

Application for Federal Assistance SF-424

Version 02

*** 1. Type of Submission:**

- Preapplication
- Application
- Changed/Corrected Application

*** 2. Type of Application:**

- New
- Continuation
- Revision

*** If Revision, select appropriate letter(s):**

*** Other (Specify)**

*** 3. Date Received:**

08/16/2007

4. Applicant Identifier:

5a. Federal Entity Identifier:

*** 5b. Federal Award Identifier:**

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*** a. Legal Name:** National Church Residences of Toledo

*** b. Employer/Taxpayer Identification Number (EIN/TIN):**

311037318

*** c. Organizational DUNS:**

d. Address:

*** Street1:** 2101 Arlington Avenue

Street2:

*** City:** Toledo

County: Lucas County

*** State:** OH: Ohio

Province:

*** Country:** USA: UNITED STATES

*** Zip / Postal Code:** 43609-1984

e. Organizational Unit:

Department Name:

Arlington By The Lake

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

Mrs.

*** First Name:**

Teresa

Middle Name:

*** Last Name:**

Allton

Suffix:

Title: Vice President of Support Services

Organizational Affiliation:

National Church Residences, 2335 N. Bank Drive, Columbus, OH

*** Telephone Number:**

Fax Number:

*** Email:**

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9. Type of Applicant 1: Select Applicant Type:

M: Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

US Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.191

CFDA Title:

Multifamily Housing Service Coordinators

*** 12. Funding Opportunity Number:**

FR-5100-N-03

* Title:

Service Coordinators in Multifamily Housing

13. Competition Identification Number:

SCMH-03

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Toledo, Lucas, Ohio

*** 15. Descriptive Title of Applicant's Project:**

Section 202

Attach supporting documents as specified in agency instructions.

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16. Congressional Districts Of:

* a. Applicant

* b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

* a. Start Date:

* b. End Date:

18. Estimated Funding (\$):

* a. Federal	<input type="text" value="106,567.26"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="106,567.26"/>

* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?

- a. This application was made available to the State under the Executive Order 12372 Process for review on
- b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- c. Program is not covered by E.O. 12372.

* 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)

- Yes
- No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name:

Middle Name:

* Last Name:

Suffix:

* Title:

* Telephone Number: Fax Number:

* Email:

* Signature of Authorized Representative: * Date Signed:

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Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

Application for Federal Assistance SF-424

Version 02

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

[Empty text input field]

Attachments

AdditionalCongressionalDistricts
File Name

Mime Type

AdditionalProjectTitle
File Name

Mime Type

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

Approved by OMB

0348-0046

<p>1. * Type of Federal Action:</p> <p><input type="checkbox"/> a. contract</p> <p><input checked="" type="checkbox"/> b. grant</p> <p><input type="checkbox"/> c. cooperative agreement</p> <p><input type="checkbox"/> d. loan</p> <p><input type="checkbox"/> e. loan guarantee</p> <p><input type="checkbox"/> f. loan insurance</p>	<p>2. * Status of Federal Action:</p> <p><input checked="" type="checkbox"/> a. bid/offer/application</p> <p><input type="checkbox"/> b. initial award</p> <p><input type="checkbox"/> c. post-award</p>	<p>3. * Report Type:</p> <p><input checked="" type="checkbox"/> a. initial filing</p> <p><input type="checkbox"/> b. material change</p> <p>For Material Change Only:</p> <p>year quarter</p> <p>date of last report</p>
<p>4. Name and Address of Reporting Entity:</p> <p><input checked="" type="checkbox"/> Prime <input type="checkbox"/> SubAwardee Tier if known:</p> <p>* Name: Arlington By The Lake</p> <p>* Address: 2101 Arlington</p> <p>Toledo</p> <p>OH: Ohio</p> <p>43609-1979</p> <p>Congressional District, if known: 9th</p>		<p>5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:</p>
<p>6. * Federal Department/Agency:</p> <p>US Dept. of Housing & Urban Dev.</p>	<p>7. * Federal Program Name/Description: Multifamily Housing Service Coordinators</p> <p>CFDA Number, if applicable: 14.191</p>	
<p>8. Federal Action Number, if known:</p>	<p>9. Award Amount, if known:</p> <p>\$106,567.26</p>	
<p>10. a. Name and Address of Lobbying Registrant (if individual, complete name):</p> <p>* Name: Not Applicable</p> <p>Not Applicable</p> <p>* Address: Not Applicable</p> <p>Not Applicable</p>	<p>b. Individual Performing Services (including address if different from No. 10a):</p> <p>* Name: Not Applicable</p> <p>Not Applicable</p> <p>* Address: Not Applicable</p> <p>Not Applicable</p>	
<p>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</p>		<p>* Signature: Teresa Allton</p> <p>* Name: Mr.</p> <p>Mark</p> <p>Ricketts</p>

