# AGENCY ON AGING OF SOUTH CENTRAL CONNECTICUT

# FY 2026 TITLE III-B APPLICATION – ADULT DAY CENTERS

**SECTION I – FACE SHEET**

|  |  |
| --- | --- |
| 1. TITLE OF AGENCY:

        | 1. TITLE OF ADULT DAY CARE:

            |
| 1. PROPOSED DATES OF PROJECT PERIOD:

FROM: **10/1/2025** TO: **9/30/2026** | 4. YEARS FUNDED BY AASCC (if applicable):    | 5. TYPE OF APPLICATION: | 6.. TYPE OF AGENCY:  |
| 7. Proposed Operating Budget for Project Period:TITLE III 0.00 NON-FEDERAL MATCH 0.00 OTHER RESOURCES 0.00 TOTAL PROGRAM COST 0.00 |
| 8. APPLICANT AGENCY:Name:      Address:            City       State CT Zip      Telephone       FAX:      E-Mail:       | 9. PROJECT NAME & ADDRESS (if different #8)Name:      Address:            City       State CT Zip      Telephone       FAX:      E-Mail:       |
| 10. PROJECT DIRECTOR:Name:      Title:      E-Mail:       | 11. PERSON PREPARING MIS/SAMS REPORTS:Name:      Title:      E-Mail:       | 12. PERSON PREPARING FINANCIAL REPORTS: Name:      Title:      E-Mail:       |
| 13. Send checks and documents to:Name:      Title:      Address Telephone       FAX      E-Mail:       | 14. Authorized Signatory Name:      Title:      E-Mail: :       |
| 15. TERMS AND CONDITIONS: It is understood and agreed by the undersigned that 1) funds awarded as a result of this request are to be expended for the purposes set forth herein and in accordance with all applicable laws, regulations, policies and procedures of the Area Agency, The State Aging Unit and the Administration on Aging U. S. Department of Health and Human Services; 2) any proposed changes in the proposal as approved will be submitted in writing by the applicant and upon Notification of Approval by the Area Agency shall be deemed incorporated into and become a part of this agreement; 3) the attached Assurance of Compliance with the DHHS Regulation issued pursuant to Title VI of the Civil Rights Act of 1964 applies to this proposal as approved; 4) the attached Public Act 91-407 Sec. 8 and Public Act 91-58 Sec. 16(b) and 5) funds awarded by the Area Agency may be terminated at any time for violations of any terms and conditions and requirements of this agreement; 6) the cash and in-kind items listed on the Non-Title III Resource Summary (p.7) do not come from federal funds (only General Revenue Sharing, Community Development Block Grant and Legal Services Corporation funds are allowable match) and they are not used to match any other federal grant. Client contributions cannot be used for federal matching funds. |
| 16. SIGNATURE OF AUTHORIZED SIGNATORY (PERSON NAMED IN BOX 14) |

**SECTION II – PROGRAM SUMMARY**

|  |
| --- |
| 1. Name of Organization:        |
| 2a. Affiliations:  OR Other (fill in affiliation):       |
| 2b. Model: | 2c. Certified: No [ ]  Yes[ ]  Date:      |
| 2d. Client Capacity:      |
| 2e. Average Daily Attendance for the Previous Year (**January 1, 2024– December 31, 2024):**    Average Daily Attendance of Clients with Alzheimer’s disease or Related Dementias:     |
| 3a. Provide a physical description of your facility (including comment on accessibility):      |
| 3b. Days/Hours of Operation:

|  |  |  |
| --- | --- | --- |
| DAY OF THE WEEK | A.M. | P.M. |
| Monday |       |       |
| Tuesday |       |       |
| Wednesday |       |       |
| Thursday |       |       |
| Friday |       |       |
| Saturday |       |       |
| Sunday |       |       |

 |
| 4. Does the facility have any outstanding violations of applicable zoning, licensing, fire code, or safety laws and regulations?  [ ] no [ ]  yes If yes, please describe in detail and furnish report of citation.       |
| 4b. Date of last inspection by Fire Marshall:       Date of last inspection by Health Department:       |

