

**SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**

118



FROM: Office on Aging

SUBMITTAL DATE:
November 3, 2009

SUBJECT: Memorandum of Understanding (#CAP-09-040) with the Community Action Partnership (CAP) and Riverside County Office on Aging/ Aging and Disability Resource Connection (OoA/ ADRC), 07/01/2009 – 09/30/2010

RECOMMENDED MOTION: That the Board of Supervisors:

1. Direct the Auditor Controller to increase the Estimated Revenue and Appropriations by \$142,004 as outlined in Attachment "A".

BACKGROUND: On February 17, President Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA). The ARRA provided CAP Riverside with approximately \$3.4 million in additional funds Federal Fiscal Year 2009 to address ARRA priorities. On June 6, 2009 the BOS approved agenda item 3.21(06-02-09) agreement. CAP Riverside in partnership with the Office On Aging will utilize \$177,505 to fund the following project:

The project will fund 5 Community Outreach Specialist positions to provide information and assistance to seniors and disabled individuals who may benefit from Weatherization and energy efficiency services as well as other CAP and OoA/ ADRC supports. The Community Outreach Specialist will operate out of the offices located in Hemet, and Palm Desert and the Office on Aging main office in Riverside to ensure consumers have countywide access to this project.

Continued (Page 2)

Edward F. Walsh
Edward F. Walsh, Director

FINANCIAL DATA	Current F.Y. Total Cost:	\$ 142,004	In Current Year Budget:	No
	Current F.Y. Net County Cost:	\$ 0	Budget Adjustment:	Yes
	Annual Net County Cost:	\$ 0	For Fiscal Year:	09/10

SOURCE OF FUNDS: 100% Federal – American Recovery and Reinvestment Act of 2009	Positions To Be Deleted Per A-30	<input type="checkbox"/>
	Requires 4/5 Vote	<input checked="" type="checkbox"/>

C.E.O. RECOMMENDATION:

APPROVE

BY: *Lani Sioson*
Lani Sioson

County Executive Office Signature

Prev. Agn. Ref.: 3.21 (06-02-09)

District: All

Agenda Number:

3.23

ATTACHMENTS FILED
WITH THE CLERK OF THE BOARD

FISCAL PROCEDURES APPROVED
ROBERT E. BYRD, AUDITOR-CONTROLLER
BY: *[Signature]* 11/19/09
SUSANA GARCIA-BOCANEGRA

FORM APPROVED COUNTY COUNSEL
BY: *[Signature]* DATE
N. AL K. KIPNIS

Departmental Concurrence

Dept't Recomm.: Consent Policy

Per Exec. Ofc.: Consent Policy

Currently, the \$142,004 allocated to this project is not in the OoA/ ADRC 09/10 fiscal year budget. In order to meet the objectives of the project the allocated funds need to be added to the Estimated Revenue and Appropriations FY 09/10.

The total allocation for program from the grant is \$177,505. We anticipate spending \$142,004 in FY09/10 based on the guidelines disclosed. The additional \$35,501 and any over and under expenditures will be carried over to FY10/11.

There is no impact to county general fund and there are no matching requirements.

Office on Aging
Attachment A
FY 2009-2010

INCREASED ESTIMATED REVENUE

5300100000-21450-767140	Fed-Misc Reimbursement	2009-2010 <u>142,004</u>
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INCREASED APPROPRIATION

5300100000-21450-510040	Regular Salaries	6,455
5300100000-21450-510330	Tap Salaries	114,639
5300100000-21450-520200	Communication	1,200
5300100000-21450-520260	Computer Lines	1,200
5300100000-21450-521640	Maint-Software	1,648
5300100000-21450-523700	Office Supplies	800
5300100000-21450-523720	Photocopying	400
5300100000-21450-523760	Postage-Mailing	400
5300100000-21450-523840	Computer Equipment-Software	2,243
5300100000-21450-527780	Special Program Expense	7,502
5300100000-21450-528920	Car Pool Expense	1,360
5300100000-21450-529040	Private Mileage Reimbursement	<u>4,157</u>
	Total	142,004

Attachment A; CAP (The American Recovery & Reinvestment Act of 2009)

Date: November 3, 2009

**ATTACHMENT A:
SCOPE OF SERVICE**

FUNDING INITIATIVE: 2009 CSBG Recovery Local Plan	
CAP Riverside will fund 4 Community Outreach Specialist positions to be located in Office on Aging sites (Riverside Main office, Hemet and Palm Desert offices) to provide information and referrals for senior/disabled individuals throughout Riverside County. Information will be provided on CAP Riverside programs, food stamps, eligibility and application processes, long-term care assessments/options, assistance with various program application processes (CARE, utility assistance, weatherization, etc.), etc. Home visits will be conducted for home-bound seniors/disabled.	
Geographic Area(s) of Service: West County	
Program Outcome(s)	
1. 3 of 4 (75%) participants will increase their income by retaining a job for 12 months or longer by the end of the contract term.	
Program Output(s)	
1. 20,000 seniors will receive outreach materials on available community services.	
Budget	
Personnel: Salaries/Wages/Benefits	\$151,368
Direct Program Costs	\$10,000
Indirect Cost	\$16,137
Total Grant:	\$177,505

Community Action Partnership of Riverside County

2038 Iowa Avenue, Suite B-102

Riverside, CA 92507

MEMORANDUM OF UNDERSTANDING: CAP-09-040

PROVIDER: Riverside County Office on Aging

MEMORANDUM OF UNDERSTANDING TERM: July 1, 2009 through September 30, 2010

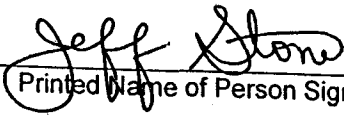
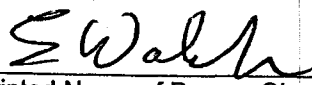
MAXIMUM REIMBURSABLE AMOUNT: \$177,505


WHEREAS, the Community Action Partnership of Riverside County, hereinafter referred to as CAP Riverside, desires to provide a Senior Information and Referral Project;


WHEREAS, Riverside County Office on Aging is qualified to provide outreach services to seniors;

WHEREAS, CAP Riverside desires Riverside County Office on Aging hereinafter referred to as the PROVIDER, to perform these services in accordance with the TERMS and CONDITIONS (T&C) attached hereto and incorporated herein by this reference. The T&C specify the responsibilities of CAP Riverside and the PROVIDER;

NOW THEREFORE, CAP Riverside and the PROVIDER do hereby covenant and agree that the PROVIDER shall provide said services in return for monetary compensation, all in accordance with the terms and conditions contained herein, of this Memorandum of Understanding, hereinafter referred to as MOU.