	Title: Senior Vice President/Chief Operating Officer Telephone No. [REDACTED] Date: 06-16-2007
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

Public Burden Disclosure Statement

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

**Applicant/Recipient
Disclosure/Update Report**

U.S. Department of Housing
and Urban Development

OMB Approval No. 2510-0011
(exp. 12/31/2006)

Applicant/Recipient Information * Duns Number: [REDACTED] * Report Type: INITIAL

1. Applicant/Recipient Name, Address, and Phone (include area code):

* Applicant Name:

National Church Residences of Toledo

* Street1: 2101 Arlington Avenue

Street2: [REDACTED]

* City: Toledo

County: Lucas County

* State: OH: Ohio

* Zip Code: 43609-1984

* Country: USA: UNITED STATES

* Phone: [REDACTED]

2. Social Security Number or Employer ID Number: 311037318

* 3. HUD Program Name:

Multifamily Housing Service Coordinators

* 4. Amount of HUD Assistance Requested/Received: \$ 106,567.26

5. State the name and location (street address, City and State) of the project or activity:

* Project Name: Arlington By The Lake

* Street1: 2101 Arlington Avenue

Street2: [REDACTED]

* City: Toledo

County: Lucas County

* State: OH: Ohio

* Zip Code: 43609-1979

* Country: USA: UNITED STATES

Part I Threshold Determinations

* 1. Are you applying for assistance for a specific project or activity? These terms do not include formula grants, such as public housing operating subsidy or CDBG block grants. (For further information see 24 CFR Sec. 4.3).

* 2. Have you received or do you expect to receive assistance within the jurisdiction of the Department (HUD), involving the project or activity in this application, in excess of \$200,000 during this fiscal year (Oct. 1 - Sep. 30)? For further information, see 24 CFR Sec. 4.9

Yes No

Yes No

If you answered "No" to either question 1 or 2, **Stop!** You do not need to complete the remainder of this form.

However, you must sign the certification at the end of the report.

Part II Other Government Assistance Provided or Requested / Expected Sources and Use of Funds.

Such assistance includes, but is not limited to, any grant, loan, subsidy, guarantee, insurance, payment, credit, or tax benefit.

Department/State/Local Agency Name:

* Government Agency Name:

Government Agency Address:

* Street1:

Street2:

* City:

County:

* State:

* Zip Code:

* Country:

* Type of Assistance:

* Amount Requested/Provided: \$

* Expected Uses of the Funds:

Department/State/Local Agency Name:

* Government Agency Name:

Government Agency Address:

* Street1:

Street2:

* City:

County:

* State:

* Zip Code:

* Country:

* Type of Assistance:

* Amount Requested/Provided: \$

* Expected Uses of the Funds:

(Note: Use Additional pages if necessary.)

Part III Interested Parties. You must disclose:

1. All developers, contractors, or consultants involved in the application for the assistance or in the planning, development, or implementation of the project or activity and
2. any other person who has a financial interest in the project or activity for which the assistance is sought that exceeds \$50,000 or 10 percent of the assistance (whichever is lower).

