

ALZHEIMER’S AIDE PROJECT

SFY ’26 APPLICATION

**A. IDENTIFYING INFORMATION**

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| 1. **Name of Sponsoring Agency:** | | | |
| 1a.  Address:    City       State CT Zip | | 1b. Contact Person  Name:  Title:  E-Mail:  Telephone:       FAX: | |
| 2. **Name of Adult Day Care:** | | | |
| 2a.  Address:    City       State CT Zip | | 2b. Contact Person  Name:  Title:  E-Mail:  Telephone:       FAX: | |
| 3. **Type of Certification ADC Received**:  Date of (Re)Certification: | 4. **ADC type:** | | 6. **Is the facility handicap accessible?**  yes  no |
| 5. **ADC affiliation:** | |
| 6. **ADC Liability Insurance Information**  Carrier:  Amount: | | 7. **Has ADC been cited for violations of any local zoning, licensing (e.g., food service), fire and/or safety regulations?**  yes  no  (if yes, please attach report and formal response) | |
| 1. **Days/Hours of Operation:**   Monday             Saturday  Tuesday             Sunday  Wednesday  Thursday  Friday | | | |
| 10. **How many clients can the ADC accommodate weekly**  **(please use an average service day from opening to closing)?**  Total number of all clients:       Total Alzheimer’s clients: | | | |

**B. PROGRAM OPERATIONS**

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| 1. How many hours a day is the nurse on duty?       Hours  Qualifications (RN/LPN) |
| 2. For hours not covered by an on-duty nurse, is a nurse on call?  Yes  No  Qualifications (RN/LPN) |
| 3. Is there a social worker on duty at the ADC at all times?  Yes  No  On Call |
| 4. Does the ADC have written Policies and Procedures on file?  Yes  No  (including statements on admission, discharge and client care) |
| 5. What are the procedures for client intake and eligibility determination? |
| *6. All clients* served under this grant must have been diagnosed by a physician with Alzheimer’s or related dementia. Which staff person is responsible for obtaining and maintaining the physicians’ diagnostic letters for each client?  Name:       Title: |
| *6.* List the amount and carrier of the ADC liability insurance.  Amount:       Carrier: |

**C. SERVICE INFORMATION**

SERVICE DATA

1. Day care clients with Alzheimer’s disease or related dementias:

|  |  |  |
| --- | --- | --- |
|  | **Last SFY**  **7/1/24-6/30/25** | **Projected SFY Year**  **7/1/25-6/30/26** |
| A. Total number of days the ADC was open |  |  |
| B. Total unduplicated clients the ADC served on a daily basis (all clients) |  |  |
| C. Total Alzheimer’s clients the ADC served on a daily basis |  |  |
| D. Total number of days of service provided to all clients |  |  |
| E. Total number of days of service provided to Alzheimer’s clients |  |  |
| F. Average daily attendance for Alzheimer’s clients  (Row E divided by Row A) |  |  |
| G. Average number of persons who work with Alzheimer’s clients daily (include Title V workers; exclude volunteers, office and kitchen workers) |  |  |
| H. Ratio of Alzheimer’s clients to client care staff (including Title V workers; excluding volunteers) on duty on premises over the course of a full day of operation |  |  |
| I. Total number of volunteers on site daily, on average |  |  |

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

**3. If there are significant differences between the past year and the project year, please give the reason.**

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**SERVICE PROFILE**

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

**3. Describe the agency’s capacity and experience in serving Alzheimer’s clients and include information on the ADC’s particular strengths in doing so.**

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**4. Describe the specific support services for family and/or other caregivers through your program. Indicate the frequency of support group meetings and the average attendance per year.**

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1. **Training Information:**
2. List staff person(s) responsible for training and supervising Alzheimer’s aides:

Qualifications:

1. Describe type and frequency of training offered to Alzheimer’s aides (e.g. orientation, on-the-job training, in-service).

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**D. BUDGET FOR CURRENT STATE FISCAL YEAR (7/1/25-6/30/26)**

**Income**

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



**Expenses**

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

**

**PERSONNEL/BUDGET EXPLANATION**

(Please note current staff assigned to Alzheimer’s clients by using an \*.)

|  |  |  |
| --- | --- | --- |
| POSITION | FTE | **COST (SALARY + FRINGE)** |
| Director |  |  |
| Secretary |  |  |
| Program Coordinator |  |  |
| RN |  |  |
| LPN |  |  |
| Health Aide |  |  |
| Social Worker |  |  |
| Therapist |  |  |
| Program Aide |  |  |
| Volunteers |  |  |
| Drivers |  |  |
| Cook |  |  |
| Custodial/Housekeeping |  |  |
| Other |  |  |

Does the ADC conduct an annual audit that covers all revenues and expenses and identifies this funding separately?

Yes  No

If yes, name of audit firm:

**ATTACHMENTS**

1. Attach resumes for the current director and other professional staff.

2. Attach the aide position job description.

3. Attach the most recent agency annual audit and annual report. **(Submit one copy only with the Original Application)**

**AGREEMENT**

The       agrees to do the following:

(Agency Name)

A. We will comply with statistical reporting requirements and the requirement for an independent audit as described in the Request for Proposal on page 3.

B. We will comply with all applicable state and federal regulations, executive orders and state statutes regarding non-discrimination.

C. We will assure that the ADC has licensed professional staff providing supervision of aides and services needed by Alzheimer’s clients.

D. We will assure that aides hired under this grant will be appropriately trained in both physical care of and method of interaction with individuals diagnosed with dementia.

E. We will assure that clients served under this grant have been diagnosed by a physician with dementia.

F. We will assure that records on daily attendance are maintained and that documentation is kept on each unduplicated client under this program sufficient to establish that a physician has diagnosed the client with Alzheimer’s disease or a related dementia.

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Signature

Name

Title

Date