Authorized Signature for Purchasing: 	Authorized Signature for PROVIDER: 
Printed Name of Person Signing: Jeff Stone	Printed Name of Person Signing: Ed Walsh
Title: Chairman, Board of Supervisors	Title: Director
Address: 4080 Lemon Street Riverside, CA 92501	Address: 6296 Rivercrest Drive #K Riverside, CA 92507-0738
Date Signed: JUN 02 2009	Date Signed:

ATTEST:
KECIA HARPER-IHEM, Clerk
By 
DEPUTY

FORM APPROVED COUNTY COUNSEL
BY:  8/18/09
TADISA B. MOYER

Riverside County Office on Aging
MEMORANDUM OF UNDERSTANDING
TERMS AND CONDITIONS

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LIST OF EXHIBITS AND ATTACHMENTS

- Attachment A – Scope of Work
- Exhibit A – Contractor Payment Request Form 2076A
- Exhibit B – Form 2076B
- Exhibit C – Instructions for Form 2076A and 2076B
- Exhibit D – Monthly Program Performance Report
- Exhibit E – CSBG Programmatic Data – Client Characteristic Report (CSD 295-CCR)

MOU TERMS AND CONDITIONS

I. CAP RIVERSIDE RESPONSIBILITIES

- A. CAP Riverside will assign staff to act as liaison between the PROVIDER and CAP Riverside.
- B. CAP Riverside will monitor the performance of the PROVIDER in meeting the terms, conditions, and services in this MOU. CAP Riverside, at its sole discretion, may monitor the performance of the PROVIDER through any combination of the following methods: periodic on-site visits, annual inspections, evaluations, and PROVIDER self-monitoring.

II. PROVIDER RESPONSIBILITIES

- A. Assign staff to act as liaison to CAP RIVERSIDE.
- B. Provide services as described in the Scope of Work attached hereto and incorporated herein as "Attachment A".

III. FISCAL PROVISIONS

A. MAXIMUM AMOUNT

Total payment under this MOU shall not exceed \$177,505

B. LINE ITEM BUDGET

Personnel: Salaries/Wages/Benefits	\$151,368
Direct Program Costs	\$10,000
Indirect Costs	\$16,137
Total Grant:	\$177,505

C. METHOD, TIME, AND SCHEDULE/CONDITION OF PAYMENTS

1. CAP Riverside will reimburse the PROVIDER for services provided in accordance with the terms and conditions contained herein, in this MOU.
1. The Contractor shall submit the Contractor Payment Request Form 2076A (Exhibit A) and the Form 2076B (Exhibit B) on a calendar month basis, following the instructions in Instructions for Form 2076A and 2076B (Exhibit C). **The Form 2076B is due on a monthly basis regardless of activity.** Supporting documentation such as pay stubs must accompany the 2076A. Exhibits A, B, C are attached hereto and incorporated herein by these references.
2. Each claiming period shall consist of a calendar month claiming period. Contractor invoices are due no later than the 5th day of the month after which services were rendered. Any invoice not received within the time period indicated above may be rejected by CAP Riverside in its entirety if it is not feasible for CAP Riverside to make payment.
3. All invoices submitted in a timely manner shall be processed by CAP Riverside within ten (10) working days of receipt by CAP Riverside and forwarded to the Auditor-Controller's Office for payment.
4. If the PROVIDER ceases operation for any period, then no payment will apply for that period.

3. All invoices submitted in a timely manner shall be processed by CAP Riverside within ten (10) working days of receipt by CAP Riverside and forwarded to the Auditor-Controller's Office for payment.
 4. If the PROVIDER ceases operation for any period, then no payment will apply for that period.
- D. RECORDS, INSPECTIONS, AND AUDITS**

The PROVIDER shall maintain auditable books, records, documents, and other evidence pertaining to costs and expenses in this MOU. The PROVIDER shall maintain these records for three (3) years after final payment has been made or until all pending county, state, and federal audits, if any, are completed, whichever is later.

1. Any authorized representative of the County of Riverside, the State of California, and the federal government shall have access to any books, documents, papers, electronic data, and other records, which these representatives may determine to be pertinent to this MOU, for the purpose of performing an audit, evaluation, inspection, review, assessment, or examination. These representatives are authorized to obtain excerpts, transcripts, and copies, as they deem necessary. Further, these authorized representatives shall have the right at all reasonable times to inspect or otherwise evaluate the work performed, or being performed, under this MOU and the premises in which it is being performed.
2. This access to records includes, but is not limited to, service delivery, referral, financial, and administrative documents for three (3) years after final payment is made, or until all pending county, state, and federal audits are completed, whichever is later.
3. Should the PROVIDER disagree with any audit conducted by CAP Riverside, the PROVIDER shall have the right to employ a licensed, Certified Public Accountant (CPA) to prepare and file with CAP Riverside a certified financial and compliance audit that is in compliance with generally-accepted government accounting standards of related services provided during the term of this MOU. The PROVIDER shall not be reimbursed by CAP Riverside for such an audit.
4. In the event the PROVIDER does not make available its books and financial records at the location where they are normally maintained, the PROVIDER agrees to pay all necessary and reasonable expenses, including legal fees, incurred by CAP Riverside in conducting such an audit.

