submission in accordance with agency instructions.
• Preapplication • Application • Changed/Corrected Application – If AoA requests, check if this submission is to change or correct a previously submitted application.

2. **Type of Application**: (Required) Select one type of application in accordance with agency instructions.
• New . • Continuation • Revision

3. **Date Received:** Leave this field blank.

4. **Applicant Identifier**: Leave this field blank

5a **Federal Entity Identifier**: Leave this field blank

5b. **Federal Award Identifier**: For new applications leave blank. For a continuation or revision to an existing award, enter the previously assigned Federal award (grant) number.

6. **Date Received by State:** Leave this field blank.

7. **State Application Identifier:** Leave this field blank.

8. **Applicant Information**: Enter the following in accordance with agency instructions:

a. Legal Name: (Required): Enter the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the Grants.gov website.

b. Employer/Taxpayer Number (EIN/TIN): (Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.

c. Organizational DUNS: (Required) Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov website.

d. Address: (Required) Enter the complete address including the county.

e. Organizational Unit: Enter the name of the primary organizational unit (and department or division, if applicable**)** that will undertake the project.

f. Name and contact information of person to be contacted on matters involving this application: Enter the name (First and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and email address (Required) of the person to contact on matters related to this application.

9. **Type of Applicant:** (Required) Select the applicant organization "type" from the following drop down list.
A. State Government B. County Government C. City or Township Government D. Special District Government E. Regional Organization F. U.S. Territory or Possession G. Independent School District H. Public/State Controlled Institution of Higher Education I. Indian/Native American Tribal Government (Federally Recognized) J. Indian/Native American Tribal Government (Other than Federally Recognized) K. Indian/Native American Tribally Designated Organization L. Public/Indian Housing Authority M. Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education) N. Nonprofit without 501C3 IRS Status (Other than Institution of Higher Education) O. Private Institution of Higher Education P. Individual Q. For-Profit Organization (Other than Small Business) R. Small Business S. Hispanic-serving Institution T. Historically Black Colleges and Universities (HBCUs) U. Tribally Controlled Colleges and Universities (TCCUs) V. Alaska Native and Native Hawaiian Serving Institutions W. Non-domestic (non-US) Entity X. Other (specify)

10. **Name Of Federal Agency**: (Required) Enter U.S. Administration on Aging

11. **Catalog Of Federal Domestic Assistance Number/Title:** The CFDA number can be found on page one of the Program Announcement.

12. **Funding Opportunity Number/Title:** (Required) The Funding Opportunity Number and title of the opportunity can be found on page one of the program announcement.

13. **Competition Identification Number/Title:** Leave this field blank.

14. **Areas Affected By Project:** List the largest political entity affected (cities, counties, state etc).

15. **Descriptive Title of Applicant's Project:** (Required) Enter a brief descriptive title of the project.

16. **Congressional Districts Of**: (Required) 16a. Enter the applicant's Congressional District, and 16b. Enter all district(s) affected by the program or project. Enter in the format: 2 characters State Abbreviation – 3 characters District Number, e.g., CA-005 for California 5th district, CA-012 for California 12th district, NC-103 for North Carolina's 103rd district. • If all congressional districts in a state are affected, enter "all" for the district number, e.g., MD-all for all congressional districts in Maryland. • If nationwide, i.e. all districts within all states are affected, enter US-all.

17. **Proposed Project Start and End Dates**: (Required) Enter the proposed start date and end date of the project.

18. **Estimated Funding:** (Required) Enter the amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines, as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses.

NOTE: Applicants should review cost sharing or matching principles contained in Subpart C of 45 CFR Part 74 or 45 CFR Part 92 before completing Item 18 and the Budget Information Sections A, B and C noted below.

All budget information entered under item 18 should cover the upcoming budget period. For sub-item 18a, enter the federal funds being requested. Sub-items 18b-18e is considered matching funds. The dollar amounts entered in sub-items 18b-18f must total at least 1/3rd of the amount of federal funds being requested (the amount in 18a). For a full explanation of AoA's match requirements, see the information in the box below. For sub-item 18f, enter only the amount, if any, that is going to be used as part of the required match.

There are two types of match: non-federal cash; and non-federal non-cash (i.e., in-kind). In general, costs borne by the applicant and cash contributions of any and all third parties involved in the project, including sub-grantees, contractors and consultants, are considered cash matching funds. Generally, most contributions from third parties will be non-cash (i.e., in-kind) matching funds. Examples of non-cash (in-kind) match include: volunteered time and use of facilities to hold meetings or conduct project activities.
NOTE: **Indirect charges** may only be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another federal agency; or (2) the applicant is a state or local government agency. State governments should enter the amount of indirect costs determined in accordance with DHHS requirements. **If indirect costs are to be included in the application, a copy of the approved indirect cost agreement must be included with the application.**

AOA's Match Requirement

Under this and other OAA programs, AoA will fund no more than 75 % of the **project's total cost**, which means the applicant must cover at least 25% of the **project's total cost** with non-federal resources. In other words, for every three (3) dollars received in federal funding, the applicant must contribute at least one (1) dollar in non-federal resources toward the project's total cost (i.e., the amount on line 18g.). This "three-to-one" ratio is reflected in the following formula which you can use to calculate your minimum required match:

$$\frac{\textbf{Federal Funds Requested (i.e., amount on line 15a)}}{\textbf{3}} = \textbf{Minimum Match Requirement}$$

For example, if you request $100,000 in federal funds, then your <u>minimum</u> match requirement is $100,000/3 or $33,333. In this example the **project's total cost** would be $133,333.