**5. Geographic Service Area: (Please check towns served)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Ansonia | [ ]  | Bethany | [ ]  | Branford | [ ]  | Derby  | [ ]  |
| East Haven | [ ]  | Guilford | [ ]  | Hamden | [ ]  | Madison | [ ]  |
| Meriden | [ ]  | Milford | [ ]  | New Haven | [ ]  | N. Branford | [ ]  |
| North Haven | [ ]  | Orange | [ ]  | Oxford | [ ]  | Seymour | [ ]  |
| Shelton | [ ]  | Wallingford | [ ]  | West Haven | [ ]  | Woodbridge | [ ]  |

**6. Staffing Pattern for the Project:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title**  | **Individual holding position** | **Works with Alzheimer’s clients?**  | **F/T** | **P/T** | **On call** |
|  |  | [ ] **Yes** [ ] **No** | [ ]  | [ ]  | [ ]  |
|  |  | **[ ] Yes [ ] No** | **[ ]**  | **[ ]**  | **[ ]**  |
|  |  | **[ ] Yes [ ] No** | **[ ]**  | **[ ]**  | **[ ]**  |
|  |  | **[ ] Yes [ ] No** | **[ ]**  | **[ ]**  | **[ ]**  |
|  |  | **[ ] Yes [ ] No** | **[ ]**  | **[ ]**  | **[ ]**  |
|  |  | **[ ] Yes [ ] No** | **[ ]**  | **[ ]**  | **[ ]**  |
|  |  | **[ ] Yes [ ] No** | **[ ]**  | **[ ]**  | **[ ]**  |
|  |  | **[ ] Yes [ ] No** | **[ ]**  | **[ ]**  | **[ ]**  |
|  |  | **[ ] Yes [ ] No** | **[ ]**  | **[ ]**  | **[ ]**  |
|  |  | **[ ] Yes [ ] No** | **[ ]**  | **[ ]**  | **[ ]**  |

**7. TITLE III-B ADULT DAY CARE SERVICE PROFILE:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SERVICE** | **NOT****PROVIDED** | **FREQUENCY****HOW OFTEN?** | **ASSIGNED STAFF PERSON** | **ADD’L CHARGE?** | **SUB-CONTRACTOR****(if any)** |
|  |  | **Daily** | **Or (select one)** |  |  |  |
| **A. CARE PLANNING** |  |  |  |  |  |  |
| Physical assessment | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Physical reassessment | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Health status monitoring | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Development of care plan | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Updates on progress notes | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Referrals to other needed services | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Consultation with caregivers | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| **B. CORE SERVICES** |  |  |  |  |  |  |
| Nursing supervision | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Nursing care | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Therapeutic recreation | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Sedentary activities | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Outings | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Meals | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Snacks | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Special diets | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Transportation | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Physical therapy | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Occupational therapy | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| **C. PERSONAL CARE** |  |  |  |  |  |  |
| Personal health / hygiene instruction | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Bath service | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Personal hygiene | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| ADL assistance  | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Hair dresser / barber services | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Beautician | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| **D. COUNSELING** |  |  |  |  |  |  |
| Individual counseling | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Group Counseling | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Mental health counseling  | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Dietary evaluation / counseling | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| **E. CAREGIVER SUPPORT** |  |  |  |  |  |  |
| Counseling | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Caregiver training | [ ]  | [ ]  |    time(s) / |       | **[ ] Yes [ ] No** |       |
| Support group | [ ]  | [ ]  |    time(s) per  |       | **[ ] Yes [ ] No** |       |

**SECTION III -TITLE III PROGRAM NARRATIVE**

Please answer all questions in the outlined format and limit your response to the three (3) attached pages (plus supplemental data). At minimum, margins must be one inch with font no smaller than 11 point in plain text (no italics).

**1. SERVICE DESCRIPTION: GOALS AND OBJECTIVES**

*Describe the project and the services for which you are requesting funding. What are the goals and objectives for the project year? How do you intend to meet these goals during the project year?*

**2. DEMONSTRATED NEED:**

*Describe the project's target population(s) and explain how the project will meet their needs. Using needs assessment data, the AASCC area plan, wait lists, census data, municipal demographics, etc., detail why the service need in your area.*

**3. OUTREACH:**

*Describe in detail your plan to perform outreach in the following three target areas:*

*a) outreach to low income minority elders; b) outreach to persons with severe disabilities and individuals with Alzheimer’s or related disorders (and/or their caregivers); and c) outreach designed to improve access to services through collaborative work with other local organizations.*

*Renewal Applicants: Describe also the activities/efforts undertaken in the previous grant year to achieve outreach goals. Comment on the success/failure of your outreach to the target populations listed above in the past year. Where efforts were unsuccessful, note proposed changes for the coming year.*