Alphabetical list of all persons with a reportable financial interest in the project or activity (For individuals, give the last name first)	* Social Security No. or Employee ID No.	* Type of Participation in Project/Activity	* Financial Interest in Project/Activity (\$ and %)
			\$ _____ %
			\$ _____ %
			\$ _____ %
			\$ _____ %
			\$ _____ %

(Note: Use Additional pages if necessary.) _____

Certification

Warning: If you knowingly make a false statement on this form, you may be subject to civil or criminal penalties under Section 1001 of Title 18 of the United States Code. In addition, any person who knowingly and materially violates any required disclosures of information, including intentional non-disclosure, is subject to civil money penalty not to exceed \$10,000 for each violation. I certify that this information is true and complete.

* Signature:

Teresa Allton

* Date: (mm/dd/yyyy)

06/16/2007

Attachments

AdditionalInfo_attDataGroup0
File Name

Mime Type

AdditionalInfo1_attDataGroup0
File Name

Mime Type

Survey on Ensuring Equal Opportunity for Applicants

OMB NO. 1890-0014 EXP. 2/28/2009

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:

National Church Residences of Toledo

Applicant's DUNS Name:

Federal Program:

Service Coordinators in Multifamily Housing

CFDA Number:

14.191

- | | |
|--|--|
| 1. Has the applicant ever received a grant or contract from the Federal government?
<input checked="" type="radio"/> Yes <input type="radio"/> No | 5. Is the applicant a local affiliate of a national organization?
<input checked="" type="radio"/> Yes <input type="radio"/> No |
| 2. Is the applicant a faith-based organization?
<input checked="" type="radio"/> Yes <input type="radio"/> No | 6. How many full-time equivalent employees does the applicant have? (Check only one box).
<input type="radio"/> 3 or Fewer <input type="radio"/> 15 - 50
<input checked="" type="radio"/> 4 - 5 <input type="radio"/> 51 - 100
<input type="radio"/> 6 - 14 <input type="radio"/> Over 1000 |
| 3. Is the applicant a secular organization?
<input type="radio"/> Yes <input checked="" type="radio"/> No | 7. What is the size of the applicant's annual budget? (Check only one box.)
<input checked="" type="radio"/> Less Than \$150,000
<input type="radio"/> \$150,000 - \$299,999
<input type="radio"/> 300,000 - \$499,999
<input type="radio"/> 500,000 - \$999,999
<input type="radio"/> 1,000,000 - \$4,999,999
<input type="radio"/> 5,000,000 or more |
| 4. Does the applicant have 501(c)(3) status?
<input checked="" type="radio"/> Yes <input type="radio"/> No | |

Survey on Ensuring Equal Opportunity for Applicants

OMB NO. 1890-0014 EXP. 2/28/2009

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

1. Self-explanatory.

2. Self-identify.

3. Self-identify.

4. 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.

5. Self-explanatory.

6. 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.

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

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: The Agency Contact listed in this grant application package.

Attachments Form

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

- 1) Please attach Attachment 1 3073-SCMF-National_Church_Residenc Mime Type:
es_of_Toledo.zip application/x-zip-compressed
- 2) Please attach Attachment 2 7373-Arlington_by_the_Lake_ADL_Sum Mime Type:
mary.zip application/x-zip-compressed
- 3) Please attach Attachment 3 4633-Quality_Assurance_Narrative_200 Mime Type:
7.zip application/x-zip-compressed
- 4) Please attach Attachment 4 6686-Narrative_-_Plan_to_address_co Mime Type:
mmunity_resident_needs.zip application/x-zip-compressed
- 5) Please attach Attachment 5 4906-Arlington_by_the_Lake-SALARY_ Mime Type:
COMPARISON.zip application/x-zip-compressed
- 6) Please attach Attachment 6 6915-Arlington_by_the_Lake-_Salary_C. Mime Type:
omparison.zip application/x-zip-compressed
- 7) Please attach Attachment 7 0033-Arlington_by_the_lake_Bal._Sheet Mime Type:
.zip application/x-zip-compressed
- 8) Please attach Attachment 8 7795-Method_of_estimating_how_many Mime Type:
_Residents_of_the_development_are_fr application/x-zip-compressed
ail_or_at.zip
- 9) Please attach Attachment 9 9345-HUD-91186_National_Church_Re Mime Type:
sidences_of_Toledo_Budget.zip application/x-zip-compressed
- 10) Please attach Attachment 10 4323-Arlington_Office_Space_Question Mime Type:
naire.zip application/x-zip-compressed
- 11) Please attach Attachment 11 2632-RESIDUAL_RECEIPT_DOCUME Mime Type:
NTATION.zip application/x-zip-compressed
- 12) Please attach Attachment 12
- 13) Please attach Attachment 13
- 14) Please attach Attachment 14
- 15) Please attach Attachment 15