A **common error** applicants make is to match 25% of the federal share, rather than 25% of the project's total cost, so be sure to use one of the formulas above to calculate your match requirement.

If the required non-federal share is not met by a funded project, AoA will disallow any unmatched federal dollars.

19. **Is Application Subject to Review by State Under Executive Order 12372 Process?** Check c. Program is not covered by E.O. 12372

20. **Is the Applicant Delinquent on any Federal Debt?** (Required) This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

21. **Authorized Representative**: (Required) To be signed and dated by the authorized representative of the applicant organization. Enter the name (First and last name required) title (Required), telephone number (Required), fax number, and email address (Required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

b. Standard Form 424A

NOTE: Standard Form 424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this AoA program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. Unless otherwise indicated, the SF 424A should reflect a one year budget.

Section A - Budget Summary

Line 5: Leave columns (c) and (d) blank. Enter TOTAL federal costs in column (e) and total non-federal costs (including third party in-kind contributions and any program income to be used as part of the grantee match) in column (f). Enter the sum of columns (e) and (f) in column (g).

Section B - Budget Categories

Column 3: Enter the breakdown of how you plan to use the federal funds being requested by object class category (see instructions for each object class category below).

Column 4: Enter the breakdown of how you plan to use the non-federal share by object class category.

Column 5: Enter the total funds required for the project (the sum of Columns 3 and 4) by object class category.

Separate Budget Narrative/Justification Requirement

You must submit a separate budget narrative as part of your application. **A blank sample format (and one with examples) has been included in the attachments for your use in developing and presenting your Budget Narrative.** In your budget justification, you should include a breakdown of the budget which shows the costs for all of the object class categories noted in Section B, across three columns: federal; non-federal cash; and non-federal in-kind. The justification should fully explain and justify the costs in each of the major budget items for each of the object class categories, as described below. Third party in-kind contributions and program income designated as non-federal match contributions should be clearly identified and justified separately from the justification for the budget line items. The full budget justification should be included in the application immediately following the SF 424 forms. **The budget justification should provide a detailed breakdown of large dollar values.**

Line 6a: Personnel: Enter total costs of salaries and wages of applicant/grantee staff. Do not include the costs of consultants; consultant costs should be included under 6h - Other. In the Justification: Identify the project director, if known. Specify the key staff, their titles, brief summary of project related duties, and the percent of their time commitments to the project in the budget justification.

Line 6b: Fringe Benefits: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate. In the Justification: Provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement insurance, etc.

Line 6c: Travel: Enter total costs of out-of-town travel (travel requiring per diem) for staff of the project. Do not enter costs for consultant's travel - this should be included in line 6h. In the Justification: Include the total number of trips, destinations, purpose, length of stay, subsistence allowances and transportation costs (including mileage rates).

Line 6d: Equipment: Enter the total costs of all equipment to be acquired by the project. For all grantees, "equipment" is non-expendable tangible personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. If the item does not meet the $5,000 threshold, include it in your budget under Supplies, line 6e. In the Justification: Equipment to be purchased with federal funds must be justified as necessary to conduct project activities. The equipment must be used for project-related functions; the equipment, or a reasonable facsimile, must not be otherwise available to the applicant or its sub-grantees. The justification also must contain plans for the use or disposal of the equipment after the project ends.

Line 6e: Supplies: Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d. In the Justification: Provide general description of types of items included.

Line 6f: Contractual: Enter the total costs of all contracts, including (1) procurement contracts (except those, which belong on other lines such as equipment, supplies, etc.). Also include any contracts with organizations for the provision of technical assistance. Do not include payments to individuals on this line. In the Justification: Attach a list of contractors indicating the name of the organization, the purpose of the contract, and the estimated dollar amount. If the name of the contractor, scope of work, and estimated costs are not available or have not been negotiated, indicate when this information will be available. Whenever the applicant/grantee intends to delegate a substantial part (one-third, or more) of the project work to another agency, the applicant/grantee must provide a completed copy of Section B, Budget Categories for each contractor, along with supporting information and justifications.

Line 6g: Construction: Leave blank since construction is not an allowable cost under this AoA program.

Line 6h: Other: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (i.e. for project volunteers this is different from personnel fringe benefits); non-contractual fees and travel paid directly to *individual* consultants; local transportation (all travel which does not require per diem is considered local travel); postage; space and equipment rentals/lease; printing and publication; computer use; training and staff development costs (i.e. registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then rest assured this is where it belongs. In the Justification: Provide a reasonable explanation for items in this category. For individual consultants, explain the nature of services provided and the relation to activities in the work plan. Describe the types of activities for staff development costs.

Line 6i:Total Direct Charges: Show the totals of Lines 6a through 6h.

Line 6j: Indirect Charges: Enter the total amount of indirect charges (costs), if any. If no indirect costs are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another federal agency; or (2) the applicant is a state or local government agency.

