Name of Organization: __________________________City, State: ______________

Brookdale National Group Respite Program

2024 RFP Checklist

Program Design

New, Start-Up Program	***OR***	[ ]
Program Expansion (of Group Respite or EML)		[ ]
Social Model Group Respite	***OR***	[ ]
Early Memory Loss Program (EML)		[ ]
Dementia-Specific Program	***AND***	[ ]
Services Available to Caregivers/Carepartners		[ ]

Grant Application Packet (Sent via email as attachments)

Completed Application:	[ ]
Proof of Non-Profit or Public Agency Status	[ ]
Staff Résumés	[ ]
Letters of Support/Commitment	[ ]
Annual Report: Scanned and attached via email	[ ]

This page is *intentionally left blank* as a back page to the 2024 RFP Checklist.

BROOKDALE NATIONAL GROUP RESPITE PROGRAM
For Families Living with Memory Loss

2024 Request For Proposals
(Please type or print clearly)

Name of sponsoring organization: ____

____

Address: ____

City: ________________________________ State: _____ Zip:_____________________

Executive Director: ____

Email Address: ____

Phone Number: ( ) ____________________

Name and Title of person to contact if there are any questions regarding the proposal: _____

____

Email Address: ____

Phone Number: ( ) ____________________ Cell ( )____________________________

Type of sponsoring agency:

___ Aging Service Provider
___ Adult Day Care Center
___ Area Agency on Aging
___ Caregiver Resource Center
___ Community Health Center
___ Family Service Agency
___ Home Health Care Agency
___ Hospital
___ Long Term Care Facility
___ Public Agency
___ Faith-Based Organization
___ Senior Center
___ YM/YWCA, YM/YWHA or JCC
___ Senior Housing
___ Other (Specify) _________
____
____

Type of program to be expanded or developed:

___ Group Respite Program, or
___ Early Memory Loss Program

Brookdale Foundation Group previous grantee: *Yes No*

Type of facility in which proposed program will be housed:

___ Church/Synagogue
___ Community Center
___ Day Care Center
___ Hospital
___ House
___ Long Term Facility
___ Senior Center
___ YM/YWCA, YM/YWHA or JCC
___ Other (Specify) ____________
____
___ Unknown at this time

Is the program to be housed in the same facility as the sponsoring agency ? *Yes No*

Geographic location of proposed program site:

___ Rural
___ Urban
___ Small Community
___ Suburban
___ Not Yet Known

Services to be provided to caregivers: (In-person and /or virtually)

___ Individual support/consultation
___ Support groups
___ Education and training
___ Information and referral

Projected number of days and hours program will operate weekly (In-person and /or virtually):
___ Days
___ Hours

Maximum number of participants that can be served daily ____

Projected total number of participants to be served in year one: ____

Projected average daily attendance at the end of year one: ____

Anticipated start date: __________

Name of Sponsoring Organization ____

I The Sponsoring Organization

A. Brief statement of the sponsoring organization's mission and scope of existing services:

B. Statement of the capability of the sponsoring organization to serve people with dementia and their families and/or careparnters:

C. Name and title of staff person who will be administratively responsible for the proposed program:

D. Name of proposed Group Respite or EML Program Coordinator, if known, and current title and responsibilities if that person is a staff member at the present time:

Name of Sponsoring Organization ____

E. Briefly state the nature of insurance coverage relevant to the proposed program site (do not include documents):

II Description of the Proposed Program

A. Please include the number of clients you propose to serve, a daily schedule, a weekly schedule, the admission and discharge criteria you have in place or will establish, and a description of activities in which you propose to engage participants.

B. Describe the ways in which your agency will connect with and engage participants, families and care partners if or when in-person programming is not possible.

C. **For EML programs**, include the methods and/or plans for transitioning members to other services in instances when the EML program is no longer appropriate.

Name of Sponsoring Organization ______________________________

II. Description of the proposed program (continued):

Name of Sponsoring Organization ____

III. Implementation Plans

A. Plans for the recruitment of participants and caregivers:

B Plans for hiring staff and recruiting volunteers:

C. Describe the site and space available (to be used when in-person programming is appropriate) for the proposed program. Please include the square footage of space for the planned program and description of the restroom and kitchen facilities, if known. *For EML programs, also describe the entrance to the program.*

C 1. If a facility has been identified, does it have the capacity to accommodate future expansion of the program, e.g. additional hours of operation and or additional program days? (Circle one) **Yes / No** (If **No**, please explain)

C 2. Is this site currently available for your use? (Circle one) **Yes / No** (If No, please explain)

D. Does the population you propose to serve have special needs or considerations, such as varying levels of care needed, geographic challenges, cultural observances, language barriers, lack of digital access, etc.? (Circle one) **Yes / No** (If Yes, please describe briefly):

E. Transportation needs and resources available to meet those needs:

F. The capabilities of your organization to train professional staff and volunteers:

Name of Sponsoring Organization____

G. Current staff resources and services of the sponsoring organization that can be made available to the proposed program:

H. Anticipated start date (if this date is not yet known, provide an approximate time frame in which the program will be initiated):

IV. Community Resources

A. Description of dementia-specific virtual and/or in-person programs and services currently available in the community. Also list any existing EML, Group Respite or Adult Day Programs in the area, including days and hours of operation:

Name of Sponsoring Organization____

B. List community-wide resources that might be made available to enrich the services provided to participants and family caregivers in the proposed program (e.g. individual counseling, support group leadership, volunteer training, transportation, internet access). Encourage these service providers to write a letter of commitment, detailing any resources they would provide to your program:

C. State why this program is needed in your community and why your agency should be selected to expand or establish a dementia-specific program:

V. Fiscal Information:

A. REVENUES - First Year of Operation of Proposed Program

This is an estimate of your projected revenue for the first year of operation.