Facsimile Transmittal

1176820104 - 2038

U. S. Department of Housing and Urban Development
Office of Department Grants Management and Oversight

OMB Approval No. 2525-0118
exp. Date (04/30/2005)

* Name of Document Transmitting:

1. Applicant Information:

* Legal Name:
* Address:
* Street1:
Street2:
* City:
County:
* State:
* Zip Code: * Country:

2. Catalog of Federal Domestic Assistance Number:

* Organizational DUNS: CFDA No.:
Title:
Program Component:

3. Facsimile Contact Information:

Department:
Division:

4. Name and telephone number of person to be contacted on matters involving this facsimile.

Prefix: * First Name:
Middle Name:
* Last Name:
Suffix:
* Phone Number:
Fax Number:

* 5. Email:

* 6. What is your Transmittal? (Check one box per fax)

- a. Certification b. Document c. Match/Leverage Letter d. Other

* 7. How many pages (including cover) are being faxed?

OFFICE SPACE FOR A SERVICE COORDINATOR?

Property Manager's Name: [REDACTED]

Director: Nikki Brady

Property: Arlington By The Lake

- 1.) This property has adequate space for a Service Coordinator to perform his/her job in privacy. Yes No
- 2.) This property does not have space to create an office, but it does have space (such as an apartment) that could be leased out to a service coordinator for use as an office. Yes No
- 3.) We would have to create new space to provide a private office for a Service Coordinator. For example, we would have to add on to the building. Yes No
- 4.) We have some space but it would have to be renovated in some way. For example, we have a storage room or another unfinished section, which could be reconstructed to create adequate space. Yes No.
- 4.) If you answered yes to question # 4, please check the appropriate areas below:

The potential office space would need:

- Tear down walls
- Add drywall
- Add ventilation
- Add electricity, phone hook up
- Add door
- Paint, carpeting and window coverings

Please describe your thoughts on a potential office space:

The Service Coordinator will be setting her office up in what once was the craft room. Money for a desk, chairs and a filing cabinet are included in the budget.

What would you estimate the total cost to be to add an office space for the SC? N/A

(****If you estimate the cost of construction/renovation to be more than \$3000.00, you must obtain **three bids**. A copy of the bids needs to be turned in with your application.****)

Name of Property: Arlington by the Lake

RESIDUAL RECEIPT DOCUMENTATION:

This property has zero residual receipts

This property has [REDACTED] in its residual receipt account

This property has 50 (#) of Units.

50 (# Units) X [REDACTED] = [REDACTED] which must remain in the residual receipt account.

Therefore, this property will not be required to utilize any of their residual receipt funds.

The remaining balance is [REDACTED]. We will use the remainder of this money to fund the Service Coordinator program from May 2007 through December 2007. The money will be exhausted by 01/01/08. Therefore, this property must utilize \$ 0 residual receipt funds towards the service coordinator position.

Attached is this property's current Balance Sheet indicating their current residual receipt account status and bank statement (as applicable).