Justification: State governments should enter the amount of indirect costs determined in accordance with DHHS requirements. An applicant that will charge indirect costs to the grant must enclose a copy of the current rate agreement. If the applicant organization is in the process of initially developing or renegotiating a rate, it should immediately upon notification that an award will be made, develop a tentative indirect cost rate proposal based on its most recently completed fiscal year in accordance with the principles set forth in the cognizant agency's guidelines for establishing indirect cost rates, and submit it to the cognizant agency. Applicants awaiting approval of their indirect cost proposals may also request indirect costs. It should be noted that when an indirect cost rate is requested, those costs included in the indirect cost pool should not also be charged as direct costs to the grant. Also, if the applicant is requesting a rate which is less than what is allowed under the program, the authorized representative of the applicant organization must submit a signed acknowledgement that the applicant is accepting a lower rate than allowed.

Line 6k: Total: Enter the total amounts of Lines 6i and 6j.

Line 7: Program Income: If program income is expected, but is not needed to achieve matching funds, do not include that portion here or on Item 15(f) of the Form 424 face sheet.

Section C - Non-Federal Resources

Line 12: Enter the amounts of non-Federal resources that will be used in carrying out the proposed project, by source (Applicant; State; Other) and enter the total amount in Column (e).

Section D - Forecasted Cash Needs - Not applicable.

Section E - Budget Estimate of Federal Funds Needed for Balance of the Project

Line 20: NOTE: Leave this line blank. Section E is relevant only for multi-year grant applications, where the project period is 24 months or longer. This section does not apply to grant awards where the project period is less than 17 months.

Section F - Other Budget Information

Line 22: Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final or fixed) to be in effect during the funding period, the base to which the rate is applied, and the total indirect costs. Include a copy of your current Indirect Cost Rate Agreement.

Line 23: Remarks: Provide any other comments deemed necessary.

c. Standard Form 424B - Assurances

This form contains assurances required of applicants under the discretionary funds programs administered by the Administration on Aging. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

d. Certification Regarding Lobbying

This form contains certifications that are required of the applicant organization regarding (a) lobbying; (b) debarment, suspension, and other responsibility matters; and (c) drug-free workplace requirements. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

e. Other Application Components

Survey on Ensuring Equal Opportunity for Applicants

The Office of Management and Budget (OMB) has approved an HHS form to collect information on the number of faith-based groups applying for a HHS grant. Non-profit organizations, excluding private universities, are asked to include a completed survey with their grant application packet. Attached you will find the OMB approved HHS "Survey on Ensuring Equal Opportunity for Applicants" form (Attachment G). Your help in this data collection process is greatly appreciated.

Proof of Non-Profit Status

Non-profit applicants must submit proof of non-profit status. Any of the following constitutes acceptable proof of such status:

A copy of a currently valid IRS tax exemption certificate.

A statement from a State taxing body, State attorney general, or other appropriate State official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.

A certified copy of the organization's certificate of incorporation or similar document that clearly establishes non-profit status.

Indirect Cost Agreement

Applicants that have included indirect costs in their budgets must include a copy of the current indirect cost rate agreement approved by the Department of Health and Human Services or another federal agency. This is optional for applicants that have not included indirect costs in their budgets.

Attachment C: Budget Justification, Page 1 – Sample Format with EXAMPLES

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	$40,000		$5,000	$45,000	Project Supervisor (name) = .3FTE @ $50,000/yr = $15,000 Project Director (name) = 1FTE @ $30,000 = $30,000
Fringe Benefits	$12,600	0	0	$12,600	Fringes on Supervisor and Director @ 28% of salary. FICA (7.65%) = $3,442 Health (12%) = $5,400 Dental (5%) = $2,250 Life (2%) = $ 900 Workers Comp Insurance (.75%) = $ 338 Unemployment Insurance (.6%) = $ 270
Travel	$3,000	0	$ 967	$3,967	Travel to Annual Grantee Meeting: Airfare: 1 RT x 2 people x $750/RT = $1,500 Lodging: 3 nights x 2 people x $100/night = $ 600 Per Diem: 4 days x 2 people x $40/day = $ 320 Out-of-Town Project Site Visits Car mileage: 3 trips x 2 people x 350 miles/trip x $ .365/mile = $ 767 Lodging: 3 trips x 2 people x 1 night/ trip x $50/night = $300 Per Diem: 3 trips x 2 people x 2days/trip x $40/day = $480

Attachment C: Budget Justification, Page 2 - Sample Format with EXAMPLES

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	*TOTAL*	Justification
Equipment	0	0	0	0	No equipment requested
Supplies	$1,500		$2,000	$3,500	Laptop computer for use in client intakes = $1,340 Consumable supplies (paper, pens, etc.) $100/mo x 12 months = $1,200 Copying $80/mo x 12 months = $ 960
Contractual	$200,000	$50,000	0	$250,000	Contracts to A,B,C direct service providers (name providers) adult day care contractor = $75,000 respite care contractor in home= $75,000 respite care contractor-NF = $50,000 personal care/companion provider = $50,000 See detailed budget justification for each provider (and then provide it!)

