

# Application for Proposal

for the selection of Providers to provide

## Legal Services

for the period

**July 1, 2023 through June 30, 2027**

**Area Agency on Aging *Serving Eastern Idaho***

a division of  
**Eastern Idaho Community Action Partnership**  
935 E Lincoln Drive  
Idaho Falls, ID 83401  
(208) 522-5391



**Completed applications must be physically in the possession of the Area Agency on Aging by 4:30 p.m., April 28, 2023.**

### **Instructions for Application:**

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

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## Applicant Information

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

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

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

Telephone number: \_\_\_\_\_ Fax: \_\_\_\_\_ Email of business: \_\_\_\_\_

1. IRS Employer ID #: \_\_\_\_\_
2. DUNS#: \_\_\_\_\_
3. Legal status of Provider:  Private Non-Profit  Public Non-Profit  
 For-Profit  Other, describe: \_\_\_\_\_

• If you are a Non-Profit Provider –

A. Attach copies of the Provider's:

- a. Article of Incorporation, **(Label Attachment #1)**
- b. Bylaws, **(Label Attachment #2)**
- c. 501(c)(3) status. **(Label Attachment #3)**

B. If Provider's receive over \$300,000 of Federal funding in past year?

- No  
 Yes – please attach the most recent audit. **(Label Attachment #4)**

• If you are a For-Profit Provider –

A. What type of For-Profit Provider is your organization?

- Incorporated  Sole Proprietorship  LLC  Partnership  
 Other: \_\_\_\_\_

4. Business Types: (Check all that apply **and attach documentation**): **(Label Attachment #5)**

(To qualify you must have certified through the U.S. Small Business Administration, <https://certify.sba.gov/> )

- Small business Owned  
 Woman-Owned, 51% or more owned by 1 or more women  
 Veteran-Owned, 51% or more owned by a Veteran  
 Disabled Veteran-Owned, 51% or more owned by a Disabled Veteran  
 Historically Black College & University Minority Institution  
 HUBZone Small Business Concern, Historically Underutilized Business Zones as Certified with SBA  
 Disadvantaged, 51% or more owned by one or more socially or economically disadvantaged Individuals, including Black Americans, Hispanic Americans, Native Americans, Asian-Pacific Americans

5. Provide **ONE** of the following documents to this application which demonstrates the Provider's financial soundness: **(Label Attachment #6)**

- Audit Report, within the past 12 months  Better Business Bureau report  
 Credit Report  Income Tax Statements



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

10. What is the mission of the Provider?  
\_\_\_\_\_

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

Position Title	Paid/Volunteer	Major Responsibilities

12. Summarize the history of your organization, describing the programs and clients you serve.  
\_\_\_\_\_

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

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

### Assurances.

15. The Provider will ensure access to the Legal Services will be equally available and prioritized to all eligible seniors (individuals aged over 60 years or as approved by ICOA or AAA).

Yes  No

16. The Provider has read, understands in full, and will follow the AAA's Legal Scope of Work – as outlined in the Guide to Request for Proposals.

Yes  No

17. The Provider will ensure the geographically difficult areas of the locale are served.

Yes  No

18. The Provider will accommodate for cultural differences and take them into account when delivering services.

Yes  No

19. The Provider will make accommodations to work with persons who have various types of disabilities, including but not limited to, vision and hearing impairments.

Yes  No

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20. The Provider will make accommodations to work with persons who speak a language other than English.  
 Yes  No
21. The Provider is an equal opportunity employer and has an affirmative action policy, if applicable.  
 Yes  No
22. The Provider will electronically report accurate fiscal and program data, on time, as required in the General Terms and Conditions of the AAA Contract, or as requested.  
 Yes  No

### **Required Activities and Application Narrative**

23. The Provider will provide Outreach to locate persons in the community who are not participating in available senior programs or receiving senior services for which they qualify. Provider will identify their service needs; provide information about aging program and services available; and assist them in accessing services they need or want to participate in.  
Describe in detail how you plan to provide outreach.  
\_\_\_\_\_
24. Describe in detail any plans for expansion of this service.  
\_\_\_\_\_
25. Describe in detail how maintaining confidentiality of client information will be handled.  
\_\_\_\_\_
26. Describe in detail the plan to maintain confidentiality of client donations.  
\_\_\_\_\_
27. Describe in detail the Emergency Procedures in the event Legal services are not operational.  
\_\_\_\_\_
28. Describe in detail how client satisfaction of services will be assessed and completed on an annual basis.  
\_\_\_\_\_
29. Describe in detail the procedures for handling injuries to clients, staff, and volunteers.  
\_\_\_\_\_
30. Describe in detail the procedures for handling, reporting, and documenting client complaints.  
\_\_\_\_\_
31. Describe in detail the Legal service(s) that the Provider has provided to individuals aged 60 years and older (seniors) and others within the last 12 months. If none, describe the Legal services for seniors the Provider is planning to undertake. Include funding sources in addition to the funding structure.  
\_\_\_\_\_

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32. Describe in detail what strengths uniquely qualify the Provider to provide Legal Services for seniors or others as approved by AAA or ICOA?