ACTIVITIES OF DAILY LIVING Assessment Analysis of Residents

Facility Name **Arlington by the Lake**
 Manager Name **[REDACTED]**

Date: **4/1/07**

of Units **50**
 # of Residents **52**

TOTAL NUMBER OF RESIDENTS WHO COULD BENEFIT FROM ASSISTANCE WITH:

Activity of Daily Living	Number	Percentage
EATING	19	37%
BATHING	16	31%
GROOMING	21	40%
DRESSING	10	19%
TRANSFERRING	15	29%
HOME MANAGEMENT	36	69%

ADL SUMMARY

of residents needing assistance with 3 or more ADL's:
 # of residents needing assistance with 1-2 ADL's:
 # of disabled residents

Number	Percentage	
17	32.69%	are FRAIL
17	32.69%	are At-Risk
4	7.69%	are Disabled
	73.08%	are FRAIL, AT RISK, and/or DISABLED



QUALITY ASSURANCE - PROGRAM NARRATIVE

This property will utilize National Church Residences (NCR) Quality Caring Program to provide Quality Assurance services. NCR provides professional Quality Assurance services for over 230 Service Coordinator programs throughout the United States and in Puerto Rico. NCR complies with the Quality Assurance provision that is outlined in the U.S. HUD Management Agent Handbook 4381.5 REV-2, CHG-2, Chapter Eight and Section 5.4 Quality Assurance of the SuperNOFA Application.

QUALIFICATIONS:

NCR has been committed to providing Service Coordinators in its' elderly housing since 1991, when the first Service Coordinator was hired. Over 10 million dollars has been invested in the development of a Resident Service Coordination program, including staff and training resources. NCR provides extensive training and social service support through its' Department of Support Services.

STAFF:

Vice President of Support Services [REDACTED] has a Bachelor's Degree in Social Work and is a state-licensed social work professional. [REDACTED] also has a Master's Degree in Healthcare Administration. [REDACTED] has 16 years of experience working with families and the elderly, and seven years experience implementing Service Coordinator programs. [REDACTED] previously was the Director of Operations at a healthcare system in Ohio and has multiple years of supervisory experience. [REDACTED] was Chair of the Board of Directors of the American Association of Service Coordinators (AASC) from [REDACTED]. In [REDACTED] received the AASC *Award of Excellence* and in [REDACTED] received the "*Excellence in Practice Award*" for supportive service programs for residents from the American Association of Homes and Services for the Aging (AAHSA).

Quality Assurance Program Manager [REDACTED] has a Bachelor's Degree and a Master's Degree in Social Work and is a state-licensed social work professional (LSW). [REDACTED] has multiple years of experience working with community assessments and evaluating social service programs and outcomes, and more than three years experience specifically managing service coordinators. [REDACTED] provides support to both NCR and non-NCR Service Coordination field staff. [REDACTED] oversees the Quality Assurance program, providing supervision to Quality Assurance Specialists and Family Specialists.

Quality Assurance Specialist [REDACTED] has a Bachelor's degree in Social Work and is a state-licensed social work professional (LSW). [REDACTED] has two years experience as a Service Coordinator at a low-income elderly property providing support services to over 150 elderly residents. [REDACTED] works with both NCR and non-NCR Service Coordination field staff and other Quality Assurance Specialists.

Quality Assurance Specialist [REDACTED] has a Bachelor's degree in Social Work and is a state-licensed social work professional (LSW). [REDACTED] has three years of experience as a Service Coordinator at a low-income elderly property providing support services to over 90 elderly residents. [REDACTED] works with NCR's Service Coordination field staff and other Quality Assurance Specialists.

Training Program Manager [REDACTED] has a Bachelor's degree in Social Work and is a state-licensed social work professional (LSW). [REDACTED] has over 19 years experience in case management, supervision of social service staff and implementing various support service programs. [REDACTED] provides training documentation oversight to assure that all service coordinators have met the HUD training requirements. [REDACTED] also works to provide specific training plans for service coordinators that may need assistance in specific clinical areas.



"QUALITY CARING" PROGRAM

NCR operates the "Quality Caring" program. The basis of the "Quality Caring" program is to provide each Service Coordinator at every facility with outcomes-based measurement tools. These tools, or monitors, provide statistically significant data that demonstrates the effectiveness of the Service Coordinator program. In turn, Service Coordinators become better at doing their jobs through learning and understanding the outcomes of this data. This allows the data to *work* for the Service Coordinators. And since the initiative solely focuses on improving the lives of the residents, the **outcomes** tell us how they are doing and how they can do it better.

