C-1: SCHEDULE OF REPORTS TO THE CITY AND COUNTY OF HONOLULU, DEPARTMENT OF COMMUNITY SERVICES, ELDERLY AFFAIRS DIVISION

Kupuna Care & Other State Funding

				Gillon															
TYPE OF REPORTS AND REPORTING SCHEDULE	EXHIBIT	TRANSMISSION	DUE DATE	COPIES	Inc	Aug	Sep	2015 Sep Oct	Nov	/ Dec	Jan	n Feb		Mar /	2016 Apr Ma	<u>'</u>	un	Jul	Bug
ONGOING									\neg	_		\dashv	{						
NAPIS FORMS	Form 1/Form 2	E-mail to I & A Designee, Data- Clerk Typist	Must be authorized by EAD	1	V	₩	4	\downarrow	\downarrow	\downarrow	+	→	V		+	→	+	₩	V
MONTHLY REPORTS	:										-		\dashv						
Service Units (MSUR)	C-2	E-mail to Data Supervisor, Data-Clerk Typist	By the 5th working day of the following month			7	o	7		<u>ග</u>	7	œ	ن	7	7	6	7	œ	
Service Provider's Invoice	C-3S/C-3M	Mail or hand-deliver. Original signature required.	By the 5th working day of the following month	Original + 3		7	8	7		6	7	<u>∞</u>	<u>51</u>	7	7	<u>ი</u>	7	<u></u>	
Service Provider's Performance Report (SPPR) & Waitlist (Senior Center Providers Only)	C-4	E-mail to County Executive, Grants Manager, Secretary	By the 5th working day of the following month	1		7	8	7		6	7	8	σı	7	7	စ	7	<u></u>	
Monthly Narrative	C-5	E-mail to County Executive, Grants Manager, Secretary	By the 5th working day of the following month	1		7	8	7		6	7	8	5	7	7	6	7	8	
QUARTERLY REPORTS																			
Financial Status Report (FSR)	C-7	Mail or hand-deliver. Original signature required. Email to Budget Analyst	By the 15th day of the following month	Original + 3				15	<u>. </u>			15			15			15	
Project Income Financial Status Report (PIFSR)	C-8	Mail or hand-deliver. Original signature required. Email to Budget Analyst	By the 15th day of the following month	Original + 3				15	<u>. </u>		1	15			15			ठ	
In-Kind Contributions Report	C-9	Mail or hand-deliver. Original signature required. Email to Budget Analyst	By the 15th day of the following month	Original + 3				15	<u>. </u>		1	15			15			5	
Utilization Profile Nutrition Services (NSUP) (Meals Providers Only)	C-10	E-mail to County Executive, Grants Manager, Secretary	By the 15th day of the following month					15	<u> </u>			15			15			15	
ANNUAL REPORTS															\dashv				
Annual Financial Status Report - FINAL	C-7	Mail or hand-deliver. Original signature required. Email to Budget Analyst	By the 45th day after the end of the contract period	Original + 3															5
Annual Project Income Financial Status Report - FINAL	C-8	Mail or hand-deliver. Original signature required. Email to Budget Analyst	By the 45th day after the end of the contract period	Original + 3															15
Standard Inventory Schedule	n/a	Fax to (808) 768-7720	By the 15th day of the following month	1														5	,
Annual Narrative (includes Special & Target Populations, Client Satisfaction Survey, Variance Report)	C-11	E-mail to County Executive, Grants Manager, Secretary	By the 45th day after the end of the contract period	_															5
Audited Financial Statements (single audit if expends \$750,000 or more of federal funds from all sources)	n/a	E-mail to County Executive, Budget Analyst, Secretary,	When independent audit is completed	_															

