

# Application for Proposals

for the selection of Providers to provide

## **Nutrition Services:**

**Congregate Meals**

**Home Delivered Meals**

For the period

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

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

**A division of  
Eastern Idaho Community Action Partnership  
935 E. Lincoln Rd.  
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.**

**If the space provided is not adequate, it is permissible to use a separate sheet of paper as long as the questions are numbered and stapled to the bid.**

## **Instructions for Application:**

- All organizations bidding for service please complete the application in its entirety.
- Be clear and concise in 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.
- To checkmark boxes, double click on the box, under default value choose the box that says checked.
- Please submit typed answers only.

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## Applicant Information

### Basic Information and Provider Capability

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. Did the Provider receive over \$750,000 of Federal funding in the 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
- ☐ Credit Report
- ☐ Income Tax Statements

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6. The provider chooses appropriate boxes below, to indicate which Nutrition Service program(s):

<input style="width: 80%; height: 20px;" type="checkbox"/> Congregate Meals	<input style="width: 80%; height: 20px;" type="checkbox"/> Home Delivered Meals
-----------------------------------------------------------------------------	---------------------------------------------------------------------------------

7. The provider submits the application to provide in the following location(s) by service:

Cong.	HDM	Bonneville Co
		Ammon
		Idaho Falls
		Iona
		Irwin
		Swan Valley
		Ucon

Cong.	HDM	Fremont Co
		Ashton
		Drummond
		Island Park
		Saint Anthony
		Warm River

Cong.	HDM	Jefferson Co.
		Lewisville
		Menan
		Mud Lake
		Rigby
		Ririe

Cong.	HDM	Butte Co.
		Arco
		Butte City
		Moore

Cong.	HDM	Teton Co.
		Driggs
		Tetonia
		Victor

Cong.	HDM	Clark Co.
		Dubois
		Spencer
		Mackay
		Stanley

Cong.	HDM	Custer Co.
		Challis
		Clayton

Cong.	HDM	Lemhi Co
		Leadore
		Salmon

Cong.	HDM	Madison Co.
		Rexburg
		Sugar City

If Provider chooses a specific city or locale, will Home- Delivered Meal service have boundaries?

☐ Yes ☐ No

**Explain Boundaries:** \_\_\_\_\_

8. Attach job descriptions, by title, for **all** personnel, paid and volunteer, including administrative personnel who will support the Nutrition Meals program. **(Label Attachment #7)**

9. Attach a current list of the names of the Board of Directors with addresses, telephone numbers, office positions, year elected, and terms of office. **(Label Attachment #8)**

10. What is the mission of the Provider?

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11. What governing body will be responsible for the oversight of the program? Complete the 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. Attach a copy of the Provider's current health inspection and permit: **(Label Attachment #10)**

15. Attach a copy of the Provider's current Food Safety Manager's Certificate **(Label Attachment #11)**

16. Does the Provider ☐ Own **or** ☐ Lease any facilities needed to deliver the proposed service?  
**(Label Attachment #12 – Leased Facilities only)**

### Assurances

17. The Provider will ensure access to the Nutrition program will be equally available to all eligible seniors (individuals aged over 60 years and others as approved by ICOA).

☐ Yes ☐ No

18. The Provider is applying to provide Home-Delivered Meals service within the geographic area in and surrounding the location of the Congregate Meal site.

☐ Yes ☐ No

A. If no, explain in detail how the Home-Delivered Meals needs of homebound seniors are now and will be met in the geographic area. If the Provider's explanation is satisfactory to the AAA, the AAA may, in its sole and absolute discretion, exempt the Provider from the AAA's requirement to provide both Congregate and Home-Delivered Meals.

19. The Provider has read, understands in full, and will follow the AAA's Nutrition Scope(s) of Work – as outlined in the Contract Terms and Conditions.

☐ Yes ☐ No

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20. The Provider will accommodate for cultural differences and take them into account when delivering services.  
☐ Yes ☐ No
21. 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
22. The Provider will make accommodations to work with persons who speak a language other than English.  
☐ Yes ☐ No
23. The Provider is an equal opportunity employer and has an affirmative action policy, if applicable.  
☐ Yes ☐ No
24. 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**

25. 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 and increase usage of your organization.
26. Describe in detail any plans for expansion of this service.
27. Describe in detail how maintaining confidentiality of client information will be handled:
28. Describe in detail the plan to maintain confidentiality of client donations:
29. Describe in detail the Emergency Procedures in the event nutrition services are not operational (Please see Site Disaster Plan at the end of this application):
30. Describe in detail how annually client satisfaction of services will be assessed and completed on an annual basis:
31. Describe in detail the procedures for handling injuries to clients, staff, and volunteers:

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32. Describe in detail the procedures for handling, reporting, and documenting client complaints:
33. Describe in detail the Nutrition 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 Nutrition service(s) for seniors the Provider is planning to undertake. Include funding sources in addition to the funding structure:
34. Describe in detail what strengths uniquely qualify the Provider to provide Nutrition Services for seniors:
35. Describe in detail how you will identify ways to help reduce or combat social isolation for the seniors in your service area?

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

36. Describe in detail how the Provider has sufficient financial and in-kind resources to preclude total dependency on AAA funds:
36. 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:
37. 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.:

### **Program Sustainability**

38. Describe in detail the various activities and methods the Provider employs that are designed to increase community involvement, participation, and donations for Nutrition Meal services:

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39. 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):

40. How will the Provider assure services are provided throughout the contract within the confines of funding? (I.e., Provider budgeted for 10,000 units from January through December, served 8,000 units by October, how will this affect the program):

### **Budget(s)**

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

The intent of the funding provided by the AAA is to help support 1/3 of the cost of a meal.

Provider's Congregate Meal Budget is as follows:

<b>REVENUE</b>	<b>Amount</b>	<b>Comments</b>
AAA Funds ( <b>not to exceed \$2.80 per Congregate Meal</b> )		
County Funds		
City Funds		
Other Federal/State Funds		
Client donations		
Fundraisers		
Other: (Describe)		
<b>Total Revenue</b>		

<b>EXPENSES</b>	<b>Amount</b>	<b>Comments</b>
Total Annual Expenses		

Provider's Home-Delivered Meal Budget is as follows:

<b>REVENUE</b>	<b>Amount</b>	<b>Comments</b>
AAA Funds ( <b>not to exceed \$3.25 per Home-Delivered Meal</b> )		
County Funds		
City Funds		
Other Federal/State Funds		
Client donations		
Fundraisers		
Other: (Describe)		
<b>Total Revenue</b>		

<b>EXPENSES</b>	<b>Amount</b>	<b>Comments</b>
Total Annual Expenses		

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## **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 all information provided is true, complete, and accurate to the best of the 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.
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.

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**Signature of Provider Official**

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**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.

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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 other remedies available to the federal government, the appropriate federal agency may pursue available remedies including suspension and/ or debarment.

### **Debarment Certification**

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, 29 CFR Part 98, Section 98-5.10, Participant's Responsibilities. The regulations were published as Part VII of 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 the correct order as follows:
  - ☐ Attachment 1 – Articles of Incorporation - (not applicable if the provider is a for-profit agency)
  - ☐ Attachment 2 – Bylaws – (not applicable if the provider is a for-profit agency)
  - ☐ Attachment 3 – 501(c)(3) status – (not applicable if the 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 – Health Inspection and permit
  - ☐ Attachment 11 – Food Safety Manager Certificate
  - ☐ Attachment 12 – Lease Documentation – (if applicable)