\_\_\_\_\_

33. Describe in detail the Provider's system to **prioritize** legal services?

\_\_\_\_\_

34. Describe in detail the **process** for a participant to receive Legal services?

\_\_\_\_\_

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

\_\_\_\_\_

### **Partnership, Collaboration and Fund leveraging.**

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

\_\_\_\_\_

37. Describe the Provider's networking and coordinating strategies for the following:

- a. Home Health Agencies
- b. Hospital and Physicians
- c. Local Government
- d. Long Term Care Facilities
- e. Senior Housing Complexes
- f. Other Senior Service Providers
- g. Businesses
- h. Other

\_\_\_\_\_

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

\_\_\_\_\_

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## **Cost Effectiveness**

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

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

## **Budget**

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

**The AAA's SFY 2018 per-unit reimbursement rate is \$75.00 per hour and its minimum match requirement is 15%.**

The AAA will be changing the per-unit reimbursement rate to \$70.00 in SFY 2023 to match state-wide rates.

Provider's Budget is as follows:

<b>REVENUE</b>	<b>Amount</b>	<b>Comments</b>
AAA Funds ( <b>not to exceed \$70.00 per hour</b> )		
County Funds		
City Funds		
Other Federal/State Funds		
Fundraisers		
Other: (Describe)		
<b>Total Revenue</b>		

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

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**Legal Units** (1 unit = 1 hour)

Maximum number of units to be served (at AAA's per unit price)	
Per unit price	\$70.00
<b>Total AAA Funding Application</b>	<b>\$</b>



**Legal Application 2023**  
**Application Submission Letter**

In submitting this application, Provider certifies and acknowledges that:

1. The RFP and all attached documents have been read and understood and that all information provided is true, complete, and accurate to the best of Provider's knowledge. Should an investigation at any time disclose any misrepresentation or falsification information provided by Provider to the Area Agency on Aging Serving Eastern Idaho (AAA) hereunder, this application may be rejected, and contracts entered may be terminated.
2. Enclosed, at a minimum, is **all** information requested in this RFP.
3. **One original and attachments** are being submitted in a sealed envelope as instructed within this RFP.
4. Any RFP amendments received regarding the Provider's original RFP are signed and submitted with this application.
5. Provider agrees to provide services to eligible individuals regardless of the source of funding.
6. Provider certifies that the assurances contained in this application have been met by the Provider.
7. Provider certifies that the submission of this application did not involve collusion or other anti-competitive practices.
8. Provider certifies as to non-Debarment.
9. Provider agrees to comply with all applicable Idaho Commission on Aging and Area Agency on Aging Serving Eastern Idaho service specifications, contract terms, manuals, policies and directives, and all applicable federal, state, and local laws.
10. Provider agrees to provide services to eligible individuals regardless of the source of funding.
11. Provider certifies, upon award of contract, to maintain liability insurance as specified in the General Terms and Conditions of the AAA's Contract.
12. The person signing on behalf of the Provider is legally authorized to submit this application and to make this certification.

\_\_\_\_\_  
**Signature of Provider Official**

\_\_\_\_\_  
**Date**

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### **Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion, Lower Tier Covered Transactions**

1. By signing and submitting this certification, the recipient of federal assistance funds is providing the certification as set out below. The provider will certify non-debarment by signing the RFP application.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered. If it is later determined that the recipient of federal assistance funds knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the appropriate federal agency may pursue available remedies, including suspension and/or debarment.
3. The recipient of federal assistance funds shall provide immediate, written notice to the person to which this Proposal is submitted if at any time the recipient of federal assistance funds learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstance.
4. The terms “covered transaction,” “debarred,” “suspended,” “ineligible,” “lower tier covered transaction,” “participant,” “person,” “primary covered transaction,” “principal,” “Proposal,” and “voluntarily excluded,” as used in this clause, have the means set out in the Definitions and Coverage sections of rules implementing Executive Order 12549.
5. The recipient of federal assistance funds agrees that, should the covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the appropriate federal agency.
6. The recipient of federal assistance funds further agrees that it will include the clause titled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion, Lower Tier Covered Transactions,” without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Procurement or Non-Procurement Programs.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealing.
9. Except for transactions authorized under paragraph 5 of these instructions if a participant in a covered transaction knowingly enters a lower tier transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction in addition to

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## **Debarment Certification**

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, 29 CFR Part 98, Section 98-5.1.0, Participant's Responsibilities. The regulations were published as Part VII of the May 28, 1988, Federal Register (pages 19160-19211).

Before Completing Certification, Read Instructions for Certification:

1. The recipient of federal assistance funds certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
2. Where the recipient of federal assistance funds is unable to certify to any of the statements in this certification, such participant shall attach an explanation to this proposal.
3. By signing below, I acknowledge that I have read and comply with the Instructions of Debarment.

**Agency Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Title of Authorized Representative:** \_\_\_\_\_

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## **Application Submittal Checklist**

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

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

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