Attachment C: Budget Justification, Page 3 – Sample Format with EXAMPLES

Other	$10,000	$8,000	$19,800	$37,800	Local conference registration fee (name conference) = $ 200 Printing brochures (50,000 @ $ .05 ea) = $ 2,500 Video production = $19,800 Video Reproduction = $ 3,500 NF Respite Training Manual reproduction $3/manual x $2000 manuals = $ 6,000 Postage $150/mo x 12 months = $ 1,800 Caregiver Forum meeting room rentals $200/day x 12 forums = $ 2,400 Respite Training Scholarships = $1,600
Indirect Charges	0	0	0	0	None
TOTAL	$267,100	$58,000	$27,767	$352,267	

75% or less of Total Cost

(Federal $)

25% or more of Total Cost

(Required Match)

Attachment D: Budget Justification – Page 1 – Sample Format

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel					
Fringe Benefits					
Travel					
Equipment					

Attachment D: Budget Justification – Page 2 – Sample Format

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Supplies					
Contractual					
Other					
Indirect Charges					
TOTAL					

Attachment E: Project Work Plan, Page 1 – Sample Format

Goal:														
Measurable Outcome(s):														
Major Objectives	**Key Tasks**	**Lead Person**	**Timeframe (Start and End Date by Month)**											
			1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
1.														
2.														

Attachment E: Project Work Plan, Page 2 – Sample Format

Major Objectives	Key Tasks	Lead Person	Timeframe (Start and End Date by Month)											
			1	2	3	4	5	6	7	8	9	10	11	12
3.														
4.														

Attachment E: Project Work Plan, Page 3 – Sample Format

Major Objectives	Key Tasks	Lead Person	Timeframe (Start and End Date by Month)											
			1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
5.														
6.														

NOTE: Please do note infer from this sample format that your work plan must have 6 major objectives. If you need more pages, simply repeat this format on additional pages.

Attachment F

Instructions for Completing the Project Summary/Abstract

- All applications for grant funding must include a Summary/Abstract that concisely describes the proposed project. It should be written for the general public.
- To ensure uniformity, please limit the length to no more than 265 words on a single page with a font size of not less than 11, doubled-spaced.
- The abstract must include the project's goal(s), objectives, overall approach (including target population and significant partnerships), anticipated outcomes, products, and duration. The following are very simple descriptions of these terms, and a sample Compendium abstract.

  Goal(s) – broad, overall purpose, usually in a mission statement, i.e. what you want to do, where you want to be

  Objective(s) – narrow, more specific, identifiable or measurable steps toward a goal. Part of the planning process or sequence (the "how"). Specific performances which will result in the attainment of a goal.

  Outcomes - measurable results of a project. Positive benefits or negative changes, or measurable characteristics that occur as a result of an organization's or program's activities. (outcomes are the end-point)

  Products – materials, deliverables.

- A model abstract/summary is provided below:

The grantee, Okoboji University, supports this three year Dementia Disease demonstration (DD) project in collaboration with the local Alzheimer's Association and related Dementias groups. The goal of the project is to provide comprehensive, coordinated care to individuals with memory concerns and to their caregivers. The approach is to expand the services and to integrate the bio-psycho-social aspects of care. The objectives are: 1) to provide dementia specific care, i.e., care management fully integrated into the services provided; 2) to train staff, students and volunteers; 3) to establish a system infrastructure to support services to individuals with early stage dementia and to their caregivers; 4) to develop linkages with community agencies; 5) to expand the assessment and intervention services; 6) to evaluate the impact of the added services; 7) to disseminate project information. The expected outcomes of this DD project are: patients will maintain as high a level of mental function and physical functions (thru Yoga) as possible; caregivers will increase ability to cope with changes; and pre and post – project patient evaluation will reflect positive results from expanded and integrated services. The products from this project are: a final report, including evaluation results; a website; articles for publication; data on driver assessment and in-home cognitive retraining; abstracts for national conferences.

ATTACHMENT G

Survey on Ensuring Equal Opportunity for Applicants

OMB No. 1890-0014 Exp. 1/131/2006

Purpose: The Federal government is committed to ensuring that all qualified applicants, small or large, non-religious or faith-based, have an equal opportunity to compete for Federal funding. In order for us to better understand the population of applicants for Federal funds, we are asking nonprofit private organizations (not including private universities) to fill out this survey.

Upon receipt, the survey will be separated from the application. Information provided on the survey will not be considered in any way in making funding decisions and will not be included in the Federal grants database. While your help in this data collection process is greatly appreciated, completion of this survey is voluntary.

Instructions for Submitting the Survey: If you are applying using a hard copy application, please place the completed survey in an envelope labeled "Applicant Survey." Seal the envelope and include it along with your application package. If you are applying electronically, please submit this survey along with your application.

Applicant's (Organization) Name: ______________________________

Applicant's DUNS Number: ______________________________

Grant Name: ______________________________**CFDA Number:** ______________

1. Does the applicant have 501(c)(3) status?

   ☐ Yes ☐ No

2. How many full-time equivalent employees does the applicant have? *(Check only one box).*

   ☐ 3 or Fewer ☐ 15-50
   ☐ 4-5 ☐ 51-100
   ☐ 6-14 ☐ over 100

3. What is the size of the applicant's annual budget?

   (Check only one box.)