**4. EVALUATION:**

*Describe the project’s plan for measuring client and/or caregiver satisfaction including planned methodology, frequency of measurement, and follow-up activities to ensure quality improvement.*

*Renewal Applicants: Provide a composite summary of results of client and/or caregiver satisfaction data gathered over the most recent project year. Describe procedures for responding to and resolving negative client feedback.*

**5. CLIENT CONTRIBUTIONS**:

*Describe the project's proposed method for soliciting and collecting client contributions. Address the following: a) method (e.g. appeal letters, envelopes); b) frequency of appeal; c) responsible staff; and d) safeguards for confidentiality.*

**6. MAJOR CHANGES IN APPLICATION (RENEWAL APPLICANTS ONLY):**

*Comment on any major changes in project administration, outreach, funding levels, etc. in the application.*

**SECTION III -TITLE III PROGRAM NARRATIVE**

**Response Page 5A**

**SECTION III -TITLE III PROGRAM NARRATIVE**

**Response Page 5B**

**SECTION III -TITLE III PROGRAM NARRATIVE**

**Response Page 5C**

**SECTION IV – SERVICE CHARTS**

**COMPLETE THIS CHART FOR TITLE III-B CLIENTS ONLY!!**

**(FOR RENEWAL APPLICANTS USE SEPTEMBER 2024 MIS YTD FOR FY’24 ACTUALS)**

**Service Type: Adult Day Care Unit of Measure: one unit = one hour of service**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CATEGORY:** | **Actual unduplicated Title III-B client count for FY’24** | **Targeted unduplicated Title III-B client count for FY’24** | **Actual hours of service to this population for** **FY’26** | **Targeted hours of service to this population for FY’26** |
| **All Title III-B clients age 60+** |  |  |  |  |
|  |  |  |  |  |
| **Minority Title III-B clients age 60+** |  |  |  |  |
|  |  |  |  |  |
| **Title III-B clients age 60+ at 101%-150% of poverty\*\*** |  |  |  |  |
|  |  |  |  |  |
| **Non-Minority Title III-B clients age 60+ at or below 100% of poverty** |  |  |  |  |
|  |  |  |  |  |
| **Minority Title III-B clients age 60+ at or below 100% of poverty** |  |  |  |  |
|  |  |  |  |  |
| **Title III-B clients with limited English proficiency** |  |  |  |  |
|  |  |  |  |  |
| **Title III-B clients with severe disability\*** |  |  |  |  |
|  |  |  |  |  |
| **Title III-B clients with Alzheimer’s & Related Disorders** |  |  |  |  |
|  |  |  |  |  |
| **Title III-B clients at-risk for institutionalization\*** |  |  |  |  |

\*Severe disability**:** reported need for assistance with 3 or more ADLs (Activities of Daily Living) on the Consumer Registration Form.

At Risk for Institutionalization: need for assistance with 3 or more ADLs and does not reside in nursing home and: lives alone or below 100% FPL or 80 or older



**\***\*Severe disability**:** reported need for assistance with 3 or more ADLs (Activities of Daily Living) on the Consumer Registration Form.

At Risk for Institutionalization: need for assistance with 3 or more ADLs and does not reside in nursing home and: lives alone or below 100% FPL or 80 or older

**PERSONNEL EXPLANATION SHEET**

Complete each column and list each position by Title, the total for salary for this project and its distribution by funding source.

*Double click on table to activate and add information. Click outside the table to close.*

****

**BUDGET NARRATIVE/COST EXPLANATION**

Please show your computation for determining the cost and your justification of each line item expense by providing an underlying rationale for Column G (Total), lines 2-16 of the program budget. (p. 8)

*Do not wrap text. When you arrive at the end of a line, press enter to bring cursor to next line.*

**LINE ITEM:**

|  |
| --- |
| 1. *FRINGE BENEFITS – This category should include all those commonly accepted fringe benefits paid on behalf of employees; such as retirement, FICA, health and life insurance, workers****’*** *compensation, unemployment insurance and other payroll related costs.*

      |
| 1. *CONTRACTUAL SERVICES - This category includes costs, type of service and with whom you will contract services for this project.*

      |
| 1. *SPACE - This category includes rent, mortgage payments, maintenance and janitorial expenses.*

      |
| 1. *UTILITIES – This category should list all utility-related costs.*

 |
| 1. *TELEPHONE – This category includes all regular telephone charges, the rent or lease of telephone and fax equipment, long distance calls and Internet charges*