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Medicaid – QExA:	<u> </u>	es	Ш	NO		Don	MIOW	· 							4.51				
ADL's – Can the Client I	On the F	followin	a Wi	thout	t Help:	100			IA.	Dl.'s	– Ca	n the	Client	Do the F	olloy	wing V	Without	Help	11
Eating		011011111		Yes	No.	J						Meal		DV 1		Yes	No	~	,
Dressing			H	Yes	No	_					pping		·- <u>.</u>		╼	Yes	No	-1	
Bathing			Н	Yes	No							edicat	tions		lacksquare	Yes	No	4	
Using Toilet			H	Yes	No	−						Mon			lacksquare	Yes	No	-1	
Transferring			М	Yes	No					_		ephor			┢═┥	Yes	No	-1	
Walking (Getting arou	und the I	house)		Yes	No					Hea	ıvy H	louse	work		-	Yes	No	-1	
			tal "			o l						usew			lacksquare	Yes	No	-1	
						<u></u>							ransport	ation	lacksquare	Yes	No	-	
Cognitive or Mental	Impairn	nent		Yes	No	0				L					tal "N			-	
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											_					***************************************			
Client Representative:												Р	hone:						
Relationship:												Phon	e(other	-1					
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Provid	ler/Program:						0 Worker			
NAME:				7 17 100 101 101		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				VPL-We have easier
	Last				First			M.		
Mutriti	onal Risk (for I	III-C o Case Man	nageme (.)						Yes	No
11 7 12 10 10 10 10 10			es in lifelong eating h	nabits b	ecause of heat	th problems?	MANAGEMENTAL SAME SAME SAME	New Tellison (Personal pro	SUPERING SERVICE SERVI	2
		eat fewer than 2					~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~] 3
			servings (1/2 cup e	ach) of	fruits or vegeta	bles every da	ay?			
			servings of dairy pr					?		\sqcap
			ting well due to prob		-					2
	1		nave enough money							
		eat alone most o								
8	Does the client	take 3 or more d	different prescribed of	or over-t	he-counter dru	gs per day?				
	1		acids, inhalers, herb							
9	Without wantin	g to, has the clier	nt lost or gained 10	pounds	in the past 6 m	nonths?				2
10	Is the client not	always physicall	ly able to shop or co	ok or fe	ed themselves	(or to get so	meone to do it	for them)?		2
11	Does the client	have 3 or more of	drinks of beer, liquo	r or wine	almost every	day?				2
								Nut	trition Risk Score:	0
(III-C F	Programs Only									
Wh	nat is the client's	nutritional risk sc	core rating?		No risk (0-2)	M	/loderate Risk (High Risk (6-21	1)
Wh	nat is the client's	body mass index	x (*BMI)	Heigl		Inche		/eight (lbs)	ВМІ	
		body mass index	x (BMI) rating?		Less than 22	E	Between 22 and		More than 27	
Der	scribe the client'	s diet type:			Regular		Modified			
NS	IP Meals Eligib	Yes Yes	Eligibility	Age	(60 or Over)		Disabled in Elde		Helper/Spo	use
L		No	Туре	Othe	∍ Γ		ribal Age Spec	ification	Volunteer	
Cliant	in receiving the	- fallowing Sand	lone:							
Client	Bathing	e following Servi	Homemaker			Chore		Home !	Delivered Meals	
							detion		ant Care	
	Case Mana	gement	Transportati	on		Assisted Tra	Insportation	Allenda	ant care	!
CARE	PLAN (Service	Order):								
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Fur	nding depending	g on availability of	funds:		特别的	Mental Property		ka Teragalan Iko	TOTAL \$	
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	16.7		tification is require		1 -					
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CITY AND COUNTY OF H	IONOLULU	J - ELDERL	Y AFFAIRS	DIVISION		Reassessn	•		55000	
Provider/Program:		323 10 210				Worker:				
NAME						391				
Last			First				M	.l.		
DATE OF BIRTH:		SSN 4-Dig	jit:	SEX:	F or	M PHON	E:			
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HOME ADDRESS:				_ City:			н	ZIP_		
MAIL ADDRESS:				City			HI	ZIP		
(If different from HOME ADDRESS)						LH	Z IF_		
			The Republic Article (1995)				reserve		arranyana pan	CONTRACTOR SERVICE
UNDERSTANDS ENGLISH?	Yes	No							196197500	ELECTRICAL PROPERTY.
If "No", Primary language:	Cantonese		Mandarin	\Box .	Tagalog	llocan	0			
	Japanese		Korean		∕isayan	Other				
ETHNICITY: Hispanic or Latin		Not Hispar	nic or Latino				,			
RACE (check all that apply below):	1000			eck all tha	t apply be	elow for each se	electe	d RAC	E):	
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Black or African American			an Americar							
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White Other		her								****
Service Servic						The Affichiance				
INCOME BELOW POVERTY: Ye	es	No		1	OES CLIE	NT LIVE ALONE:		Yes		No
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Medicald - QExA: Yes	No	Doi	n't Know					Variation (Co.	SKAROWS IN	THE STATE OF THE STATE OF
ADL's – Can the Client Do the Following	a Without H	eln-		IADI	's – Can th	e Client Do the F	ollow	na Wit	hout H	eln:
Eating	Yes	No		_	repare Mea			es	No	
Dressing	Yes	No		5	Shopping		\square_{\curlyvee}	es	No	
Bathing	Yes	No		[7	ake Medica	ations	\square	es	No	
Using Toilet	Yes	No			/lanage Mor		\square^{\vee}	es	No	
Transferring	Yes	No			Jse Telepho		↤	es	No	
Walking (Getting around the house)	Yes	No		L-	leavy Hous			es	No	
То	tal "No"	0		⊢	ight House	work Fransportation		es	No	
Comitive or Mental Impairment		Пма		Ę	ose Public I	·	tal "No	es o"	No 0	
Cognitive or Mental Impairment	Yes	No				10	1 1 1		CANAL Y	
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Client Représentative:				,	[]	Phone:				
Relationshin:					Oth	er Phone				·