E. DISALLOWANCE

In the event the PROVIDER receives payment for services under this MOU which is later disallowed for nonconformance with the terms and conditions herein by CAP Riverside, the PROVIDER shall promptly refund the disallowed amount to CAP Riverside on request, or at its option, CAP Riverside may offset the amount disallowed from any payment due to the PROVIDER under any MOU with CAP Riverside.

F. AVAILABILITY OF FUNDING

CAP Riverside's obligation for payment of any MOU is contingent upon the availability of funds from which payment can be made.

IV. GENERAL PROVISIONS

A. EFFECTIVE PERIOD

This MOU is effective July 1, 2009 through September 30, 2010.

B. NOTICES

All notices, reports, claims, correspondence, and/or statements authorized or required by this MOU shall be addressed as follows:

CAP Riverside:
County of Riverside
Community Action Partnership
of Riverside County
2038 Iowa Avenue, Suite B-102
Riverside, CA 92507-2412
(951) 955-4900

PROVIDER:
Riverside County Office on Aging
6296 Rivercrest Drive #K
Riverside, CA 92507-0738
Attention: Ed Walsh
(951) 867-3800

All notices shall be deemed effective when they are made in writing, addressed as indicated above, and deposited in the United States mail. Any notices, correspondence, reports and/or statements authorized or required by this MOU, addressed in any other fashion will not be acceptable.

C. CONFIDENTIALITY

The PROVIDER shall maintain the confidentiality of all information and records and comply with all other statutory laws and regulations relating to privacy and confidentiality.

D. REPORTING

The following reports shall be submitted to CAP Riverside no later than the due dates indicated, including periods where there is no activity. Exhibit D and E are attached hereto and incorporated herein by this reference.

EXHIBIT #	TITLE OF REPORT	DUE DATE
D	Monthly Program Performance Report	5 th day of each month
E	CSBG Programmatic Data Client Characteristic Report (CSD 295-CCR)	Quarterly: Jul - Sep due Oct 5, 2009 Oct - Dec due Jan 5, 2010 Jan - Mar due Apr 5, 2010 Apr - Jun due Jul 5, 2010 Jul - Sep due Oct 5, 2010

E. COMPLIANCE WITH RULES, REGULATIONS, REQUIREMENTS, AND DIRECTIVES

The PROVIDER shall comply with all rules, regulations, requirements, and directives of the California Department of Social Services, other applicable state agencies, and funding sources which impose duties and regulations upon CAP Riverside, which are equally applicable and made binding upon the PROVIDER as though made with the PROVIDER directly.

F. DISPUTES

Except as otherwise provided in this MOU, any dispute concerning a question of fact arising under this MOU, which is not disposed by MOU, shall be disposed by County of Riverside's Purchasing Compliance Officer which shall furnish the decision in writing. The decision of County of Riverside's Purchasing Compliance Officer shall be final and conclusive until determined by a court of competent jurisdiction to have been fraudulent or capricious, arbitrary, or so grossly erroneous as necessarily to imply bad faith. The PROVIDER shall proceed diligently with the performance of the MOU pending County of Riverside's Purchasing Compliance Officer decision.

Riverside's Purchasing Compliance Officer shall be final and conclusive until determined by a court of competent jurisdiction to have been fraudulent or capricious, arbitrary, or so grossly erroneous as necessarily to imply bad faith. The PROVIDER shall proceed diligently with the performance of the MOU pending County of Riverside's Purchasing Compliance Officer decision.

G. SANCTIONS

Failure by the PROVIDER to comply with any of the provisions covenants, requirements, or conditions of this MOU including, but not limited to, reporting and evaluation requirements, shall be a material breach of this MOU. In such event, Purchasing may immediately terminate this MOU and may take other remedies available by law, or otherwise specified in this MOU. Purchasing may also:

1. Afford the PROVIDER a time period within which to cure the breach, the period of which shall be established at the sole discretion of Purchasing and CAP Riverside; and/or
2. Discontinue reimbursement to the PROVIDER for, and during the period in which the PROVIDER is in breach, the reimbursement of which the PROVIDER shall not be entitled to recover later; and/or
3. Withhold funds pending a cure of the breach; and/or
4. Offset against any monies billed by the PROVIDER but yet unpaid by CAP Riverside. CAP Riverside shall give the PROVIDER notice of any action pursuant to this paragraph, the notice of which shall be effective when given.

H. TERMINATION

This MOU may be terminated without cause by either party by giving thirty (30) days written notification to the other party. In the event CAP Riverside elects to abandon, indefinitely postpone, or terminate the MOU, CAP Riverside shall make payment for all services performed up to the date that written notice was given in a prorated amount.

I. MODIFICATION OF TERMS

The Board of Supervisors and the COUNTY Purchasing Agent are the only authorized COUNTY representatives who may at any time, by written order, make alterations within the general scope of this MOU, in the definition of services to be performed, and the time (i.e. hours of the day, days of the week, etc.) and place of performance thereof. If any such alteration causes an increase or decrease in the cost of, or the time required for the performance of any part of the work under this MOU, an equitable adjustment shall be made in the MOU price or delivery schedule, or both, and the MOU shall be modified in writing accordingly. Any claim by the PROVIDER for adjustment under this paragraph shall be assessed within 30 days of when the PROVIDER received notice of the alteration in the work. Notwithstanding the foregoing, if the COUNTY Purchasing Agent decides that the facts provide sufficient justification, he/she may receive and act upon any claim, which is asserted by the PROVIDER at any time prior to final payment under this MOU. Failure to agree to any adjustment shall be a dispute concerning a question of fact within the meaning of the clause of this MOU entitled 'Disputes.' However, nothing in this clause shall excuse the PROVIDER from proceeding with the MOU as changed.