     *.* |

**BUDGET NARRATIVE/COST EXPLANATION**

*Do not wrap text. When you arrive at the end of a line, press enter to bring cursor to next line.*

**LINE ITEM:**

|  |
| --- |
| *7. INSURANCE – This category includes proportionate share of all types of insurance policies you currently have in place that are paid for with some or all of the Title III funding.*      |
| *8. EQUIPMENT PURCHASE - This category should list the type, quantity, and cost of each item of equipment to be purchased. If in-kind Match, list type, value, and percent of time equipment will be used by project. EQUIPMENT RENTAL/MAINTENANCE includes proportionate share of lease of rental equipment (except telephone) and maintenance costs for that equipment whether pursuant to a service contract or individual repair bills.*      |
| *9. OFFICE SUPPLIES AND EXPENSES - This category includes all basic office accessories and supplies including software and materials used in copiers.*      |
| *10. AUDIT FEES – This category includes proportionate share of expenses for auditors.*      |
| 1. *PRINTING & PUBLICATION - This category includes all costs to print and publish project related materials.*

      |

**BUDGET NARRATIVE/COST EXPLANATION**

*Do not wrap text. When you arrive at the end of a line, press enter to bring cursor to next line.*

**LINE ITEM:**

|  |
| --- |
| 1. *POSTAGE - This category includes all mailing related costs related to the project.*

      |
| 1. *PROJECT TRAVEL - This category includes all travel expenses directly related to this specific Title III funded project. Please list mileage reimbursement rate.*

      |
| *14. CONFERENCES & TRAINING - This category includes costs related to the training of project staff members.*      |
| *15. DUES & SUBSCRIPTIONS - This category includes costs related to membership dues and publication subscriptions.*      |
| *16. OTHER - This category includes all project expenses not entered above. Individual costs must be itemized.*      |

SECTION VI – ATTACHMENTS

**ALL APPLICANTS** must include the following required attachments:

1. Documentation that describes the agreement to fund, consideration of funding, denials of funding, and/or other requests for funding for this project.
2. Grievance Procedure for clients dissatisfied with or denied service under the Title III-funded portion of the proposed program.
3. Agency’s Current Operating Budget
4. Current list of agency Board of Directors.
5. Working agreements with at least two (2) area service providers that will coordinate services with the proposed project.
6. Blank copy of the satisfaction survey proposed for use.

**ALL APPLICANTS** should furnish the following on an **AS-NEEDED** basis. Please limit this section to no more than ten (10) pages:

G. Documents illustrating the unmet need that the proposed project intends to meet (e.g. academic studies; wait list information, program evaluations).

H. Letters of understanding with any proposed subcontractors, including any applicable non-profit or for-profit organizations.

I. Copies of existing outreach materials.

J. Narrative request(s) to waive any criteria listed in the Request for Proposals.

**SECTION VII – SCHEDULES**

To ensure that all forms are enclosed, please complete the checklist and sign.

[ ]  Affirmative Action Agreement (Schedule A)

[ ]  Assurance of Compliance with Title VI of the Civil Rights Act of 1964 (Schedule B)

[ ]  Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973 (Schedule C)

[ ]  Assurance of Compliance with Public Act 91-407 section 8 and Public 91-58 section

 16(b) (Schedule D)

|  |  |
| --- | --- |
| **Name** |       |
| **Authorized Signature** |       |
| **Title** |       |
| **Date** |       |

**SCHEDULE A**

AFFIRMATIVE ACTION AGREEMENT

BETWEEN

Name of Local Agency:

and

AGENCY ON AGING OF SOUTH CENTRAL CONNECTICUT

1. We certify that the principle of equal employment opportunity is observed in this agency's personnel practices. This principle applies to all individuals regardless of race, national origin, political or religious opinion or affiliation, sex, age, and physical disability, or other non-meritorious consideration. Specific sex, age, or physical qualifications, which are bona fide, job-related and necessary to proper and efficient administration, may, however, be required.

