



## APPLICATION FOR OLDER AMERICANS ACT FUNDING

Agency: \_\_\_\_\_

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

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Agency Type:**

Public/Government       Private Non-Profit       Private For Profit

**Program Area:**

<input type="checkbox"/> Personal Care	<input type="checkbox"/> Congregate Nutrition	<input type="checkbox"/> LTC Ombudsman
<input type="checkbox"/> Homemaker	<input type="checkbox"/> Transportation	<input type="checkbox"/> Family Caregiver Programs
<input type="checkbox"/> Home Delivered Meals	<input type="checkbox"/> Legal Services	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Adult Day/Health	<input type="checkbox"/> Info & Assistance	
<input type="checkbox"/> Case Management	<input type="checkbox"/> Health Services	

**Geographic Area to be Served:**

\_\_\_\_\_

**Summary of Cost (See Instructions):**

- |  |          |
|--|----------|
| 1. Older Americans Act Funds Requested | \$ _____ |
| 2. Non-Federal Match                   |          |
| A) Cash                                | \$ _____ |
| B) Value of In-Kind                    | \$ _____ |
| 3. Program Income                      | \$ _____ |
| 4. Other Non-Match, Non-Income Funds   |          |
| A) _____                               | \$ _____ |
| B) _____                               | \$ _____ |
| C) _____                               | \$ _____ |
| D) _____                               | \$ _____ |
| 5. Total Program Cost (1+2+3+4)        | \$ _____ |

The governing body of the applicant has authorized this proposal for submission.

Authorized Signature \_\_\_\_\_ Date: \_\_\_\_\_





Applicant Agency\_\_\_\_\_

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PROGRAM DESCRIPTION

As described in Section IV, Part A, #1-7

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Applicant Agency \_\_\_\_\_

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**PROGRAM DESCRIPTION**

As described in Section IV, Part A, #1-7

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PROGRAM DESCRIPTION

As described in Section IV, Part A, #1-7

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Applicant Agency \_\_\_\_\_

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**PROGRAM DESCRIPTION**

As described in Section IV, Part A, #1-7

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List the minimum number of units to be provided for each required unit of service and the unduplicated persons to be served, as described in Section IV, Part A, #1.d

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TYPE OF UNITS TO BE PROVIDED	NUMBER OF UNITS	UNDUPLICATED PERSONS
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List at least one measurable objective for each of the following program areas: reaching the target population, staffing and volunteers, coordination with other groups, public information, client input, and obtaining voluntary contributions, as described in Section IV, Part A, #8.

Program Area	Objective	How Measured
Target Population		
Staffing & Volunteers		

Coordination

Public Information



Client Input

Voluntary  
Contributions



SOURCEWISE  
COMMUNITY RESOURCE SOLUTIONS

Applicant Agency\_\_\_\_\_

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PROGRAM MANAGEMENT  
As described in Section IV, Part B.

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PROGRAM MANAGEMENT  
As described in Section IV, Part B.

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Applicant Agency \_\_\_\_\_

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PROGRAM MANAGEMENT  
As described in Section IV, Part B.

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Applicant Agency \_\_\_\_\_

Attach the following documentation:

Organizational Chart included
501c3 designation included (if necessary)
Job Descriptions included
Board of Directors roster included
Bond & Insurance information included
Documentation of Emergency plan and client's grievance process included
Transition plan for termination or transfer of services included
Plan for additional and/or decreased funding included