Bathing Homemaker Case Management Transportation Assisted Transportation Assisted Transportation Attendant Care CARE PLAN (Service Order): SERVICE FROM TO UNITS UNIT PRICE TOT PRICE Funding depending on availability of funds. TOTAL \$ - Justification for provision of Service: (attach sheet if additional justification is required) Inhereby certify that to the best of my knowledge the information above is correct. Care Plan Staff: Phone/e-mail: Signature: Date:	the control of the co				Worker:		
Cilent is receiving the following Services: Bathing			Fire				
Bathing Homemaker Chore Home Delivered Meals Assisted Transportation Assisted Transportation Attendant Care CARE PLAN (Service Order): SERVICE FROM TO UNITS UNIT PRICE TOT PRICE Funding depending on availability of funds. TOTAL \$ - Justification for provision of Service: (attach sheet if additional justification is required) hereby certify that to the best of my knowledge the Information above is correct. Care Plan Staff: Phone/e-mail: Signature: Date: Provider Staff Notified: Date:			Pirst	%			1.1.
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Method Notified: Fax Transmitted Yes No	hereby certify that to the best of r Care Plan Staff: Signature: AD Service Authorization: EAD Staff:	MANAGER AND STREET	CARDON CANADAMAN	Phone/e-mail: Date: Phone/e-mail:			
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Month	ly Service Units Report	(MSUR)
AGENCY NAME:		
Contract Number:		
Month of Report:		
Contact Person:		
Phone Number:		7 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 -
Total Number of Clients	s for the Month:	
Total Number of Units	for the Month:	
SAMS Client ID #	Client Name (Last, First)	Units Per Month
	1904.00	
	TOTAL LINITS FOR THE MONTH:	0.00

Elderly Affairs Division SERVICE PROVIDER'S INVOICE

Month	
July 2015	

Contract #	
CT-DCS-	

Vendor#	

Contractor's Name and Address:

Service Category	Unit of Measure	July 2015 Units Served	Unit Rate	Amount
Program A			\$0.00	\$0.00
			Total	\$0.00

Total Cost of Service:

Month	Account No.	Unit Rate	Units Served	Total Monthly Invoice	Balance of Contract
Total Contract Amount		\$			
Into 004F		60.00		\$0.00	
July 2015		\$0.00	0	\$0.00	\$0.00
August 2015					\$0.00
September 2015					\$0.00
October 2015					\$0.00
November 2015					\$0.00
December 2015					\$0.00
January 2016					\$0.00
February 2016					\$0.00
March 2016					\$0.00
April 2016					\$0.00
May 2016					\$0.00
June 2016					\$0.00
	Total Y-T-D			\$0.00	\$0.00

I certify that to the best of my knowledge and belief that payment is due and it has not been previously requested.

Authorized Signature	Date	For Elderly Affairs Use Only
Title:	Date	Approved for Payment

Submit: Original and 3 copies

Elderly Affairs Division SERVICE PROVIDER'S INVOICE

Month	
July 2015	

Contract #	_
CT-DCS-	

 Vendor	#	

A. Contractor's Name and Address:

Service Catergory	Unit of Measure	Annual Goal	July 2015	Unit Rate	Amount
Program A				\$0.00	\$0.00
Program B				\$0.00	\$0.00
Program C				\$0.00	\$0.00
Program D				\$0.00	\$0.00
Program E				\$0.00	\$0.00
				Total:	\$0.00

C. Total Cost of Service:

Month	Account No.	Total Monthly Invoice	Balance of Contract
Total Contract Amount			\$0.00
July 2015		\$0.00	\$0.00
August 2015	-		\$0.00
September 2015			\$0.00
October 2015			\$0.00
November 2015			\$0.00
December 2015			\$0.00
January 2016			\$0.00
February 2016			\$0.00
March 2016			\$0.00
April 2016			\$0.00
May 2016			\$0.00
June 2016			\$0.00
Total Y-T-I	D	\$0.00	\$0.00

I certify that to the best of my knowledge and belief that payment is due and it has not been previously requested.

Authorized Signature	Date	For Elderty Affairs Use Only
Title:	Date	Approved for Payment

Submit: Original and 3 copies

Monthly SPPR & Waitlist

Contract Number CT-DCS-

Program C	Program B	Program A	Waltist	Program C	Program B	Program C	Program B	Program A	Unduplicated Persons	Program E	Program D	Program C	Program B	Program A	Service Category
			July 2015	0	0	0	0	0	Unit of Measure	0	0	0	0	0	Unit of Measure
			August 2015 September 2015						Annual Goal July 2015	0	0	0	0	0	Annual Goal July 2015
			September 2015						July 2015	0.00	0.00	0.00	0.00	0.00	July 2015
			October 2015						August 2015	0.00	0.00	0.00	0.00	0.00	August 2015
			November December 2015 2015						September 2015	0.00	0.00	0.00	0.00	0.00	September 2015
		L	-	0	0	0	0	0	1st QTR Total	0.00	0.00	0.00	0.00	0.00	1st QTR Total
		_	January 2016						October 2015	0.00	0.00	0.00	0.00	0.00	October 2015
			February N	_					November 2015	0.00	0.00	0.00	0.00	0.00	November 2015
			larch 2016						December 2015	0.00	0.00	0.00	0.00	0.00	December 2015
			April 2016	0	0	0	0	0	2nd QTR Total	0.00	0.00	0.00	0.00	0.00	2nd QTR Total
			May 2016						January 2016	0.00	0.00	0.00	0.00	0.00	January 2016
			June 2016						February 2016	0.00	0.00	0.00	0.00	0.00	February 2016
									March 3 2016	0.00	0.00	0.00	0.00	0.00	March 3 2016
				0	0	0	0	0	3rd QTR Total	0.00	0.00	0.00	0.00	0.00	3rd QTR Total
							L		April M	0.00	0.00	0.00	0.00	0.00	April M
							L		ay 2016	0.00	0.00	0.00	0.00	0.00	ay 2016
									May 2016 June 2016	0.00	0.00	0.00	0.00	0.00	May 2016 June 2016
				0	0	0	0	0	4th QTR Total	0.00	0.00	0.00	0.00	0.00	4th QTR Total
				0	0	0	0	9	Year to Date Total	0.00	0.00	0.00	0.00	0.00	Year to Date Total
				#DIV/OI	#DIV/0!	#DIV/01	#DN/0!	#DIV/0!	% of Annual Goal	0.00 #DN/0i	0.00 #DIV/0!	0.00 #DIV/0!	0.00 #DIV/0!	#DN/OI	ar to % of ate Annual Goal