Our years of experience providing Quality Assurance to Service Coordinators have shown that oversight of social service personnel is vital to the success of a quality program. Appropriate leadership facilitates cooperative relationships between residents, managers, outside service providers, and the Service Coordinator. The Quality Assurance Program Manager and the Quality Assurance Specialists provide the following Quality Assurance monitoring services at National Church Residences for every Service Coordinator.

National Church Residence's "Quality Caring" Quality Assurance Program currently provides Quality Assurance to 14 Property Management Companies across the country. This enhanced Quality Assurance program's quality, performance, and coaching methods have evolved since implementing the Continuous Quality Improvement model into this program over the past year.

The "Quality Caring" program consists of the following

- Compiled HUD Semi-Annual Performance Reports
- Semi-Annual Program Assessors
- Monthly On-Line Report review and feedback
- Semi-Annual Resident File Reviews
- Annual Resident Satisfaction Survey
- Annual Property Management Survey
- On-site visits (as requested for additional fees)
- Clinical assistance with resident issues (Monday – Friday / 8am – 5pm EST)

REPORTING / ACTIVITIES

Each Service Coordinator will receive two program evaluation reviews during the first year of the Service Coordinator programs operation and one review each successive year. In the first six months of a Service Coordinators program implementation, a file review will be conducted. At this time, a review of the monthly on-line reports will also be performed. Feedback will be provided to each Service Coordinator each month with regards to problems/issues related to monthly report submissions.

Annually, every Service Coordinator who participates in the Quality Caring program will be provided with an annual performance evaluation, called the "*Assessor*." The Assessor is a compilation of results of the following data: Semi-Annual File Reviews, Annual Resident Satisfaction Survey, Training, Policy Compliance, and monthly report submission. The Property Manager Survey is not apart of the Assessor, however Service Coordinators receive direct feedback. Points are allotted from each section of the Assessor in order to create one final score. This final score provides management a report that provides information on each Service Coordinator's work and provides a method for which management can determine and compare their individual Service Coordinator program to over 230 programs across the country. This Assessor will be submitted on a semi-annual basis and is submitted along with the Service Coordinator's Semi-Annual Performance Report to HUD.



Service Menu

Effective through December 31, 2007

The overall program rate is \$90/hour for the entire program for 36 hours of annual QA services. (\$3240/year)
For those who do not participate in the Comprehensive QA Program, they can select individual services from the menu.

Quality Assurance Program Components	SC Work Annual Hrs. 1041-2080 hrs.	SC Work Annual Hrs. 1040 hrs or less
Annual Resident Satisfaction Survey	\$ 850	\$ 575
Semi Annual File Reviews	\$ 850	\$ 575
Annual Management Survey	\$ 425	\$ 275
Annual Individual Practice Assessment	\$ 375	\$ 225
Monthly Online Report Review	\$ 625	\$ 400
Semi-Annual Program Evaluations	\$ 115	\$ 110
*Site Visit (not a component of the comprehensive QA package)		\$ 750 + travel expenses / visit

NOTE: NCR will not charge more than 10% of the Service Coordinators salary, which is the approved HUD funding limit for the quality assurance.

Narrative

Description of plan to address community resident needs, if applicable.

There is no plan to address the needs of community residents.

However, pursuant to the passage of Section 851 of the American Home Ownership and Economic Opportunity Act of 2000 (Public Law 106-569) the Service Coordinator may assist, within his or her role as a Service Coordinator, "low-income elderly or disabled families living in the vicinity..." of a HUD assisted housing site. The Service Coordinator will only provide assistance if requested by a community resident or the caretaker of a community resident.

