Saratoga County Department of Aging & Youth Services

APPLICATION FOR SUBCONTRACT

Please email completed form to csokol@saratogacountyny.gov

Agency Name: _____ Received – Department of Aging & Youth Services

Address: _____ _____

_____

Phone: _____

Person completing Application (Name/Title):_____

Type of Agency (Check any that apply): Other Government Consultant
Minority Owned/Operated Women Owned/Operated Not for Profit

Amount of Reimbursable funding requested: $_____

(All sections must be completed, attach additional sheets if necessary)

Objective of Program

_____

Describe Program Format:

_____

7/2022

Geographic area for services to be provided (attach map if not entire county)

Reason for selecting this program and anticipated impact on target population

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Specifically outline what steps will be taken by your agency to assure service to the target population

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Estimate total number of elderly (60+) to be served:

Total Unduplicated Count #_____

Statistics **must** be maintained for monthly reporting

Attachments to be provided with application:

- ❖ Job descriptions for all positions to be funded under this contract
- ❖ Agency Affirmative Action Plan
- ❖ Agency Contribution Policy
- ❖ Outline Agency Audit Procedure
- ❖ Inservice training plan
- ❖ Verification of your Agency's ability to carry one million dollars ($1,000,000) of Liability Insurance (copy of certificate of insurance)
- ❖ Map of Service Area

PROPOSALS WITHOUT THE ABOVE ATTACHMENTS WILL NOT BE PROCESSED

Agency Signature: _____ Date: _____

Typed or Printed Name: _____ Title: _____