2. Further, we agree to take affirmative action in support of this principle of equal employment opportunity, with particular reference to minorities and women and older workers, including action to correct the continuing effects of past discrimination, if any. Such affirmative action means that whenever action is taken in recruitment, selection, hiring, promotion, training, disciplining, or discharging of an employee for, or of, this agency, or for any comparable personnel action, reasonable efforts will be made to achieve appropriate employment consistent with the availability, for each specific position, of qualified minorities, women, and older workers in the appropriate labor force.

3. In a case of alleged discrimination by this agency in any personnel action, the person affected has the right of appeal to an impartial local or State agency as designated by this agency and made known to employees and prospective employees. This agency will accept the decision of this impartial appellate authority as binding.

4. The appropriate appellate authority discussed in the third paragraph of this agreement is State of CT. Commission on Human Rights and Opportunities.

5. The staff profile of this agency at present (for paid staff members working more than 20 hours a week) is as follows:

White      % Black      % Hispanic      % Other minorities      %

Male      % Female      % Over 60 years of age      %

|  |  |
| --- | --- |
| **Authorized Signature** |       |
| **Title** |       |
| **Agency Name** |       |
| **Address** |            |
| **Date** |       |

**SCHEDULE B**

AGENCY ON AGING OF SOUTH CENTRAL CONNECTICUT, INC.

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

      (Name of Subgrantee or Secondary Recipient)

(hereinafter called the "Subgrantee") HEREBY AGREED THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Subgrantee receives Federal financial assistance from Agency on Aging of South Central Connecticut, Inc. a recipient of Federal financial assistance from the Department (hereinafter called "Grantor"); and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Subgrantee by the Grantor, this assurance shall obligate the Subgrantee, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Subgrantee for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Subgrantee for the period during which the Federal financial assistance is extended to it by the Grantor.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Subgrantee by the Grantor, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Subgrantee recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance and that the Grantor or the United States or both shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the sub grantee.

AOA Form 441 (To be completed by applicant for any grant from the State Agency designated to implement the Older Americans Act.)

Its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Subgrantee.

|  |  |
| --- | --- |
| **Authorized Signature** |       |
| **Title** |       |
| **Subgrantee Name** |       |
| **Address** |            |
| **Date** |       |

**SCHEDULE C**

DEPARTMENT OF HEALTH AND HUMAN SERVICES ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED

The undersigned (hereinafter called the "recipient") HEREBY AGREES THAT it will comply with section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to S84.5 (a) of the regulation (45 C.F.R. 84.5(a), the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance, including payments of other assistance made after such date on applications for federal financial assistance that were approved before such date. The recipient recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal financial assistance is extended to it by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in S84.5(b) of the regulation (45. C.F.R. 84.5(b).

The recipient: Check (a) or (b)

a. [ ]  employees fewer than fifteen persons

 **OR**

b. [ ]  employs fifteen or more persons and, pursuant to S84.7(a) of the regulation A74

 (45 C.F.R.84.7(a), has designated the following person(s) to coordinate its efforts to

 comply with the HHS regulation:

Name of Designee(s):

Name of Recipient:

Street Address or P.O. Box:

City, State and Zip:       CT

(IRS) Employer Identification Number:

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

      /      / 2025 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature and Title of Authorized Official

If there has been a change in name or ownership within the last year, please print the former name.

**SCHEDULE D**

In accordance with Public Act 91-407 section 8 and Public Act 91-58 section 16(b). The recipient agrees to the following provisions:

1) The contractor agrees and warrants that in the performance of the contract such contractor will not discriminate or permit grounds of sexual orientation, in any manner prohibited by the laws of the United States or of the State of Connecticut, that employees are treated when employed without regard to their sexual orientation.

2) The contractor agrees to provide each labor union or representative of workers with which such contractor has a collective bargaining agreement or other contract or understanding and each vendor with which such contractor has a contract of understanding, a notice to be provided by the commission on human rights and opportunities advising the labor union or workers' representative of the contractor's commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment;

3) The contractor agrees to comply with each provision of this section and sections 46a-68e and 46a-68f of the general statutes and with each regulation or relevant order issued by said commission pursuant to sections 46a-56, 46a-68e and 46a-68f of the general statutes.

4) The contractor agrees to provide the commission on human rights and opportunities with such information requested by the commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the contractor as relate to the provisions of this section and section 46a-56 of the general statues.

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| --- | --- |
| **Authorized Signature** |       |
| **Title** |       |
| **Subgrantee Name** |       |
| **Address** |            |
| **Date** |       |