Monthly Narrative Report

(Narrative should be no more than one page in length)

- I. Activities/Accomplishments
 - A. Anecdotal information, individual case studies/history
- II. Significant Findings and Events (including areas of concern)
 - A Identify any emerging issues, notable trends or any other events that occurred which may impact service quality
 - B. What plans will be taken to address these problems
- III. Personnel Changes
 - A. Any changes in program personnel since the last report
- IV. Other

SUBMIT:		(V) Remarks	がははがあ	D. Unliqui	C. Cash B.	B. Disburs	A. Resoun	(IV) Cum Balances	TOTAL	Grantee Portion	NSIP	Program Income	County Share	State Share	Federal Share	FUNDS	O LOIA	Manu Ivacua	(h) Other	(g) Raw Food	(f) Consul	(e) Travel	(d) Consu	(c) Equipment	(b) Fringe Benefits	(a) Personnel	Disbu	Prog:	Addr:	Addr:	Name:	Contracto	N V NICE
SUBMIT: Original and 3 copies		ks		D. Unliquidated Obligations	C. Cash Balance on Hand	B. Disbursements through Report Period	A. Resources Received and Contributed	(IV) Cumulative Receipts, Disbursements and Balances	TOTAL SOURCE OF FUNDS	ortion		ncome	are	G	иге		O TOTAL DINECT LACONAMI COST	I DIBECT BROCK AN COST	Typinge	ood	(f) Consultant Services		(d) Consumable Supplies	nent	Benefits	mel	Diaburrements Only)	Comments (Comments the Cost			The state of the s	Contractor's Name Address and Program	TACABLE SITTATE TATE
			SECTION OF STREET		\$0.00		\$0.00	Federal	\$0.00							(1) (2)	30.00	60 00									C)		Final	Reporting Period:	(II) Budget Period:		
	(a)		Specification of the Participant		\$0.00		\$0.00	State	\$0.00								00.00	200										The State of the S					
	of this award. Signature of Person Authorized	VI) I certify that the xpenditures reported			\$0.00		\$0.00	County	\$0.00							(3)	100.00	2000									(3)	MCCHICAN WALKERS	YES:	nm/dd/yyyy	FROM: mm/dd/yyyy		
	huthorized	(VI) I certify that the information contained in this report is accurate to the best of my knowledge, and that all expenditures reported herein have been made in accordance with appropriate grant policies and conditions			\$0.00		\$0.00	Program Income	\$0.00							(4)	30.00	200									3		No		TO		
		ed in this report is ac rade in accordance w			\$0.00		\$0.00	NSIP	\$0.00							(5)	90.00	200									(5)	THE PROPERTY OF THE PARTY OF TH		mm/dd/yyy	mm/dd/yyy		
		curate to the best of ith appropriate gran			\$0.00		\$0.00	Grantee	\$0.00							(6)	00.00	2000									(6)	Freschiological action		•			
1	•	st of my knowledge, and that grant policies and conditions	ACCORDING ALCOHOLD	\$0.00	\$0.00	\$0.00	\$0.00	Total	\$0.00							(7)	00.00	200									O						
ar area	Date	that all ions					Percentage	Disbursement	\$0.00							(8) (9)	30.00	2000									(8)		Contract Amount \$		Contract # CT-DCS		
			Grantee	NSIP	Program Income	County	State	Federal	\$0.00							はいるなはい	30.00	200											456		123		
			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	TOTAL	00.00	50.00	60.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	TOTAL	4-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0					