   ☐ Less Than $150,000
   ☐ $150,000 - $299,999
   ☐ $300,000 - $499,999
   ☐ $500,000 - $999,999
   ☐ $1,000,000 - $4,999,999
   ☐,000,000 or more

4. Is the applicant a faith-based/religious organization?

   ☐ Yes ☐ No

5. Is the applicant a non-religious community-based organization?

   ☐ Yes ☐ No

6. Is the applicant an intermediary that will manage the grant on behalf of other organizations?

   ☐ Yes ☐ No

7. Has the applicant ever received a government grant or contract (Federal, State, or local)?

   ☐ Yes ☐ No

8. Is the applicant a local affiliate of a national organization?

   ☐ Yes ☐ No

Survey Instructions on Ensuring Equal Opportunity for Applicants

Provide the applicant's (organization) name and DUNS number and the grant name and CFDA number.

1. 501(c)(3) status is a legal designation provided on application to the Internal Revenue Service by eligible organizations. Some grant programs may require nonprofit applicants to have 501(c)(3) status. Other grant programs do not.

2. For example, two part-time employees who each work half-time equal one full-time equivalent employee. If the applicant is a local affiliate of a national organization, the responses to survey questions 2 and 3 should reflect the staff and budget size of the local affiliate.

3. Annual budget means the amount of money your organization spends each year on all of its activities.

4. Self-identify.

5. An organization is considered a community-based organization if its headquarters/service location shares the same zip code as the clients you serve.

6. An "intermediary" is an organization that enables a group of small organizations to receive and manage government funds by administering the grant on their behalf.

7. Self-explanatory.

8. Self-explanatory.

Paperwork Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1890-0014. The time required to complete this information collection is estimated to average five (5) minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. **If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:** U.S. Department of Education, Washington, D.C. 2202-4651.

If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Joyce I. Mays, Application Control Center, U.S. Department of Education, 7th and D Streets, SW, ROB-3, Room 3671, Washington, D.C. 20202-4725

OMB No. 1890-0014 Exp. 1/31/2006

Attachment H:

Estimated Number of Eligible Individuals for Nursing Home Diversion by State[3]

Alabama	3,846	Montana	1,020
Alaska	219	Nebraska	1,744
Arizona	5,850	Nevada	1,849
Arkansas	2,576	New Hampshire	1,124
California	25,829	New Jersey	7,971
Colorado	3,378	New Mexico	1,627
Connecticut	3,637	New York	16,583
Delaware	854	North Carolina	7,101
District of Columbia	289	North Dakota	661
Florida	22,425	Ohio	12,108
Georgia	5,218	Oklahoma	3,256
Hawaii	1,069	Oregon	3,330
Idaho	1,166	Pennsylvania	14,844
Illinois	11,121	Rhode Island	1,102
Indiana	6,160	South Carolina	3,432
Iowa	3,606	South Dakota	759
Kansas	2,836	Tennessee	4,911
Kentucky	3,456	Texas	15,080
Louisiana	3,350	Utah	1,623
Maine	1,467	Vermont	566
Maryland	3,949	Virginia	5,258
Massachusetts	6,219	Washington	5,005
Michigan	9,904	West Virginia	2,119
Minnesota	4,580	Wisconsin	5,741
Mississippi	2,032	Wyoming	500
Missouri	5,651		

There will be an estimated 260,000 total potential eligible individuals in 2009. Individuals with two or more impairments with activities of daily living and income less than 300% supplemental security income (SSI) level ($22,932 for a single individual and $34,416 for a married individual in 2008) and financial assets above $2,000 and below $25,000.[4]

[3] Source: The Lewin Group, Inc. estimates based on the 1996 Panel of the Survey of Income and Program Participation, Wave 11 and 12 Topical modules. Due to a lack of state specific data, the potential eligible individuals in each state are allocated based on the state's relative share of the total US population age 75+ between 1.5 to 3.0 times poverty.

[4] Source: The Lewin Group, Inc. estimates based on the 1996 Panel of the Survey of Income and Program Participation, Wave 11 and 12 Topical modules.

Attachment I:
Special Opportunity To Serve Veterans
Veteran's Directed Home and Community Based Service Program Option

The Veterans Health Administration Intent

As a special component of the AoA NHDM Grant Announcement, the Veterans Health Administration is providing an additional opportunity to State Units on Aging (SUAs) and their Area Agency on Aging (AAAs) pilot sites to serve veterans at risk of nursing home placement.

The Veterans Health Administration is seeking to offer the Veteran's Directed Home and Community Based Service Program (VDHCBS) in up to 12 Veteran Integrated Service Networks (VISN's) and plans to invest approximately $3 million to serve veterans at risk of institutionalization.

SUAs interested in this special opportunity should submit an additional application titled, "Attachment I: VDHCBS Program Option Application" along with their NHDM grant application. Additional details regarding the application requirements are listed in "VDHCBS Application Process".

The Veterans Health Administration will directly purchase services from State Units on Aging and/or local Area Agencies on Aging for the VDHCBS program. Service funding will be provided by the local VA Medical Centers to State Units on Aging or their selected AAA pilot sites based on the number of veterans that will be enrolled in the VDHCBS and the estimated monthly budget for services for each enrolled veteran.

The Veteran's Directed Home and Community Based Service Program

The Veteran's Directed Home and Community Based Service Program (VDHCBS) is a program that serves veterans of any age that are at risk of nursing home placement and their family caregivers. The VDHCBS provides veterans the opportunity to receive home and community based services that enable the veterans to continue to live in their homes and communities.