J. ENTIRE MOU

This MOU constitutes the entire MOU between the parties hereto with respect to the subject matter hereof, and all prior or contemporaneous MOUs of any kind or nature relating to the same shall be deemed to be merged herein.

CONTRACTOR PAYMENT REQUEST
CAP FORM # 2076A

Exhibit A

TO: Community Action Partnership
of Riverside County
Attn: Fiscal Division
2038 Iowa Avenue Suite B-102
Riverside, CA 92507

FROM: _____
Remit to Name _____
Address _____
City _____ State _____ Zip Code _____
Contractor Name _____
Contract Number _____

Customer Name _____

Total amount requested _____ for the period of _____ 20 _____

Select Payment Type(s) Below

Advance Payment \$ _____
(If allowed by Contract/MOU)

Actual Payment \$ _____
(Same amount as CAP FORM # if required)

Unit of Service Payment

_____ (# of Units) x _____ (Unit Price) = \$ _____ (Total)

_____ (# of Units) x _____ (Unit Price) = \$ _____ (Total)

Any questions regarding this request should be directed to: _____
Name Phone #

I hereby certify under penalty of perjury that to the best of my knowledge the above is true and correct.

Authorized Signature _____ Title _____ Date _____

FOR CAP RIVERSIDE USE ONLY (DO NOT WRITE BELOW THIS LINE)

Business Unit (5) _____	Purchase Order # and line # (10) _____	Invoice # _____
Account (6) _____	Amount Authorized _____	
Fund (5) _____	<i>Comments</i>	
Dept ID (10) _____	<i>if amount</i>	_____
	<i>authorized</i>	_____
	<i>is different</i>	_____
	<i>from amount</i>	_____
	<i>requested</i>	
Program (5) _____	Programs _____	Date _____
Class (10) _____	Fiscal (Staff) _____	Date _____
Project/Grant (15) _____	Contracts _____	Date _____
Vendor Code (10) _____	Fiscal (Accountant) _____	Date _____

RETURN TO CAP RIVERSIDE, FISCAL DIVISION

**Community Action Partnership of Riverside County
Instructions for Form 2076A and Form 2076B**

Mailing Instructions: When completed, these forms will summarize all of your claims for payment. Your Claims Packet will include Form 2076A (page 1), Form 2076B (page 2 - if applicable) invoices, payroll verification, and copies of cancelled checks attached (required). If cover letter is included (not required) attach to front of Claims Packet Mail Claims Packet to address shown on upper left corner of Form 2076A [see method, time, and schedule/condition of payments]. (Please type or print information on all Forms.)

**FORM 2076A
CONTRACTOR PAYMENT REQUEST**

"Remit to Name"
The legal name of your agency.

"Address"
The remit to address used when this contract was established for your agency. All address changes must be submitted for processing prior to use.

"Contractor Name"
Business name, if different than legal name (if not leave blank).

"Contract Number"
Can be found on the first page of your contract.

"Amount Requested"
Fill in the total amount and billing period you are requesting payment for.

"Payment Type"
Check the box and enter the dollar amount for the type(s) of payment(s) you are requesting payment for.

"Any questions regarding..."
Fill in the name and phone number of the person to be contacted should any questions arise regarding your request for payment.

"Authorized Signature, Title, and Date (Contractor's)"
Self-explanatory (required).

**FORM 2076B
CONTRACTOR EXPENDITURE REPORT**

When completed, this form is attached to the front of your invoices, and behind Form 2076A (only if contract contains a line item budget, or you are to report match, or client fees collected).

"Contractor Name"
Business name, if different than legal name (if not leave blank).

"Actual Expenditures For"
The billing period you are requesting payment for.

"Contract Number"
Can be found on the first page of your contract.

"Approved Budget Amount"
Current itemized budget amount as approved (or amended) in accordance with the Fiscal Provisions of your executed agreement.

"Current Expenditures"
Itemized expenditures incurred during the billing period.

"Cumulative Expenditures"
Cumulative expenditures from previous billings plus current expenditures.

"Unexpended Budgeted Amount"
Approved budget amount less cumulative expenditures.

"In-kind/Cash Contribution"
If your contract requires that you provide a match, fill in your itemized contributions, if not leave blank (The same documentation is required for match as for actual reimbursable costs).

"Client Fees Collected"
If your contract allows you to collect client fees fill in the total amount collected (if not specifically addressed in your contract you may not collect additional fees from the client).

EVERYTHING BELOW THE THICK SOLID LINE IS FOR CAP RIVERSIDE USE ONLY AND SHOULD BE LEFT BLANK.

**Community Action Partnership of Riverside County
MONTHLY PROGRAM PROGRESS REPORT (PPR)**

Program Name: _____

Agency / Organization: _____

Reporting Period: ___/___/___ to ___/___/___

Prepared By: _____ Title: _____ Date Submitted: ___/___/___

(Answer all questions in detail. Use as much space as needed.)

1. PROGRAM OUTCOME(S)	2. PROGRAM OUTPUT(S)
1. _____	1. _____
2. _____	2. _____
OUTCOME NUMBERS ACHIEVED	OUTPUT NUMBERS ACHIEVED
1. _____	1. _____
2. _____	2. _____

3. **PROGRAM OUTCOME(S):**
 - A. What accomplishments have you made in meeting your program outcomes?
 - B. What outcomes are not on target?
 - C. What challenges have you encountered in meeting your outcomes?
 - D. What is your specific plan of action in meeting your outcomes?
 - E. How have challenges from the previous reporting period been resolved?
4. **PROGRAM OUTPUTS:**
 - F. What accomplishments have you made in meeting your program outputs?
 - G. What outputs are not on target?
 - H. What challenges have you encountered in meeting your outputs?
 - I. What is your specific plan of action in meeting your outputs?
 - J. How have challenges from the previous reporting period been resolved?
5. **PROGRAM OUTREACH ACTIVITIES:**
6. **PARTICIPANTS' SUCCESS STORIES:**
7. **ACTIVITIES PLANNED FOR NEXT REPORTING PERIOD:**

**Community Action Partnership of Riverside County
MONTHLY PROGRAM PROGRESS REPORT (PPR)
Instructions**

You must submit a monthly report for each contract month. Keep your comments brief and focused. Reports should be no longer than 3 pages, single-spaced. Please do not simply copy and paste information from the previous month. If no new achievements have been made or activities completed, please explain why and the future plans to address this.

