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

Kupuna Care & Other State Funding

TYPE OF REPORTS AND REPORTING SCHEDULE	EXHIBIT	TRANSMISSION	DUE DATE	COPIES	2015						2016							
					Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
ONGOING																		
NAPIS FORMS	Form 1/Form 2	E-mail to I & A Designee, Data-Clerk Typist	Must be authorized by EAD	1	→	→	→	→	→	→	→	→	→	→	→	→	→	→
MONTHLY REPORTS																		
Service Units (MSUR)	C-2	E-mail to Data Supervisor, Data-Clerk Typist	By the 5th **working** day of the following month	1		7	8	7	6	7	8	5	7	7	6	7	8	
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	8	5	7	7	6	7	8	
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	5	7	7	6	7	8	
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			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			15			15			15	
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			15			15			15	
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	1				15			15			15			15	
ANNUAL REPORTS																		
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														15
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													15	
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	1														15
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	1														

NAPIS Intake-Authorization Form

CITY AND COUNTY OF HONOLULU - ELDERLY AFFAIRS DIVISION

Date Registered: _____
Date Updated: _____
Reassessment Date: _____

Provider/Program: _____ Worker: _____

NAME _____ _____ _____
Last First M.I.

DATE OF BIRTH: _____ **SSN 4-Digit:** _____ **SEX:** ☐ F or ☐ M **PHONE:** _____
Mo. Day Yr.

HOME ADDRESS: _____ **City:** _____ **HI** **ZIP** _____

MAIL ADDRESS: _____ **City:** _____ **HI** **ZIP** _____
(If different from HOME ADDRESS)

UNDERSTANDS ENGLISH? ☐ Yes ☐ No
If "No", Primary language: ☐ Cantonese ☐ Mandarin ☐ Tagalog ☐ Ilocano
☐ Japanese ☐ Korean ☐ Visayan ☐ Other _____

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (check all that apply below): then select ... NATIONALITY (check all that apply below for each selected RACE):

☐ American Indian or Alaskan	☐	Am. Indian or Alaskan Native
☐ Asian	☐	Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Indian (Asian ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian
☐ Black or African American	☐	Black or African American
☐ Native Hawaiian or Other Pacific Islander	☐	Native Hawaiian ☐ Samoan ☐ Tongan Other Pacific Islander
☐ White	☐	White
☐ Other	☐	Other

INCOME BELOW POVERTY: ☐ Yes ☐ No **DOES CLIENT LIVE ALONE:** ☐ Yes ☐ No

Medicaid – QExA: ☐ Yes ☐ No ☐ Don't Know

ADL's – Can the Client Do the Following Without Help:

Eating	☐ Yes	☐ No
Dressing	☐ Yes	☐ No
Bathing	☐ Yes	☐ No
Using Toilet	☐ Yes	☐ No
Transferring	☐ Yes	☐ No
Walking (Getting around the house)	☐ Yes	☐ No
Total "No"		**0**

Cognitive or Mental Impairment ☐ Yes ☐ No

IADL's – Can the Client Do the Following Without Help:

Prepare Meals	☐ Yes	☐ No
Shopping	☐ Yes	☐ No
Take Medications	☐ Yes	☐ No
Manage Money	☐ Yes	☐ No
Use Telephone	☐ Yes	☐ No
Heavy Housework	☐ Yes	☐ No
Light Housework	☐ Yes	☐ No
Use Public Transportation	☐ Yes	☐ No
Total "No"		**0**

Client Representative: **Phone:**

Relationship: Phone(other)

Provider/Program:	0	Worker:	

NAME: Last	First	M.I.

Nutritional Risk (for III-C o Case Manageme t)

		Yes	No	
1	Has the client made any changes in lifelong eating habits because of health problems?	☐	☐	2
2	Does the client eat fewer than 2 meals per day?	☐	☐	3
3	Does the client eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?	☐	☐	1
4	Does the client eat fewer than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?	☐	☐	1
5	Does the client have trouble eating well due to problems with biting or chewing or swallowing?	☐	☐	2
6	Does the client sometimes not have enough money to buy food?	☐	☐	4
7	Does the client eat alone most of the time?	☐	☐	1
8	Does the client take 3 or more different prescribed or over-the-counter drugs per day? (Including aspirin, laxatives, antacids, inhalers, herbs, etc.)	☐	☐	1
9	Without wanting to, has the client lost or gained 10 pounds in the past 6 months?	☐	☐	2
10	Is the client not always physically able to shop or cook or feed themselves (or to get someone to do it for them)?	☐	☐	2
11	Does the client have 3 or more drinks of beer, liquor or wine almost every day?	☐	☐	2

Nutrition Risk Score: 0

(III-C Programs Only)

What is the client's nutritional risk score rating?	☐ No risk (0-2)	☐ Moderate Risk (3-5)	☐ High Risk (6-21)				
What is the client's body mass index (*BMI)	Height Feet ☐	Inches ☐	Weight (lbs) ☐	BMI ☐			
What is the client's body mass index (BMI) rating?	☐ Less than 22	☐ Between 22 and 27	☐ More than 27				
Describe the client's diet type:	☐ Regular	☐ Modified					
NSIP Meals Eligible	☐ Yes ☐ No	**Eligibility Type**	☐ Age (60 or Over)	☐ Disabled in Elderly Housing	☐ Helper/Spouse		
			☐ Other	☐ Tribal Age Specification	☐ Volunteer		

Client is receiving the following Services:

☐ Bathing	☐ Homemaker	☐ Chore	☐ Home Delivered Meals
☐ Case Management	☐ 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)

I hereby certify that to the best of my knowledge the information above is correct.