Form C-11 FEDERAL/STATE

rom C-11 FEDERADOTALE								
PROGRAM INCOME FINANCIAL STATUS REPORT								
Contractor's Name, Address and Program								
Name:	(II) Budget Period:	FROM:	mm/dd/yyyy	то	mm/dd/yyy	Contract Number: # CT-DCS-	CT-DCS-	123
Addr	Reporting Period:	FROM	mm/dd/yyyy	то	mm/dd/yyy			
Addr:	Final Report:	YES:		No		Contracted Amount: \$	ıt: \$	456
Prog:					5 9	J. J		
(III) Budget Categories (Cumulative Cash			Jacoma Tacoma	Other Court	Compton	TOTAL		
Disbursements Only)		_	r rogram mecome	Omer COAT	CIMILE	IOIAL		
(a) Personnel						\$0.00		
(b) Fringe Benefits	or o				- 1905-1 10000000000000000000000000000000000	\$0.00		
(c) Equipment		T.				\$0.00		
(d) Consumable Supplies		81 03			- 60	\$0.00		
(e) Travel						\$0.00		
f) Consultant Services						\$0.00		
g) Raw Food					100	\$0.00		
(b) Other Expenses					S 32-38	\$0.00		
I) TOTAL DIRECT PROGRAM COST			\$0.00	\$0.00	\$0.00	- 22		
(IV) Cumulative Receipts, Disbursements and Balances		I	Program Income	Other Gov't	Grantee	TOTAL		
A. Resources Received and Contributed			\$0.00	\$0.00				
B. Disbursements through Report Period			\$0.00	\$0.00				
C. Cash Balance on Hand			\$0.00	\$0.00		22		
D. Unliquidated Obligations						\$0.00		
		A Company		200102002				
(V) Remarks		(V)	(VI) I certify that the information contained in	formation contain	~	his report is accurate to the best of my knowledge, and that all	my knowledge, a	nd that all
		exp	enditures reported b	erein have been	made in accordance	expenditures reported herein have been made in accordance with appropriate grant policies and conditions	policies and con	ditions
		of 1	of this award.					
		g	Cimatum of Damon Authorized					
							2000	

SUBMIT: Original and 3 copies

DEPARTMENT OF COMMUNITY SERVICES

Elderly Affairs Division In-Kind Contributions Report (Consolidated)