1. **PROGRAM OUTCOME(S) / NUMBERS ACHIEVED:**
 - List all outcomes listed in your agreement's Scope of Service (Attachment A)
 - Each month, record the number of participants meeting the outcomes.

2. **PROGRAM OUTPUT(S) / NUMBERS ACHIEVED:**
 - List all outputs listed in your agreement's Scope of Service (Attachment A)
 - Each month, record the number of participants/ activities meeting the outputs.

3. **PROGRAM OUTCOME(S):** Provide details to answer each question.

4. **PROGRAM OUTPUT(S):** Provide details to answer each question.

5. **PROGRAM OUTREACH ACTIVITIES:** How have you advertised this project to recruit participants during this report period? If you held or participated in events, please include name of event, date, location and estimated number of people who attended.

6. **PARTICIPANTS' SUCCESS STORIES:** What successes are noteworthy during this report period?

7. **ACTIVITIES PLANNED FOR NEXT REPORTING PERIOD:** Describe key program activities, training, outreach, services planned for the next report period.

Please use the CSD 295 -- Client Characteristic Report Instructions and Helpful Hints document to complete this form.

1 Contractor Name: _____ Contract #: _____
 Prepared By (print name/title): _____ Report Period: _____

Demographic data should be collected on ALL clients receiving services under any program administered by the designated Community Action Agency.

Yellow Highlighted Sections represent demographics collected on INDIVIDUALS			
2 Total unduplicated number of persons about whom one or more characteristics were obtained			
3 Total unduplicated number of persons about whom no characteristics were obtained			
Blue Highlighted Sections represent demographics collected on FAMILIES			
4 Total unduplicated number of families about whom one or more characteristics were obtained			
5 Total unduplicated number of families about whom no characteristics were obtained			
6. Gender		12. Family Size	
a. Male	Number of Persons*	a. One	Number of Families***
b. Female		b. Two	
		c. Three	
		d. Four	
		e. Five	
		f. Six	
		g. Seven	
		h. Eight or more	
	*Total		***Total
7. Age		13. Source of Family Income	
a. 0-5	Number of Persons*	a. Unduplicated # of Families Reporting One or More Sources of Income**	Number of Families
b. 6-11		b. Unduplicated # of Families Reporting No Income	
c. 12-17		Total UNDUP Families who responded as either having a source of income or having no income	
d. 18-23		Record the sources of each family income as reported in 13a above:	
e. 24-44		c. TANF	
f. 45-54	Sum of 7e thru 7h =	d. SSI	
g. 55-69		e. Social Security	
h. 70+		f. Pension	
	*Total	g. General Assistance	
8. Ethnicity/Race		i. Unemployment Insurance	
i. Ethnicity		j. Employment + other source	
a. Hispanic or Latino		k. Employment only	
b. Not Hispanic or Latino		l. Other	
	*Total		
ii. Race			
a. White			
b. African American			
c. Native American and Alaskan Native			
d. Asian			
e. Native Hawaiian and Other Pacific Islander			
f. Other			
g. Multi-Race (any 2 or more of the above)			
	*Total		
9. Education Level of Adults		14. Level of Family Income % of HHS guideline	
a. 0-8	Number of Persons 24+**	a. Up to 50%	Number of Families***
b. 9-12/non-graduate		b. 51% to 75%	
c. High sch. Grad./GED		c. 76% to 100%	
d. 12+ some post secondary		d. 101% to 125%	
e. 2 or 4 yr. College graduates		e. 126% to 150%	
	**Total	f. 151% and over	
			***Total
10. Other Characteristics		15. Housing	
a. No Health insurance	# of Persons	a. Own	Number of Families***
b. Disabled	# Surveyed	b. Rent	
		c. Homeless	
		d. Other	
			****Total
11. Family Type		16. Other family characteristics	
a. Single parent/female	Number of Families***	a. Farmer	Number of Families***
b. Single parent/male		b. Migrant Farmworker	
c. Two-parent household		c. Seasonal Farmworker	
d. Single person			
e. Two adults - no children			
f. Other			
	***Total		

* The sum in this category should not exceed the value of Section 2.
 ** The sum in this category should not exceed the value of Section 7e-h.
 *** The sum in this category should not exceed the value of Section 4.
 **** The numbers reported under either column should not exceed the value of Section 2.

Purpose: Utilize this document to assist in the completion of the CSD 295—Client Characteristic Report.

- The 295 is designed to collect demographics on all clients served by the agency.
 - ✓ *Non-Profit Agencies: data should be collected on all clients served by any of the programs administered by the Community Action Agency.*
 - ✓ *Local Government Agencies: data should be collected on all clients served by the Department/Unit that has been designated to administer CSBG. This would include client data from all programs administered by the designated Department/Unit.*

Retrieving the form:

- This form can be downloaded from the CSD Web Page at www.csd.ca.gov
- The correct form should have the revision date (located at the top left corner) of 11/07.
- Use the form as is – do not recreate or alter the form in any way. Any form that has been altered or recreated will not be accepted. NOTE: This form has been created for IBM compatible users.

Completing the CSD 295:

- Use the Tab key to navigate to the next data entry cell, using Shift & Tab will send you to the previous data entry cell.
- Do not use characters such as N/A, if the data is unavailable or not applicable to your agency, leave the cell blank.
- Please note that zeros should not be used to indicate that you do not collect that information, but rather used to indicate the null value (0).

