Home and Community Based Services (HCBS)

ANNUAL DOCUMENTS

Schedule for Annual Documents Submission:

Senior Center Evaluation- ***June 30th***

Senior Center Waiver Request- ***June 30th***

Succession Plan Annual Certification-***July 1st***

ADA Compliance Certification- ***July 15th***

Declaration of Nepotism- ***July 15th***

III D Annual Certification -***July 15th***

Insurance Certification-***July 15th***

By-Laws Certification-***July 31st***

Senior Center Evaluation

Fiscal Year:

Date:

Senior Center: A State-Funded Senior Center must have or provide access to nutrition services; transportation; information and assistance; education and enrichment; and wellness per the GOEA Policy and Procedure Manual, §1233.D.3.

GOEA requires that a Senior Center shall serve an average of 20 participants per day and shall operate four hours a day, five days per week. Note: At its discretion, GOEA may grant waiver(s) on a case by case evaluation.

Waiver Approved by GOEA: ☐ Yes : ☐ No

Senior Center Contact Information:

Agency:	
Name of Senior Center:	
Street Address (No P.O. Boxes):	
City: Pineville	**State:**
Site Manager's Name:	**Title:**
Telephone Number:	
Website Address:	

Minimum Requirements:

Below are the services you **must** provide or have access to as a Senior Center. Please verify and check the services the Senior Center offers.

☐ Nutrition Services (Meals/Nutrition Education)
☐ Transportation (To and from Senior Center)
☐ Information & Assistance
☐ Education & Enrichment
☐ Wellness (IIIB or IIID)

What day(s) of the week is the Senior Center operating? Please specify the actual hours of operation (example: 8:00 am-12:00 pm).

Day of the Week	Hours of Operation
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

On average, how many participants are served by the Senior Center daily?

_____

Does the Senior Center have:		
Participants aged 60 and older only?	☐ Yes	☐ No
Assessments performed on each participant annually?	☐ Yes	☐ No
Signs identifying the building as a Senior Center?	☐ Yes	☐ No
Adequate handicapped parking?	☐ Yes	☐ No
Handicapped bathrooms?	☐ Yes	☐ No
Mission Statement?	☐ Yes	☐ No
Goals and Objectives?	☐ Yes	☐ No
Grievance Procedures/Form?	☐ Yes	☐ No
Code of Conduct for participants posted?	☐ Yes	☐ No
Current menu posted?	☐ Yes	☐ No
Donation box located away from the sign-in sheet?	☐ Yes	☐ No
Suggested donation amount listed on or near the donation box?	☐ Yes	☐ No
Sign stating that leftover food cannot be taken out of the building?	☐ Yes	☐ No
Brochure or calendar of events to distribute to participants?	☐ Yes	☐ No
State and Federal Labor Laws posted for employees?	☐ Yes	☐ No
Procedure Manual for the staff and volunteers?	☐ Yes	☐ No
Staff trained in First Aid, CPR, and Blood borne pathogens (at a minimum)?	☐ Yes	☐ No
Volunteers trained in First Aid, CPR, and Blood borne pathogens (at a minimum)?	☐ Yes	☐ No
Easily accessible First Aid kit?	☐ Yes	☐ No
Easily accessible Blood borne pathogen kit?	☐ Yes	☐ No

Are there plans to expand or enhance current services offered by the Senior Center?

☐ Yes ☐ No

If yes, please explain:

_____

_____

Note: GOEA may request any and all information from this evaluation during its monitoring process.

Senior Center Satellite Evaluation

Fiscal Year:

Date:

Senior Center Satellite: An activity site which meets less than the minimum standards required for a Senior Center.

Agency:		
Name of Senior Center Satellite:		
Street Address (No P.O. Boxes):		
City:	**State:**	**Zip:**
Site Manager's Name:	**Title:**	
Telephone Number:		
Website Address: www.		

What day(s) of the week is the Senior Center operating? Please specify the actual hours of operation (example: 8:00 am-12:00 pm).

Day of the Week	Hours of Operation
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

On average, how many participants are served by the Senior Center Satellite Site daily?

_____

Which of the following services is NOT provided by the Senior Center Satellite Site?

- ☐ Nutrition Services (Meals/Nutrition Education)
- ☐ Transportation (to and from Satellite Site)
- ☐ Information & Assistance
- ☐ Education & Enrichment
- ☐ Wellness (IIIB or IIID)

Additional Information:

_____

_____

_____

Note: GOEA may request any and all information from this evaluation during its monitoring process.

Meal Site Evaluation

Fiscal Year:

Date:

Meal Site: A place where older adults come together for congregate meals **only**.

Agency:		
Name of Meal Site:		
Street Address (No P.O. Boxes):		
City:	**State:**	**Zip:**
Site Manager's Name:	**Title:**	
Telephone Number:		
Website Address: www.		