**Recommended Service Coordinator Salary
May, 2007**

**Name of Property
City, State**

Arlington by the Lake
Toledo, OH

DATA SOURCE Annual Salary Hourly Rate

Service Coordinator employed at: Arlington by the Lake located in: (city,state) Toledo, Ohio		\$15.00
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Salary.Com Social Worker (BSW) www.salary.com	(median) \$41,440.00	\$19.92
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United States Bureau of Labor Statistics Community & Social Service Occupations "Child, Family & School Social Worker" http://stats.bls.gov/home "Wages Earnings & Benefits"	\$36,857.60	(mean hourly) \$17.72
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RECOMMENDED SALARY RATE FOR SERVICE COORDINATOR	\$39,148.80	\$17.55
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Arlington by the lake




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The median expected salary for a typical Social Worker (BSW) in **Toledo, OH 43609** is **\$41,440**.

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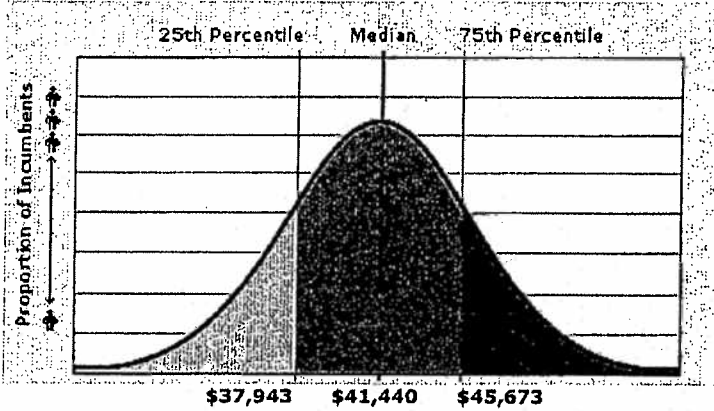
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BASE SALARY | BONUSES | BENEFITS | NET PAYCHECK ESTIMATE

Base pay only



HR Reported data as of May 2007

Social Worker (BSW)	25th%ile	Median	75th%ile
Toledo, OH 43609	\$37,943	\$41,440	\$45,673

Arlington by the Lake

Community and Social Services Occupations top						
Occupation Code	Occupation Title (click on the occupation title to view an occupational profile)	Employment (1)	Wage Estimates			
			Median Hourly	Mean Hourly	Mean Annual (2)	Mean RSE (3)
21-0000	Community and Social Services Occupations	61,240	\$17.21	\$18.40	\$38,270	0.7 %
21-1011	Substance Abuse and Behavioral Disorder Counselors	2,200	\$16.61	\$16.99	\$35,350	1.2 %
21-1012	Educational, Vocational, and School Counselors	7,770	\$26.49	\$26.08	\$54,250	1.0 %
21-1013	Marriage and Family Therapists	330	\$22.98	\$26.83	\$55,810	5.0 %
21-1014	Mental Health Counselors	2,630	\$17.58	\$18.46	\$38,390	1.7 %
21-1015	Rehabilitation Counselors	3,160	\$17.72	\$19.05	\$39,620	3.1 %
21-1019	Counselors, All Other	1,000	\$18.70	\$19.91	\$41,400	2.9 %
21-1021	Child, Family, and School Social Workers	10,300	\$16.97	\$17.72	\$36,870	1.4 %
21-1022	Medical and Public Health Social Workers	5,950	\$18.89	\$19.21	\$39,970	0.9 %
21-1023	Mental Health and Substance Abuse Social Workers	5,350	\$16.38	\$17.33	\$36,040	1.0 %
21-1029	Social Workers, All Other	3,980	\$18.54	\$19.84	\$41,270	1.6 %
21-1091	Health Educators	1,680	\$19.86	\$20.22	\$42,050	1.5 %
21-1092	Probation Officers and Correctional Treatment	2,530	\$19.75	\$20.15	\$41,920	1.2 %

Method of estimating how many Residents of the development are frail or at-risk elderly or non-elderly people with disabilities

The Property Manager at the development compiled a list of all current residents and their respective ages. The Property Manager and other available property staff held a meeting to review each resident on the list. The purpose of the meeting was to decide if each resident was able to perform his/her Activities of Daily Living independently or is in need of assistance. The six Activities of Daily Living (ADL) are Eating, Bathing, Grooming, Dressing, Transferring and Home Management.