Printing the form for your records:

- When printing the 295 for your records, the form should be already formatted. However some printers, have different defaults that can alter the settings set by CSD. Therefore if you are experiencing the following problems here are some solutions to try:
 - **One or more columns are printing on a separate page:**
 1. Go to view,
 2. Click Page Break Preview. (This will show where the page is breaking with either blue solid lines and/or blue broken lines.)
 3. Click and grab the blue line that is breaking the columns and drag to the last column. (This should reformat the page to one page wide.)
 4. Select print and the problem should be corrected.

Submitting the forms:

- Please do not send hard copies of the CSD 295, CSD only wants the electronic copy.
- Submit the report via e-mail to CSBGReports@csd.ca.gov by January 20, 2008 for the January 2007—December 2007 Program Year.
- Please do not send the reports directly to your Field Representative or Field Operations managers. Please only send a copy to CSBGReports@csd.ca.gov.

CSD 295 –General Hints:

- Make sure to use the correct CSD 295 reporting form. This form has a revision date of 11/07.
- The cells that show a red triangle in the right corner are cells that have a comment/reminder to assist in the completion of the form. To see the comment place the mouse in that cell and the message will pop up. Another option is to right click in the cell with a comment and choose *show comment* and the comment will appear permanently. To hide the comment, right click in the cell again and choose *hide comment* and it will disappear.
- Make sure to double check the footnote verifications to make sure the values entered fall within the proper verification.
 - ✓ * *The sum in this category should not exceed the value of Section 2.*
 - ✓ ** *The sum in this category should not exceed the value of Section 7e-h.*
 - ✓ *** *The sum in this category should not exceed the value of Section 4.*
 - ✓ **** *The numbers reported under either column should not exceed the value of Section 2.*
- Sections 2, 3, and 6-10 collect INDIVIDUAL demographic data.
- Sections 4, 5 and 11-16 collect FAMILY demographic data.
- Both Individual AND Family demographic data should be collected on all clients.
 - ✓ *1 client = 1 individual and 1 family.*
 - ✓ *4 clients from same family = 4 individuals and 1 family.*
 - ✓ *"Family" is self-defined by the client(s) being served.*

Section 1:

- Enter contractor name, report period, preparer's name and contract number.

Sections 2, 3 and 6 – 10 Collects Demographics on INDIVIDUALS**Section 2 – Total Unduplicated Number of Persons about whom one or more characteristics were obtained:**

- To the extent possible, agencies should attempt to report unduplicated counts.
- To obtain unduplicated counts, an agency will need to have a system to distinguish each individual so the number of services the individual is provided can be assigned to that individual.
 - ✓ *For example: if a person enters an agency and receives seven different services, an unduplicated count would record one person, not seven services.*

Section 3 – Total Unduplicated number of persons about whom no characteristics were obtained:

- Enter the total the number of persons for whom characteristics were not obtained.
 - ✓ *Please note: This would include any clients that were served, however demographics were not collected.*

Section 6 – Gender:

- Report the Gender on individuals receiving services.
- Make sure that the total of this section does not exceed the value in Section 2. See Asterisk Note * on the CSD 295.

Section 7—Age:

- Report the age of the individuals receiving services.
- Make sure that the total of this section does not exceed the value in Section 2. See Asterisk Note * on the CSD 295.

Section 8 – Ethnicity and Race:

- Report one ethnicity AND one race for each individual receiving services.
- Ethnicity and Race are determined by self-identification: *Ethnicity and Race shall not be limited to being biologically or genetically determined, it can also be thought of in terms of social and cultural characteristics as well as ancestry.*
- Make sure that the total of this section does not exceed the value in Section 2. See Asterisk Note * on the CSD 295.

Section 9 – Education Level of Individuals 24 years or older:

- Only collect the education level of those individuals receiving services that are 24 years or older.
- The total of this section cannot exceed the sum of Section 7e-7h. See Asterisk Note ** on the CSD 295.

Section 10 – Other Characteristics:

- Report the number of individuals receiving services that were surveyed about their health insurance or disability. All individuals that are asked about each of the two items should be reported in the # Surveyed column. Of those surveyed, the number that report having no health insurance and/or disabled should be reported in the # of Persons column. If an individual receiving services has any form of health insurance, including Medicare or Medicaid, they should be included in the # surveyed column only. Do not count any other family members.
- The definition of “disabled” used in this form is taken from the Americans With Disabilities Act of 1990: “The term disability means, with respect to an individual (a) a physical or mental impairment that substantially limits one or more of the major life activities of such individual, (b) a record of such an impairment, (c) being regarded as having such an impairment.” Any individual who responded to this question but is not disabled should be included in the # Surveyed column only.
- The number reported under the column # of Persons should not exceed the number reported under # Surveyed for that line item.
- Make sure that the total of this section does not exceed the value in Section 2. See Asterisk Note **** on the CSD 295.

Sections 4, 5 and 11-16 Collects Demographics on FAMILIES**Section 4 – Total Unduplicated number of families about whom one or more characteristics were obtained:**

- To the extent possible the numbers reported here should be unduplicated.
- This requires that a similar system of unique identifiers be in place, which, in addition to identifying an individual, also identifies a family.
 - ✓ *For example: if a family member comes in and receives four services and another family member comes in and receives six services, an unduplicated count would record one family, and two individuals.*

Section 5 – Total unduplicated number of families about whom no characteristics were obtained:

- Enter the total number of families for whom characteristics were not obtained. Please note: This number would include clients that were served, but demographics were not collected on the family.
- To the extent possible the numbers reported here should be unduplicated.

Section 11 – Family Type:

- Based on the clients, family composition, report the type of family. If the family type of the recipient is not reflected in one of these types please mark "other."
- Make sure that the total of this section does not exceed the value in Section 4. See Asterisk Note *** on the CSD 295.

