**Attachment 2**

**Application Cover Page and Minimum Eligibility Attestation**

**RFA 20563 - Community Aging in Place - Advancing Better Living for Elders (CAPABLE)**

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| **Application to Implement CAPABLE: Community Aging in Place – Advancing Better Lives for Elders** |

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| --- | --- | --- |
| **Applicant Organization:** |  | |
| **Address:** |  | |
| **City, State, Zip:** |  | |
| **Region for which Applicant is applying\*:** |  | |
| **\***Applicants may apply to multiple regions but must submit **one application per each region**. | | |
| **SPONSOR AGENCY DOCUMENTATION** | | |
| **NYS SFS Vendor Identification #:** | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **INDIVIDUAL TO CONTACT REGARDING THIS APPLICATION** | | | |
| **Name:** |  | | |
| **Title:** |  | **Phone:** |  |
| **Email:** |  | **Fax:** |  |

**MINIMUM ELIGIBILITY ATTESTATION**

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| --- | --- | --- |
| * Applicant is prequalified in the New York State Statewide Financial System (SFS), if not exempt, on the date and time Applications in response to this Request for Applications (RFA) are due. |  | **Yes** |
|  | **No** |

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| --- | --- | --- |
| * Applicant is a 501(c)(3) not-for-profit organization, or a for-profit organization, either of which provides or arranges for services for aging individuals with a functional need for assistance or chronic health conditions. |  | **Yes** |
|  | **No** |
| * Applicant is authorized to do business in New York State. If located outside of New York State, the applicant has a brick-and-mortar location in New York State. |  | **Yes** |
|  | **No** |
| * Applicant submits this Attachment 2 – Application Cover Page and Minimum Eligibility Attestation signed by the Chief Executive Officer (CEO), or another authorized individual designated to sign on behalf of the organization, to certify they meet all minimum qualifications of the RFA. |  | **Yes** |
|  | **No** |
|  |  |
| * Applicant must either be an entity licensed under Article 36 of the Public Health Law or contracts with an entity licensed under Article 36 of the Public Health Law to provide nursing and occupational therapy services in participants’ homes. Each applicant must provide Article 36 licensure information in the table below for nursing and occupational services to be provided for the CAPABLE program.  |  |  |  | | --- | --- | --- | | **ARTICLE 36 LICENSURE INFORMATION** | | | | **APPLICANT INFORMATION** | | | | **Applicant Name** |  | | | **Applicant License Number, if applicable** |  | | | **Counties the Applicant Proposes to Serve** |  | | | **SUBCONTRACTOR INFORMATION, IF APPLICABLE**  **(for nursing and occupational therapy services only)** | | | | **Subcontractor Name** | **County** |  | | **License**  **Number** |  | | **Services**  **(RN, OT,**  **Both)** |  | | **Subcontractor Name** | **County** |  | | **License**  **Number** |  | | **Services**  **(RN, OT,**  **Both)** |  | |  | **Yes** |
|  | **No** |
|  |  |

**AUTHORIZED APPLICANT AGENCY ADMINISTRATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **AGENCY CEO, EXECUTIVE DIRECTOR OR ADMINISTRATOR** | | | | |
| **Name:** |  | | | |
| **Title:** |  | | | |
| **Email:** |  | | | |
|  | | | | |
| **AGENCY FISCAL OFFICER** | | | | |
| **Name:** |  | | | |
| **Title:** |  | | | |
| **Email:** |  | | | |
|  | | | | |
| **AUTHORIZED SIGNATORY** | | | | |
| **Name:** | |  | | |
| **Title:** | |  | | |
| **Email:** | |  | | |
| **Signature:** | |  | **Date:** |  |

By signing above the Applicant certifies that all information provided is true and correct and acknowledges its role with respect to the implementation of the CAPABLE program as described in the RFA. The Applicant understands, and hereby agrees, that submission of a complete Application, and the subsequent execution of a contract to implement the CAPABLE program, carries with it the obligation to provide CAPABLE services and perform all required Program Tasks. These include, but are not limited to, those listed in the RFA.