Notes: The Total Revenue should equal Total Cash Support and Total In-Kind Support. The Total Revenue and Total Expenses (page 9) should be equal.

Cash Support	
Grants (Please Specify)	
Brookdale	$ **20,000**
	$
	$
	$
	$
Client Fees	**$**
Medicaid	**$**
Other Gov't Fee-for-Service	**$**
Insurance/Respite Subsidy	**$**
USDA/Meal Reimbursement	**$**
Transportation	**$**
Fundraising Events	**$**
Donations/Contributions	**$**
Interest Income	**$**
Other (Please Specify)	
	$
	$
Total Cash Support	$

In-Kind Support (Please specify type of support)*		Donor/ Source
	$	
	$	
	$	
	$	
	$	
Total In-Kind Support	$	
Total Revenue	$	

***In-Kind Support** could include any unpaid services or resources you receive, such as volunteer time, rental space, utilities, printing, supplies, meals, internet connectivity, etc.

Name of Sponsoring Organization____

V. Fiscal Information (continued):

B. EXPENSES - First Year of Operation of Proposed Program

This is an estimate of your projected expenses for the first year of operation.

Notes: Brookdale columns (Personnel and OTPS combined) must total $20,000. TOTAL EXPENSES should equal Total Personnel Expenses and Total OTPS Expenses from all sources **including In-Kind Support and their monetary value in the appropriate expense columns.**

Personnel (by Position) (Full-Time Equivalent)	Brookdale	Sponsoring Agency	Other Amount	Specify Source
Project Director (______% FTE)	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	
Benefits (at__________%)	$	$	$	
Total Personnel Expenses	$	$	$	

Other Than Personnel Services (OTPS)	Brookdale	Sponsoring Agency	Other Amount	Specify Source
Space/Rental	$	$	$	
Utilities	$	$	$	
Meals	$	$	$	
Equipment	$	$	$	
Program Supplies	$	$	$	
Printing/Copying	$	$	$	
Telephone	$	$	$	
Postage	$	$	$	
Travel/Transit	$	$	$	
Insurance	$	$	$	
Other (Please Specify)				
	$	$	$	
	$	$	$	
	$	$	$	
Total OTPS Expenses		$	$	
Total Personnel & OTPS	$ 20,000	$	$	
TOTAL EXPENSES (TOTAL OF ALL 3 COLUMNS)	$			

Name of Sponsoring Organization ______________________________

C. Are the funds (cash and/or in-kind) for the matching contribution of the sponsoring organization currently available? (Circle one) **Yes / No**

If Yes, funds should be indicated on your list of revenues. If No, when is it anticipated that funds will be made available?

D. What is the planned fee for this service? Please describe the fee schedule.

E. Indicate the specific plans for future funding and fundraising activities that will guarantee continuity of the program for the second year and beyond:

F. What is the sponsoring agency's total annual budget?

Name of Sponsoring Organization____

G. Does your state have requirements for licensure, certification or regulations for adult day care or for respite programs? (Circle one) **Yes / No**

If so, how will your proposed program meet these requirements?

VI. Attachments – The grant proposal is to be emailed, and the attachments must be named accordingly, i.e., A, B, C, and D. **The name of the organization, city and state must be included in the subject line of the submitted email.**

A. Verification of organization's 501(C)(3), public entity or equivalent tax exempt status - (labeled as Attachment A).
B. Resume of staff person who will be administratively responsible for the Alzheimer's Program (labeled as Attachment B).
C. Resume of proposed Alzheimer's Program Coordinator, if known (labeled as Attachment C).
D. Up to seven letters of support from key service agencies in the community are encouraged (e.g. Area Agency on Aging, Alzheimer's Association, etc.) [All letters of support must be submitted *with* the proposals* and be labeled as Attachment D].

**Letters of support mailed separately or sent by facsimile will not be accepted.*

VII. Annual Report – One (1) copy of most recent Annual Report must be sent (scanned or a PDF) and labeled *"Annual Report for (NAME OF AGENCY)."*

All attachments *must* be submitted with the proposal. Letters of support, the annual report or other attachments *will not be accepted* if they are sent separately from the submission of the proposal. Proposals that do not follow the above format or are not received by **Thursday, July 25, 2024** will not be accepted.

Submit the Grant Application and required attachments to: **rfp@brookdalefoundation.org**