Collaboration Between U.S. Veterans Health Administration and U.S. Administration on Aging

As directed by the President and Congress, through the reauthorization of the Older American's Act in 2006, the U.S. Administration on Aging (AoA), State Units on Aging, Area Agencies on Aging, ADRC's and aging service providers collectively known as "the Aging Network" are building an integrated home and community based long term care delivery system to serve the nation. Instead of duplicating effort and resources, the Veterans Health Administration is interested in serving veterans through the Aging Network's integrated home and community based long term care delivery system.

Who is Eligible to Apply for the VDHCBS Opportunity?

State Units on Aging that apply for the NHDM grant are eligible to also apply to deliver the Veteran's Directed Home and Community Based Service Program Option. **The VDHCBS Program Option application shall be submitted along with the NHDM grant application.**

Who May Receive VDHCBS Awards?

NHDM grant applicants that are awarded AoA NHDM grants **and** submitted a complete Veteran's Directed Home and Community Based Service Program Option application along with their NHDM grant application.

What is the Aging Network's Role in the deliver of the VDHCBS Program?

State Units on Aging and their selected AAA pilot sites will conduct assessments to determine if the veteran is at risk of institutionalization, work with the veteran and their family caregiver to develop service plans, provide consumer directed models of care, arrange services and provide case management to veterans and their family caregivers in partnership with their local VA Medical Center(s). Service funding will be provided by the local VA Medical Centers to State Units on Aging or their selected AAA pilot sites based on the number of veterans that will be enrolled in the VDHCBS and the estimated monthly budget for services for each enrolled veteran.

VDHCBS Application Process:

To apply, the NHDM grant application must contain an "Attachment I: VDHCBS Program Option Application". The application shall include a brief narrative, a letter of commitment from the local VA Medical Center and letters of commitment from the State Unit on Aging and Area Agencies on Aging involved in the delivery of the VDHCBS program.

The letter of commitment from the local VA Medical Center at a minimum should include:

a. The projected number of veterans that will be served through the VDHCBS program throughout the 18 month NHDM grant period.
b. The "not to exceed" estimated monthly budget for services for each enrolled veteran.

The proposal will include a brief narrative of the planned intervention and partnership that the State Unit on Aging, selected AAA pilot site(s), and VA Medical Center(s) will employ.

The narrative at a minimum is to include:

a. Definition of service area
b. Description of the system that will be used to serve veterans and their family caregivers including targeting, assessment, service planning, services that will be provided,
c. A statement that the same functional targeting criteria used in the NHDM grant program will be used to conduct assessments to determine veterans' risk of nursing home placement.
d. Description of consumer-directed service model to be used (e.g. Cash and Counseling)

e. Proposed range for monthly client budgets, including a "not-to-exceed" threshold (e.g.. the threshold could be based on local data or the state's TBI waiver or aged/disability waiver cost maximum)
f. Number of estimated veterans to be served over 18 month NHDM grant period
g. Estimated administrative costs to deliver the program

The letter(s) of commitment from the State Unit on Aging and/or selected AAA pilot site(s), at a minimum is to include:

a. The projected number of veterans that will be served through the VDHCBS program throughout the 18 month NHDM grant period.
b. The "not to exceed" estimated monthly budget(s) for services for each enrolled veteran.
c. The projected timeframe from the point of a finalized Arrangement to enrollment of veterans into the VDHCBS and initiation of services.
d. Definition of the service area.
e. The method by which the VA Medical Center and the Aging Network will regularly communicate regarding the status of the program.

The "Attachment I: VDHCBS Program Option Application" required to apply for this option will <u>not</u> be counted as part of the grant Project Narrative for purposes of the 20-page limit.

<u>VDHCBS Option Award:</u>

Applicant's eligibility and receipt of an award from the VHA for this option is dependent upon approval of their AoA NHDM grant application. The VDHCBS Option awards will be made no later than September 30, 2008. At the time a Notice of Award is made by AoA for a NHDM grant to an NHDM applicant that also applies for this option, the VHA in partnership with AoA will make contact with all committed parties as demonstrated by the letters of support, to discuss and establish the details of their proposal for partnership and to enable them to finalize arrangements between the local VA Medical Center(s) and the State Unit on Aging or local AAA pilot site(s).

VHA reserves the right to offer and negotiate a funding level that differs from the requested amount for this option. VHA actual obligations will be based on the number of veterans that will be enrolled in VDHCBS and the estimated monthly budget for services for each enrolled veteran.

On Thursday July 31, additional guidance regarding what details applicants should include in letters of support was provided by the VHA to the VHA Network due to a number of concerns and misunderstandings that both VHA and SUA/AAA organizations have brought to bear regarding the VDHCBS opportunity and the process to apply for this opportunity. Following is the guidance provided:

Geriatrics and Extended Care
Veterans Directed Home and Community Based Care
Updated Information Prior to State Units on Aging Bid For AOA Nursing Home Diversion Grant

Letter of Support

A number of VISNs/VAMCs have been approached by State Units or Area Agencies on Aging, seeking letters of support for their application for the Administration on Aging Nursing Home Diversion Grant. (See e-mail package of 3 July 2008). These requests are expected and, whenever possible, should be considered in a positive light. Nineteen states have indicated an interest in pursuing a "veteran focus" as part of their grant application.