What day(s) of the week is the Meal Site operating? Please specify the actual hours of operation (example: 8:00 am-12:00 pm).

Day of the Week	Hours of Operation
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

On average, how many participants are served by the Meal Site daily?

_____

Additional Information:

_____

_____

_____

_____

Note: GOEA may request any and all information from this evaluation during its monitoring process.

OFFICE OF ELDERLY AFFAIRS
SENIOR CENTER WAIVER REQUEST

Agency Name: _____

Senior Center: _____

Address: _____

_____

Date: _____

REQUESTING WAIVER OF:

☐ GOEA Policy Manual §*1233.D.5* - To operate less than four (4) hours per day.

Proposed Hours of Operation: _____

☐ GOEA Policy Manual §*1233.D.5* - To operate less than five (5) days per week.

Proposed Days of Operation: _____

☐ GOEA Policy Manual §*1233.D.4* – To serve less than twenty (20) participants per day.

Proposed Average Number of Participants per day: _____

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GOEA USE ONLY

WAIVER APPROVED: ☐ Yes ☐ No

REASON(S) FOR NON-APPROVAL: _____

_____

_____

_____

GOEA Administration Approval (Signature/Title/Date)

NOTE: Both pages of PAF 4028 must be filled out before GOEA will review the waiver request.

OFFICE OF ELDERLY AFFAIRS
SENIOR CENTER WAIVER REPORT

Agency Name: _____

Senior Center: _____

Date: _____

Please include the following information in your report.

1. Describe the outreach activities implemented to increase attendance at the center.

2. What community planning activities did the agency engage in with other community agencies?

3. Did the participant attendance increase due to the outreach efforts? How much?

NOTE: Both pages of PAF 4028 must be filled out before GOEA will review the waiver request.

SUCCESSION PLAN
CERTIFICATION FORM

This is to certify that the Board of Directors of the _____ Council on Aging reviewed its Succession Plan at its board meeting on _____.

The Succession Plan dated _____, *has____ or has not* _____ been revised. *If the Succession Plan has been revised*, a copy of the current *updated* Succession Plan is attached. ____ *Yes* ____ *No*

_____	_____	_____
Board Secretary (typed)	Signature	Date

_____	_____	_____
Director (typed)	Signature	Date

Certification is due to GOEA by July 1st of each year if the Succession Plan has not been changed.

Annual Certification of
American with Disabilities (ADA) Compliance

Agency: _____

Per the Americans with Disabilities (ADA) Act (www.ada.gov), public buildings must be accessible to individuals with disabilities. This is to certify that the agency's buildings (AAA, COA, Meal Sites, Satellite Sites, etc.) are in compliance with the ADA. If not, attach a plan of action for corrections.

Please list the sites that are **not** ADA Accessible:

_____

_____

_____

_____

Director's Signature: _____

Date: _____

Board Chairman's Signature: _____

Date: _____

Must be received by GOEA July 15th Annually

PAF 4045
Revised 08/2017

Declaration of Nepotism Form

Agency: _____

For the purpose of this form, "Immediate family" is defined as follows: husband, wife, father, father-in-law, mother, mother-in-law, brother, brother-in-law, sister, sister-in-law, son, son-in-law, daughter, daughter-in-law, grandfather, grandmother.

Does this Area Agency on Aging/Council on Aging employ any immediate family member of the Agency Head or of the Board of Directors?

☐ Yes
☐ No

Director's Signature: _____

Date: _____

IIID EVIDENCE BASED – HIGHEST LEVEL
CERTIFICATION FORM

This is to certify that the Board of Directors of the _____ Area Agency on Aging reviewed IIID Evidenced Based Program and certifies that it meets the requirements of Highest Level Evidence Based. The certification documents are on file for the current year.

The program approved by GOEA effective 7/1/2015 is still being provided **____YES ____ NO**. If not, attached is the request to provide the **_____ IIID Evidenced Based Highest Level Program** (include a copy of the certification documents/certificate) effective _____.

_____	_____	_____
Board Secretary (typed)	Signature	Date
_____	_____	_____
Director (typed)	Signature	Date

Certification is due to GOEA by July 15th of each year.

BOARD OF DIRECTORS
BY-LAWS CERTIFICATION

This is to certify that the Board of Directors of _____ Council on Aging reviewed its by-laws dated _____ at its Board of Director's meeting on _____ and found them to be in compliance with the Governor's Office of Elderly Affairs (GOEA) Policy and Procedure Manual, §1161.

The by-laws, dated _____, *have* _____ *or have not* _____ been revised. *If by-laws have been revised,* a copy of the current updated by-laws were forwarded to GOEA by a letter of transmittal dated _____. The by-laws were found to concur with the Agency's Articles of Incorporation.

_____ _____

Board Secretary (Printed Name) Board Secretary Signature

_____

Date

Certification must be received by GOEA July 31st of each year.