	O O	Contract Amt.	0	
Contractor:	Name:	Prog		
Address:	Addr:	Add	r:	
Report Period:	From: mm/dd/yyyy	To: mr	n/dd/yyy	. =
I certify that	I personally or the organization or	business, Prog:		
which I repre	esent has furnished the following i	n-kind services or goods to the above	e program as in-k	ind
matching to	the Department of Community Se	rvices, Elderly Affairs Division.		
e and Services:			Total V	alue \$0.00
	Attach list of Service, Hourly Ra	te, Total Hours per person		
	Type of services (planning, ac-	counting, clerical, etc.) contributed.		
2. <u>Travel</u> :	0 miles of perso	nal car mileage at	\$0.11 per mile	= \$0.00
	Bus Fare.	-	•••••	\$0.00
3. Office or	meeting space: Indicate method of calculating sp		Total V	alue \$0.00
ent or supplies:	List kind of equipment or supplie	es contributed:		
ent or supplies:	List kind of equipment or supplie	es contributed:	Total V	alue \$0.00
ent or supplies:	List kind of equipment or supplie	es contributed:	Total V	\$0.00
	minutes of radio or TV to	ime at \$ per minute = \$		alue\$0.00
	minutes of radio or TV to	ime at \$ per minute = \$ ace at \$ per inch = \$		alue\$0.00
5. <u>Publicity</u> :	minutes of radio or TV to	ime at \$ per minute = \$ ace at \$ per inch = \$		\$0.00 \$0.00
	minutes of radio or TV to	ime at \$ per minute = \$ ace at \$ per inch = \$		
5. <u>Publicity</u> :	minutes of radio or TV to	ime at \$ per minute = \$ ace at \$ per inch = \$		\$0.00
5. <u>Publicity</u> :	minutes of radio or TV to	ime at \$ per minute = \$ ace at \$ per inch = \$		\$0.00 \$0.00
5. <u>Publicity</u> :	minutes of radio or TV to	ime at \$ per minute = \$ ace at \$ per inch = \$	· ·	\$0.00 \$0.00
5. <u>Publicity</u> :	minutes of radio or TV to inches of newspaper sp for posters, brochures, of (specify)	ime at \$ per minute = \$ ace at \$ per inch = \$	· ·	\$0.00 \$0.00
5. Publicity: contributions:	minutes of radio or TV to inches of newspaper sp for posters, brochures, of (specify)	ime at \$ per minute = \$ ace at \$ per inch = \$ etc. (Contractor)	· ·	\$0.00 \$0.00
5. Publicity: contributions: Date Signature (Contractor)	minutes of radio or TV to inches of newspaper sp for posters, brochures, of (specify)	ime at \$ per minute = \$ ace at \$ per inch = \$ etc. (Contractor)	· ·	\$0.00 \$0.00

INSTRUCTIONS:

- This report should include the sum total of all in-kinds by categories, i.e., in-kind directly contributed by contractors themselves and in-kinds indirectly contributed contractors - in-kinds contractor secures for project from outside his own (contractor's) organization.
- 2. The totals for each category should be documented with Supporting Reports, attached each further documented, if necessary.

SUBMIT: Original and 3 copies

Nutrition Services Utilization Profile Report

AAA	١D	ı:		Quarterly Rep	port:			
AAA	, Cc	ontact:		Annual Report for:	FY_	- 6	State	Federal
PRO	FIL	<u> E - HOM</u>	IE DELIVERED MEAL	.S				
HON	ΛE	DELIVE	RED MEALS				This Quarter	Year-To-Date
1.	V	olunteer	S T					
	a.	Total N	umber of Full & Part	-time Volunteers (Any Age	3)			
_			lumber of Volunteer I					
2.			ivered Meals Informa					
	a.	Total N	umber of NSIP Eligib	ole Meals (Sum of 1,2, & 3	below)	1		
		(1)	Meals Served:	Elderly 60+				
		(2)	Meals Served:	Disabled Under 60		_		
		(3)	Meals Served:	Volunteer Any Age				
		(4)	Meals Served:	Spouse/Helper (any age	e)			
	b.	Numbe	r of Home-Delivered	(HD) Meals Served Accord	ding to	the Fo	llowing Catego	ries:
		(1)	Regular Meals					
		(2)	Special Menu Meals	<u> </u>				
				ow Fat, Low Salt, Low Ca		·		
			<u> </u>	epared Under the Supervis	sion of	a Regis	stered Dietician)
3.			Education:					
	а.	Numbe	r of Persons Provide	ed with Nutrition Education	<u>n</u>			
4.			Counseling:					
	<u>a.</u>	Numbe	r of Persons Who Re	eceived Nutrition Counseli	ing Pro	vided b	y a Qualified In	dividual
	b.	Total N	umber of Hours of N	utritional Counseling Prov	vided		<u> </u>	·····
5.	N	utritiona	l Health Checklist:					
	_		er Screened by All Des					
	b.	. Numbe	r of Persons Assesse	ed as High Nutritional Ris	k			
	C.	Total N	lumber of Persons Sc	creened for Body Mass Inc	dex (BI	VI)		
		(1)		with BMI Less than 22				
		(2)	Number of Persons	with BMI Greater than 27	•		1	

Annual Narrative Requirements

A. Service(s) Provided

- How many units did you serve?
- How many unduplicated persons did you serve?
- Describe any program-specific initiatives or activities.