GEC sees much potential in Veteran Directed H&CBC. It should improve access to LTC services, keep veterans at home and avoid nursing home admission, provide greater choice for veterans and their families in services and providers, strengthen services and access for rural veterans (in some states), provide an opportunity for more comprehensive H&CBC services for TBI veterans.

In a letter of support, VISNs/VAMCs might include:

1) General Statement reflecting a positive sense of government agencies working together for the benefit of veterans;

2) More Specific Statement reflecting on the potential benefits of Veteran Directed H&CBC, as noted above; and,

3) Estimate of VA referrals or workload to such a program, assuming the agencies can agree on details.

The estimate is just that, an estimate. VAMC staff may have some insight as to how attractive this approach to home care might be in the veteran population. Or staff may rely on the experience in adding a new H&CBC provider. Or staff may use a percentage of FY 2008 workload, e.g., 10%, as the estimate. Nationally, GEC projected 10-25 ADC per VAMC. Frankly, it is not clear how desirable this program might be.

GEC does not recommend estimating expenditures in the letter of support. It is too early in the process and there are too many unknowns. There will be quality pricing information for those VAMCs in states with successful bids, once the service packages are better defined.

Grant applications are due to the Administration on Aging on 14 August 2008. Grant awards are expected in early September. Work on VA agreements with State Units/Area Agencies will begin at that time.

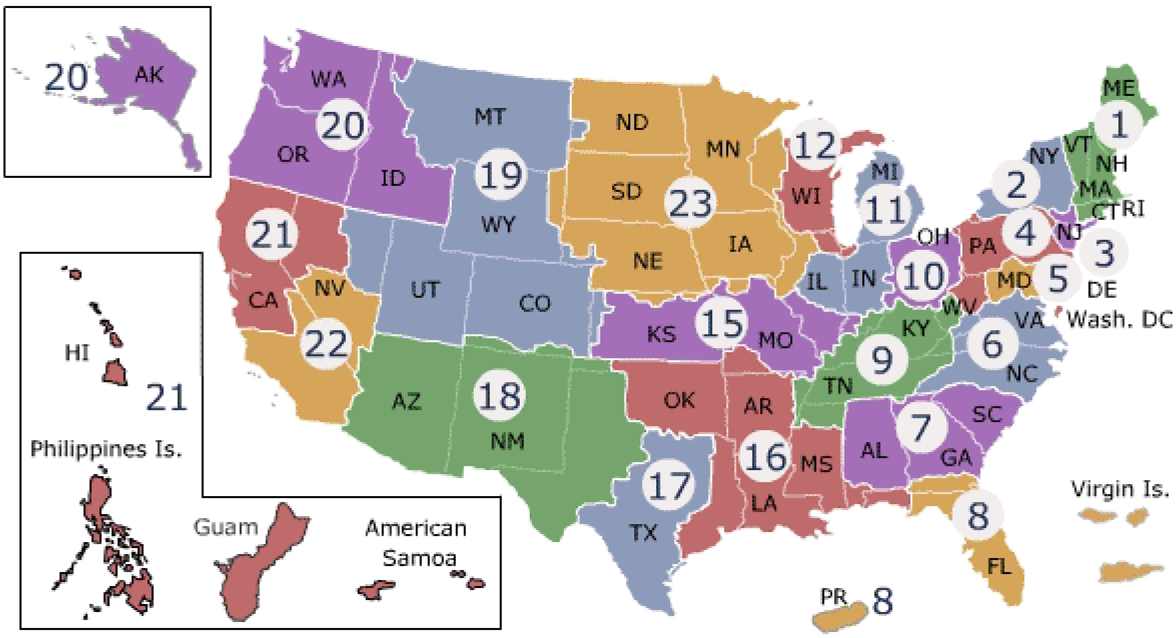
Related Items of Interest

Consumer Directed Care shows good potential for lowering unit costs as well as overall long-term care expenditures. GEC is planning to propose incentives in the workload count for the H&CBC measure in support of this initiative.

A message from 10N on this subject is expected in the next few days. If you have any questions, please feel free to contact Patrick Brady or Daniel Schoeps in Geriatrics and Extended Care.

Attachment J:
"Veterans Integrated Service Network (VISN) Map"

Veterans Health Administration



VISN 1: VA New England Healthcare System
VISN 2: VA Healthcare Network Upstate New York
VISN 3: VA NY/NJ Veterans Healthcare Network
VISN 4: VA Healthcare - VISN 4
VISN 5: VA Capitol Health Care Network
VISN 6: VA Mid-Atlantic Health Care Network
VISN7: VA Southeast Network
VISN 8: VA Sunshine Healthcare Network
VISN 9: VA Mid South Healthcare Network
VISN 10: VA Healthcare System of Ohio
VISN 11: Veterans In Partnership
VISN 12: VA Great Lakes Health Care System
VISN 15: VA Heartland Network
VISN 16: South Central VA Health Care Network
VISN 17: VA Heart of Texas Health Care Network
VISN 18: VA Southwest Health Care Network
VISN 19: Rocky Mountain Network
VISN 20: Northwest Network
VISN 21: Sierra Pacific Network
VISN 22: Desert Pacific Healthcare Network
VISN 23: VA Midwest Health Care Network

<u>Attachment K:</u>

NURSING HOME DIVERSION MODERNIZATION GRANT PROGRAM (HHS-2008-AoA-CD-0814)

COOPERATIVE AGREEMENT

Consistent with the Federal Grant and Cooperative Agreement Act of 1977 (P.L. 95-224), the **(Grantee name)**, also herein referred to as the **grantee**, has received a Notice of Award to establish a Cooperative Agreement between the Administration on Aging (AoA) and the **grantee**. This Cooperative Agreement, whose terms are described below, provides for the substantial involvement and collaboration of AoA in activities the recipient organization will complete in accordance with the provisions of the approved grant award.