Section 12 – Family Size:

- Report the number of persons in the client's family.
- Make sure that the total of this section does not exceed the value in Section 4. See Asterisk Note *** on the CSD 295.

Section 13 – Source of Family Income:

- 13a: Enter the total number of families reporting one or more sources of income
- 13b: Enter the total number of families reporting NO income
- Please enter the type or types of income received by all persons in the family.
- Food Stamps, Medicaid and other in-kind benefits (LIHEAP, WAP, etc.) will not be included in these calculations.
 - ✓ Item 13a: Unduplicated # of Families Reporting One or More Sources of Income: With this Section we are attempting to collect an *unduplicated* count of families who indicated that the household receives one or more sources of income.
 - ✓ Item 13b: Unduplicated # of Families Reporting No Income: This section attempts to collect an *unduplicated* count of families who indicate that the household has no income.
 - ✓ Item 13c: TANF: Enter the unduplicated number of families who receive funds from the HHS Temporary Assistance for Needy Families program.
 - ✓ Item 13d: SSI - Supplemental Security Income: This is federal assistance usually provided to persons whose Social Security payments are inadequate. Please enter the unduplicated number of families who receive SSI benefits.
 - ✓ Item 13e: Social Security: Enter the unduplicated number of families who receive Social Security benefits.
 - ✓ Item 13f: Pension: Any type of income earned from private pensions, e.g., company retirement, IRA income or 401(k)(Keough). Please enter the number of families who receive Pension benefits.
 - ✓ Item 13g: General Assistance: This is usually a state-funded program available for emergencies and in some instances becomes a regular source of income for single clients. It has a variety of names, for instance, in some states it is called General Relief. Please enter the unduplicated number of families that receive General Assistance.
 - ✓ Item 13h: Unemployment insurance payments: Enter the unduplicated number of families that receive Unemployment Insurance payments.

- ✓ **Item 13i: Employment plus any other sources:** Enter the unduplicated number of families that have income from employment *and* from any other sources such as those included in this list.
 - ✓ **Item 13j: Employment only:** Please enter the unduplicated number of families for whom employment is the only source of income. Employment is considered wages and salaries before deductions and self-employed income less operating expenses. Sections 13.i and 13.h are mutually exclusive.
 - ✓ **Item 13k: Other:** Enter the unduplicated number of families that report other sources of income, including investments, rent, etc.
- Make sure that the values reported in Item 13a and 13b do not exceed the value in Section 4. See Asterisk Note *** on the CSD 295
 - The value in item a, should be greater than or equal to the values reported in items c-k.
 - For all the items you will report the number of families receiving that source, not the number of individuals in the family receiving the source.
 - ✓ *For example:* A family of four, where both parents are employed and the mother is receiving SSI, and the father and mother has 2 types of investments would be reported as follows:
 - Item 13a = 1
 - Item 13d = 1
 - Item 13j = 1
 - Item 13k = 1

Each item they have would be reported as 1, even though both parents are working because they are 1 family.

Section 14 – Level of Family Income % of HHS Guidelines:

- Section refers to income levels of the families served compared to the current HHS Poverty Income Guidelines, published annually in the Federal Register.
- Make sure that the total of this section does not exceed the value in Section 4. See Asterisk Note ***.

Section 15 – Housing:

- Report the housing situation of the family:
 - ✓ **Item 15a: Own:** Please enter the number of families that own their home.
 - ✓ **Item 15b: Rent:** Please enter the number of families that rent their housing. Rent can be considered as money or services exchanged for housing and payment of a portion of rent in units shared with others.
 - ✓ **Item 15c: Homeless:** Please enter the number of families that were homeless. The definition of the term "Homeless" used for this form, taken from the Stewart B. McKinney Homeless Assistance Act, follows: "Homeless" or "homeless individual" includes: (1) An individual who lacks a fixed, regular, and adequate nighttime residence; and (2) An individual who has a primary nighttime residence that is: A supervised, publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); An institution that provides a temporary residence for individuals intended to be institutionalized; A temporary, makeshift arrangement in the accommodations of other persons or A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." The term "homeless" or "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law.
 - ✓ **Item 15d: Other:** If neither Items 15a, 15b nor 15c describe the family's housing situation record them here.

- Make sure that the total of this section does not exceed the value in Section 4. See Asterisk Note *** on the CSD 295.

Section 16 – Other Family Characteristics:

- Report families that are farmworkers in the categories below:
 - ✓ Item 16a: Farmer: Enter the number of families served who are farmers. The value of this item should not exceed the value in Section 4.
 - ✓ Item 16b: Migrant Farmworker: Enter the number of families served who are migrant farm workers. The value of this item should not exceed the value in Section 4.
 - ✓ Item 16c: Seasonal Farmworker: Enter the number of families served who are seasonal farm workers. The value of this item should not exceed the value in Section 4.
 - Make sure that the value of each item in this section does not exceed the value in Section 4. See Asterisk Note *** on the CSD 295.
-

If you need further training and technical assistance, please contact your assigned Field Representative.

CSBG - ARRA

REIMBURSEMENT REQUEST

Remit to:
Community Action Partnership
Attn: Fiscal Department
2038 Iowa Avenue, Suite B102
Riverside, CA 92507

CAARC Voucher # _____

Today's Date: _____

Vendor #: _____

Amount Requested: _____

Contract #: _____

Payable To: _____

Address: _____

Program Manager Approval _____

Date _____

FISCAL USE ONLY

Accounting String _____ 21050 _____ 5200300000 _____

Invoice number _____

Adjustments _____

Management Approval _____

Date _____

Contract Approval _____

Date _____

Purchase Order # _____

Date _____

Fiscal Approval _____

Date _____

DRUG-FREE WORKPLACE CERTIFICATION

Exhibit F

STD. 21 (REV. 12-93)

CERTIFICATION

I, the official named below, hereby swear that I am duly authorized legally to bind the contractor or grant recipient to the certification described below. I am fully aware that this certification, executed on the date below, is made under penalty of perjury under the laws of the State of California.