Service Category	Unit of Measure	Total served in FY2016
Name of Service	1 person, session, trip etc.	
Unduplicated Persons	Unit of Measure	Total served in FY2016
Name of Service	1 person	and the No. No. No. of Proc April 19 and 19

B. Client Satisfaction Survey

- Please provide specific methodologies of how your client satisfaction survey is conducted (i.e. conducted annually, after each class, etc.)
- Please summarize the results of your client satisfaction survey.
- Please provide a sample form of your client satisfaction survey.

C. Target Population

According to the Hawaii State Databook 2013, there are over 200,000 adults 60 years or older living in Oahu. It is divided into the categories listed in the table below. Please complete the table.

• Please state the total number of clients and percentage of each targeted group as indicated by the table

Description	FY2014	Provider Numbers
Cognitive Impairment	9.1%	
Disabled	28.3%	
Low-Income	7.2%	
Minority	79.8%	
Low-Income Minority	7.6%	
Language Barrier (speaking English not well or not at all)	11.8%	
Lives Alone	16.6%	

Categories	Total Clients FY 2015	Percentage for FY 2015	Total Clients FY 2014	Percentage for FY 2014	Total Clients FY 2013	Percentage for FY 2013
Ethnicity						100
Afro American						
• Cambodian						
• Chinese						
• Filipino						
Hispanic	 					
• Indian (Asian)						
• Korean						
• Japanese		Was Tarrison				
• Laotian						
Hawaiian/Part Hawaiian						
Native Alaskan/ American Indian						
• Samoan						
• Tongan						
• Vietnamese						
• White						
Other Asian						
Other Pacific Islander						
• Unknown			40			

(1) Severe Disability – Severe, chronic disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that: is likely to continue indefinitely; and results in substantial functional limitation in 3 or more of the following major life activities: (A) self-care, (B) receptive and expressive language, (C) learning, (D) mobility, (E) self-direction, (F) capacity for independent living, (G) economic self-sufficiency, (H) cognitive functioning and (I) emotional adjustment. (OAA, Sec. 102 (9)). For purposes of this report, "Severe Disabled" means if the person is determined to be functionally impaired because the individual is unable to perform at least two (2) activities of daily living (ADL's) without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual (EOA Guidelines 11/2006).

(2) Greatest Social Need – The need caused by non-economic factors, which include: (A) physical and mental disabilities, (B) language barriers and (C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that: (i) restricts the ability of an individual to perform normal daily tasks, or (ii) threatens the capacity of the individual to live independently. (OAA, Sec. 102 (28)). For purposes of this report, "Greatest Social Need" shall be based on three factors: (1) Disability: It is operationally defined as "having impairment of at least two ADLs, IADLs, or substantive cognitive impairment; and an unmet need of at least one or more ADLs, or one or more IADLs"; (2) Language Barrier: It is operationally defined as speaking English "not well" or "not at all"; (3) Geographic Isolation: It is operationally defined as living in a rural area, "Rural is defined as areas that are not urban. (EOA Guidelines 11/2006).

- How does your agency compare to these statistics?
- If the variance is greater or less than 10%, what is being done to serve this population(s)?

D. Issues and Trends

- Describe concerns, issues, and trends that have affected your program this past year.
- Do you foresee these factors continuing during in the future? How do you plan to address them?
- What do you see as the biggest challenges or concerns for your organization in the next fiscal year?
- What gaps in services have you noticed during the year? How are you planning to address them in the future?