

**Elderbridge Agency on Aging**  
**Application for Nutrition Program Funds FY 2026 (July 1, 2025-June 30, 2026)**  
**APPLICANT INFORMATION SHEET**

**Name of Subcontractor (person or group taking responsibility of contract):**

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**Name of Subcontractor Primary Contact**

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**Address:**

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**City, State, Zip:**

**Email:**

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**Checks payable to:**

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Services this organization currently offers are open to persons, regardless of sex, ethnicity, religion, or race.  Yes  No

If no, explain:

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List each meal site included in this application	Cities Served	Counties Served	Funds Requested – from worksheet
1.			\$
2.			\$
3.			\$
4.			\$
5.			\$
6.			\$
7.			\$
8.			\$

Meal Site Contact Information

Meal site location: \_\_\_\_\_

Sub-sites (sites your site provides food for): \_\_\_\_\_

Meal site address (physical location of meal site):  
\_\_\_\_\_

Meal site phone number: \_\_\_\_\_

Days serving during week: \_\_\_\_\_ Serving time: \_\_\_\_\_

Type of meal served: \_\_\_\_\_ Congregate \_\_\_\_\_ Home Delivered \_\_\_\_\_ Pick-up

Site manager name: \_\_\_\_\_

Site manager address \_\_\_\_\_

Phone number: \_\_\_\_\_ Email address: \_\_\_\_\_

Co-site manager name (if applicable) \_\_\_\_\_

Co-site manager address \_\_\_\_\_

Phone number: \_\_\_\_\_ Email address: \_\_\_\_\_

Cook name: \_\_\_\_\_ Cook phone number: \_\_\_\_\_

Cook address: \_\_\_\_\_ Cook email address: \_\_\_\_\_

Cook name: \_\_\_\_\_ Cook phone number: \_\_\_\_\_

Cook address: \_\_\_\_\_ Cook email address: \_\_\_\_\_

Cook name: \_\_\_\_\_ Cook phone number: \_\_\_\_\_

Cook address: \_\_\_\_\_ Cook email address: \_\_\_\_\_

Certified Food Protection Manager Name (s) \_\_\_\_\_

Expiration date of certificate \_\_\_\_\_

Bookkeeper name: \_\_\_\_\_

Bookkeeper address: \_\_\_\_\_

Bookkeeper phone number: \_\_\_\_\_

Bookkeeper email: \_\_\_\_\_

Unit Cost Worksheet FY '26  
(use this to figure out unit cost)

**Estimated Budget: Based on 254 serving days**

Wages and Benefits – Site Manager	\$ _____
Wages and Benefits – Cook (s)	\$ _____
Food (purchased food or catered meal costs) amount times number of meals served per year	\$ _____
Other _____	\$ _____
Other _____	\$ _____
Other _____	\$ _____

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1. Total Expenditures	\$ _____
2. Total Number of Meals served: (254 x est. #/day)	\$ _____
3. Total Cost Per Meal: (#1 divided #2)	\$ _____

**Full total cost reimbursement per meal is not guaranteed dependent on available funding and number of meal sites requesting funding.**

## PROGRAM NARRATIVE

**Instructions:** Submit a separate narrative for each service included in this request for funding. The program narrative should address the following:

1. Plan for providing the service, geographic area to be served, contribution process, staffing, hours and days of service, and other pertinent information.
2. Breakdown of salaries and wages from cost worksheet.
3. Services already provided by the applicant to the older adult population (60 yrs and older).
4. Efforts to coordinate services with other aging service provide



## PROGRAM ASSURANCES

All recipients of Elderbridge funds agree to comply with the following conditions and/or assurances. The applicant shall:

1. Have the capability to deliver the program as described and be financially accountable for the program.
2. Agree to secure, maintain, and have on file for review, liability insurance, with sufficient coverage to meet any claims resulting from, or the act of, providing services under this program.
3. Agree to secure, maintain, and have on file for review, all required licenses, permits or certifications for the service(s).
4. Assure compliance with any required criminal background checks, such as criminal history and dependent adult abuse record checks, as required by law.
5. Assure that they are not currently, nor have been in the past, prohibited from participating in Medicare or Medical Assistance programs.
6. Understand that funds awarded by Elderbridge may be terminated at any time for violations of any terms and requirements of the funding source.
7. Agree not to enter into any subcontracts for the provision of services without prior approval, in writing, from Elderbridge.
8. Have a formal grievance and appeals procedure for perceived discrimination and/or decisions that appear unfavorable to clients concerning the provision of service.
9. Assure that 3<sup>rd</sup> party reimbursement will be sought first, whether that is Medicaid, Medicare or private insurance.
10. Assure that funds are not spent for someone who is eligible for Title XIX/elderly waiver service, or other 3<sup>rd</sup> party payment source, who refuses to utilize the 3<sup>rd</sup> party funding source.
11. Utilize these funds to serve only persons eligible for Congregate or Home Delivered Meals.
12. Assure the confidentiality of all information relating to clients. Information shall not be disclosed without the individual's informed consent (or consent from his/her representative).
13. Assure that participants have an opportunity to make confidential contributions for the service funded by Elderbridge funding.
14. Assure that older people will not be denied service based on their ability to pay.
15. Assure that program income (client contributions) are not to be used as match for federal funds, However, program income can be used to match state funds.
16. Agree to maintain records to easily identify the utilization of Elderbridge funds, and make those records available for audit and assessment for three (3) years beyond the end of the award period.

17. Agree to submit all reports and requests for reimbursement, as specified by Elderbridge, in a timely manner.
18. Submit Aging & Disability Network Consumer Intake forms and monthly service rosters in a timely manner.
19. Assure funds will be released for which appropriate use is not anticipated according to respective Elderbridge reallocation process.
20. Understand that failure to generate the 25% match requirement, whether it be cash or in-kind, may result in a suspension of Elderbridge funding.
21. Assure compliance with all applicable local, state, and federal laws, and if applicable, all requirements for nonprofit entities.
22. Operate within the requirements of ***Iowa Code 249.H and IAC 321, Chapter 28.***

I, \_\_\_\_\_, agree to comply with the conditions and assurances listed above.  
(Name of Subcontractor Applicant)

## Applicant Checklist

**Service Provider: Please fill out this checklist to assure that you have provided all information requested and submit with your application.**

**YES    NO**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Application information sheet.</b>            |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Meal Site Contact Information sheet</b>       |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Unit Cost Worksheet.</b>                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Program Narrative</b>                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Assurances reviewed, accepted, and dated.</b> |

**Service providers may:**

E-mail to: [japplegate@elderbridge.org](mailto:japplegate@elderbridge.org) by 4:30 p.m. Monday, April 14, 2025 - or-Send a hard copy of application to:

**Jody Applegate  
Healthy Aging Director  
Elderbridge Agency on Aging  
1190 Briarstone Dr., Ste. 3  
Mason City, Iowa 50401**