The staff were asked to consider the following when making their determinations regarding each resident:

First - Is the resident receiving a service to assist with a specific Activity of Daily Living? If he or she is, it would be considered a deficiency.

Second - Would the resident benefit from a service for the Activity of Daily Living? This takes into account a resident may not be receiving a service that is needed. If he or she would benefit, it would be considered a deficiency.

Third - Does the resident have a degenerative disease (Alzheimer's disease, dementia) that will inevitably require that he/she will need assistance in this area?

As the staff discussed each resident, they were asked to use the following definitions provided by the US Department of Housing and Urban Development regarding the minimum requirements for an ADL deficiency. As they considered each ADL, if a resident performs above the minimum requirement, he or she would be considered as having no deficiency in that specific ADL. A resident performing at or below the minimum requirement was counted as having a deficiency in that ADL. The ADL minimum requirements are described below. HUD's descriptions of minimum requirements are noted in italics. Additional information and examples for consideration by the staff at the property is also listed under each ADL.

1 *Eating*

The resident can feed him or herself but needs assistance with cooking, preparing or serving food.

(The resident receiving meals-on-wheels or participating in congregate meals is most likely deficient in this ADL. The resident who no longer uses the stove or oven would be considered deficient in this ADL.)

2 *Dressing*

The resident can dress him or herself but needs occasional assistance.

(The resident who has a visiting home health aide or who uses adaptive equipment to assist with dressing is most likely deficient in this ADL. The resident who only wears certain items because she can no longer manipulate the buttons and zippers would be deficient in this ADL. The resident needing assistance to select appropriate clothing would be considered deficient.)

3 *Bathing*

The resident can bathe him or herself but may need assistance in getting in and out of the shower or tub.

(The resident who has handrails installed in the tub/shower or who only bathes when her daughter is present is deficient in this ADL.)

4 *Grooming*

The resident is able to take care of his or her personal appearance, but needs assistance washing his or her hair.

(The resident who visits the stylist weekly because she is no longer able to wash her hair is most likely deficient in this ADL.)

5 *Transferring*

The resident needs assistance getting in and out of a bed or chair, walking, going outdoors, or using the toilet.

(A resident using equipment such as a walker or a cane would be deficient in this ADL.)

6 *Home Management Activities*

The resident is mobile but needs assistance in doing housework or laundry or getting to and from one location to another for activities such as going to the doctor or shopping.

(The resident who needs transportation assistance because he or she can no longer drive would be considered deficient in this ADL.)

The staff were provided with a spreadsheet to record their determinations. The rows of the spreadsheet made it possible to enter each resident and his/her age. The columns of the spreadsheet listed each respective ADL. Each ADL was then further specified as follows;

ADL #1			ADL #2		ADL #3			ADL #4	
Eating			Bathing		Grooming			Dressing	
w/cooking	Preparing meals	serving food	In/Out of Tub	washing	Hair care	toe nails	Shaving or makeup	assistance	select clothes

ADL #5				ADL #6							
Transferring				Home Management							
in/out of bed	walking	going outdoors	using toilet	House Keeping	Laundry	Transportation	Appointments	Completing forms	Finances	Shopping	Entitlements

The Staff placed an X in the corresponding column if the resident needed assistance with the activity. If an X was present for any of the sub-columns under an ADL, the ADL was counted as a deficiency. The total number of ADL deficiencies for each resident was gathered. Those residents with one or two ADL deficiencies and age 62 or above were counted as "at-risk". Those residents with three or more ADL deficiencies and age 62 or above were listed as "frail". Those residents under the age of 62 who had at least one deficiency in an ADL were counted as Disabled.

The final process was to determine the percentage of at-risk and frail residents and disabled residents.

The total number of at-risk residents was divided by the total number of residents at the property to determine the percentage of at-risk residents.

The total number of frail residents was divided by the total number of residents at the property to determine the percentage of frail residents.

The total number of at-risk and frail residents were added together and divided by the total number of residents at the property to determine the percentage of at-risk and frail residents.

The total number of disabled residents was divided by the total number of residents at the property to determine the percentage of disabled residents.