CONTRACTOR/BIDDER FIRM NAME <i>Riverside County Office on Aging</i>		FEDERAL ID NUMBER <i>95-6000-930 W</i>
BY (Authorized Signature) <i>[Signature]</i>		DATE EXECUTED <i>5/14/09</i>
PRINTED NAME AND TITLE OF PERSON SIGNING <i>(Director) Edward F. Walsh</i>		TELEPHONE NUMBER (Include Area Code) <i>(951) 867-3800</i>
TITLE <i>Director</i>		
CONTRACTOR/BIDDER FIRM'S MAILING ADDRESS <i>6296 River Crest Dr., Suite K, Riverside, CA 92507</i>		

The contractor or grant recipient named above hereby certifies compliance with Government Code Section 8355 in matters relating to providing a drug-free workplace. The above named contractor or grant recipient will:

1. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations, as required by Government Code Section 8355(a).
2. Establish a Drug-Free Awareness Program as required by Government Code Section 8355(b), to inform employees about all of the following:
 - (a) The dangers of drug abuse in the workplace,
 - (b) The person's or organization's policy of maintaining a drug-free workplace,
 - (c) Any available counseling, rehabilitation and employee assistance programs, and
 - (d) Penalties that may be imposed upon employees for drug abuse violations.
3. Provide as required by Government Code Section 8355(c), that every employee who works on the proposed contract or grant:
 - (a) Will receive a copy of the company's drug-free workplace policy statement, and
 - (b) Will agree to abide by the terms of the company's statement as a condition of employment on the contract or grant.
4. At the election of the contractor or grantee, from and after the "Date Executed" and until _____ (DATE) (NOT TO EXCEED 36 MONTHS), the state will regard this certificate as valid for all contracts or grants entered into between the contractor or grantee and this state agency without requiring the contractor or grantee to provide a new and individual certificate for each contract or grant. If the contractor or grantee elects to fill in the blank date, then the terms and conditions of this certificate shall have the same force, meaning, effect and enforceability as if a certificate were separately, specifically, and individually provided for each contract or grant between the contractor or grantee and this state agency.

**CERTIFICATION REGARDING LOBBYING
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

FAMILY SUPPORT ADMINISTRATION

Program: CSBG Stimulus Recovery Funds

Period: July 1, 2009 through September 30, 2010

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Edward F. Walker Signature Director Title

Riverside Co. Office on Aging Agency/Organizations 5/14/09 Date

CSBG ARRA Risk Assessment of Grantees, Sub-Grantees and Vendors/Contractors

Name of Entity: Riverside County Office of Aging (OOA)	Date September 23, 2009		
Please check "Yes" or "No" for each of the following questions. Comments should be completed when a specific system needs enhancement instead of the total system or process.			
Risk Assessment Questions	Yes	No	Comments should include supplemental support documentation
1. Have there been any material weaknesses and reportable conditions, questioned costs and other findings cited within the last three years in annual audits, State monitoring assessments, Inspector General Reviews, or other Government Agency reviews of entity finances and operations that have not been corrected?		X	
2. Does the entity have in place standard financial and operating controls to ensure assets and information are protected against fraud, waste and abuse, and mismanagement of Federal funds?	X		
3. Does the entity have in place clearly stated and current administrative, fiscal and programmatic policies and operating procedures in accordance with the CSBG statute? Does the entity assure that policies and procedures are distributed to staff accompanied by training?	X		
4. Does the entity have in place a methodology for monitoring compliance with internal policies and procedures? Have internal policies and procedures been reviewed for compliance with requirements of the CSBG Act, ARRA, CSBG Information Memoranda, OMB Circulars, ACF Grant Terms and Conditions and other contractual terms and conditions?	X		
5. What procedures are in place to assure that any general purpose equipment purchased using CSBG ARRA funds is directly related to specific CSBG services under the ACF Grant Terms and Conditions applicable to ARRA?	X		
6. If any purchase or improvement of land, or the purchase, construction, or permanent improvement (other than low-cost residential weatherization or other energy-related home repairs) of any building or other facility, has a Federal waiver been requested and approved as required under the CSBG Statute?			N/A to this contract
Risk Mitigation Activities – A "yes" to question number one indicates a potential risk area for CSBG ARRA implementation. A "no" to questions 2-6 indicates a potential risk area. For any identified risks, please describe current risk mitigation plans or compensating controls established. Attach additional sheets as necessary.			

GAO -01-1008G, Internal Control and Evaluation Tool August 2001
 2 CFR Part 225, Cost Principles for State, Local, and Indian Tribal Governments dated August 29, 1997;
 and 2 CFR Part 230, Cost Principles for Non-Profit Organizations dated June 1, 1998. SEC. 678F (a) (1)
 Limitation on Use of Funds.

**CSBG ARRA Risk Assessment of
Grantees, Sub-Grantees and Vendors/Contractors**

Certification Statement: I certify that a risk assessment has been conducted to assure appropriate expenditures of Community Services Block Grant funds received through the American Recovery and Reinvestment Act of 2009. This risk assessment addressed previous audit or monitoring findings within the last three years, a review of existing internal controls, a review of statutory and regulatory compliance, and a review of equipment and property procedures to assure a direct relationship to CSBG services. Where potential risks have been identified, appropriate risk mitigation measures and compensating controls have been identified.

Chief Executive Edward F. Walsh

Board Chairperson Lori Morgan-Hays

State CSBG Lead Agency Comments

- I concur with the eligible entity's assessment of risk with no additional comment.
- I have attached comments on additional areas of risk within this entity or Statewide.

State CSBG Program Manager _____