Grantee Responsibilities
As proposed in its approved application, the **grantee** agrees to carry out the objectives and activities of the project announced as the Nursing Home Diversion Modernization Grants Program. The **grantee** will design and implement a Nursing Home Diversion Program in accordance with the following conditions described in the *Nursing Home Diversion Modernization Grants* Program Announcement:

> The **grantee** will partner with one or more Area Agencies on Aging (AAA), and work in collaboration with aging service provider organizations and other long-term care stakeholders, to modernize existing efforts to help individuals who are not eligible for Medicaid to avoid unnecessary nursing home placement and spend down to Medicaid.

Projects to be funded under this Announcement must:

1. No later than the end of the 9th month of the project period, have at least one local project up and running and delivering services to the high-risk individuals targeted under this Announcement in a way that:

A. Uses a Single-entry-point (SEP) program to identify individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down to Medicaid,
B. Uses formal protocols and other tools across, and by, key stakeholder organizations (e.g., SEP, aging services providers, AAAs, hospitals, nursing homes, Centers for Independent Living, Veterans Health Administration, etc.) for making client referrals, prioritizing clients, authorizing services, and following-up with clients to ensure that the local project can rapidly provide home and community-based services and supports to the high –risk individuals who are identified by the Single-entry-point program, and that the services for these individuals can be quickly adjusted as necessary as their needs change.

C. Has in place formal SUA and AAA policies which are in effect-at least in the PSA(s) where the local project(s) are operating—that support the investment of some OAA dollars to serve the high-risk individuals who are targeted under this Announcement.

3. No later than the end of the 15th month of the project period, in addition to the items in #1, be providing a full range of service options to the individuals who are targeted under this Announcement, as well as giving them the option to use consumer-directed models.

4. Projects funded under this Announcement must be able to monitor and follow-up with the individuals they are serving to ensure that the necessary services are being rapidly authorized and initiated, that client and family needs are being met, and that necessary adjustments in services are rapidly being made as the needs of the client and/or family caregiver change.

5. Projects must also be able to track individual clients and be able to document and report on the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down.

6. Agree to work with AoA, the NHDM Technical Assistance Center, and the other NHDM grantees to identify and collect common measures.

7. Fully coordinate the project(s) with other state-administered long-term care programs and rebalancing efforts.

8. Provide home and community-based services to significant numbers of clients in the target population in one or more geographic areas of the state over the 18 months of the grant period.

The **grantee** agrees that activities under this initiative will not duplicate activities funded under other resources.

AoA Responsibilities

The Administration on Aging agrees to work cooperatively in the development and execution of the activities of the project as follows:

1.) AoA Project Officer will perform the day-to-day Federal responsibilities of managing the Nursing Home Diversion Modernization Grants Program.

2.) AoA and the **grantee** will work cooperatively to clarify the programmatic and budgetary issues to be addressed by the project. Based on these negotiations, the **grantee** will revise the project work plan detailing expectations for major activities and products during the 18 month grant. The work plan will include key tasks, timelines, and staff assignments. AoA or the **grantee** can propose a revision in the final work plan at any time. Any changes in the final work plan will require agreement of both parties.

3.) AoA will assist the **grantee** project leadership in understanding the policy concerns and/or priorities of AoA by conducting periodic briefings and by carrying out ongoing consultations.

4.) AoA will work with the **grantee** to ensure that the minimum requirements of the grant are met. Particular attention will be paid to the development of flexible service options and targeting criteria for identifying individuals at risk of institutionalization and spend down to Medicaid, and the use of Single Entry Point systems.

5.) AoA will work with the **grantee** on the development and implementation of evaluation and quality assurance systems in an effort to ensure consistency with program goals and the activities of other NHDM grantees.

6.) AoA will designate technical assistance providers to design and implement, in cooperation with AoA**,** technical assistance to support grantee activities.

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The grant period for this project is up to 18 months beginning no later than **September 30, 2008**.

Requests to modify or amend this Cooperative Agreement may be made at any time by AoA or the grantee. Any modifications and/or amendments shall be effective upon the mutual agreement of both parties.

Attachment L

FY 2008 Nursing Home Diversion Modernization Grants
Including a Special Funding Opportunity to Serve Veterans

QUESTIONS AND ANSWERS DOCUMENT

The Administration on Aging held an Applicant Teleconference call on Thursday, July 10. Based on that call and others questions received by AoA regarding this grant opportunity, a "Frequently Asked Questions Document" has been created and posted at: http://www.aoa.gov/prof/Nursing/docs/NHDMG_FAQ_2008.doc. This document will be updated on a regular basis so we invite you to visit this link regularly. The last date the document has been updated will be noted at the top of the opening page of the document.