Care Plan Staff: **Phone/e-mail:**

Signature: **Date:** 1/0/1900

EAD Service Authorization:

EAD Staff:	**Phone/e-mail:**
Signature:	**Date:**

Provider Staff Notified:			**Date:**	
Method Notified:	**Fax Transmitted**	☐ **Yes**	☐ **No**	

NAPIS Intake-Authorization Form

CITY AND COUNTY OF HONOLULU - ELDERLY AFFAIRS DIVISION

Date Registered: _____
Date Updated: _____
Reassessment Date: _____

Provider/Program: _____ Worker: _____

NAME _____ _____ _____
Last First M.I.

DATE OF BIRTH: _____ **SSN 4-Digit:** _____ **SEX:** ☐ F or ☐ M **PHONE:** _____
Mo. Day Yr.

HOME ADDRESS: _____ **City:** _____ **HI** **ZIP** _____

MAIL ADDRESS: _____ **City:** _____ **HI** **ZIP** _____
(If different from HOME ADDRESS)

UNDERSTANDS ENGLISH? ☐ Yes ☐ No
If "No", Primary language: ☐ Cantonese ☐ Mandarin ☐ Tagalog ☐ Ilocano
☐ Japanese ☐ Korean ☐ Visayan ☐ Other _____

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (check all that apply below): then select ... NATIONALITY (check all that apply below for each selected RACE):

☐	American Indian or Alaskan	☐	Am. Indian or Alaskan Native						
☐	Asian	☐	Cambodian	☐	Chinese	☐	Filipino	☐	Japanese
		☐	Korean	☐	Laotian	☐	Vietnamese	☐	Other Asian
☐	Black or African American	☐	Black or African American						
☐	Native Hawaiian or Other Pacific Islander	☐	Native Hawaiian	☐	Samoan	☐	Tongan		
		☐	Other Pacific Islander						
☐	White	☐	White						
☐	Other	☐	Other						

INCOME BELOW POVERTY: ☐ Yes ☐ No **DOES CLIENT LIVE ALONE:** ☐ Yes ☐ No

Medicaid – QExA: ☐ Yes ☐ No ☐ Don't Know

ADL's – Can the Client Do the Following Without Help:

Eating	☐ Yes	☐ No
Dressing	☐ Yes	☐ No
Bathing	☐ Yes	☐ No
Using Toilet	☐ Yes	☐ No
Transferring	☐ Yes	☐ No
Walking (Getting around the house)	☐ Yes	☐ No
Total "No"		0

Cognitive or Mental Impairment ☐ Yes ☐ No

IADL's – Can the Client Do the Following Without Help:

Prepare Meals	☐ Yes	☐ No
Shopping	☐ Yes	☐ No
Take Medications	☐ Yes	☐ No
Manage Money	☐ Yes	☐ No
Use Telephone	☐ Yes	☐ No
Heavy Housework	☐ Yes	☐ No
Light Housework	☐ Yes	☐ No
Use Public Transportation	☐ Yes	☐ No
Total "No"		0

Client Representative: **Phone:**

Relationship: Other Phone

Provider/Program:	0	Worker:	

NAME: Last | First | M.I.

Client is receiving the following Services:

☐	Bathing	☐	Homemaker	☐	Chore	☐	Home Delivered Meals
☐	Case Management	☐	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)

I hereby certify that to the best of my knowledge the information above is correct.

Care Plan Staff: **Phone/e-mail:**

Signature: **Date:**

EAD Service Authorization:

EAD Staff:	**Phone/e-mail:**
Signature:	**Date:**

Provider Staff Notified:				**Date:**	
Method Notified:	**Fax Transmitted**	☐	**Yes**	☐	**No**

Monthly Service Units Report (MSUR)

AGENCY NAME:		
Contract Number:		
Month of Report:		
Contact Person:		
Phone Number:		
Total Number of Clients for the Month:		
Total Number of Units for the Month:		

SAMS Client ID #	Client Name (Last, First)	Units Per Month
	TOTAL UNITS 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					
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-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

Monthly SPPR & Waitlist

Contractor's Name & Address
0
0
0

Contract Number
CT-DCS-

Service Category	Unit of Measure	Annual Goal	July 2015	August 2015	September 2015	1st QTR Total	October 2015	November 2015	December 2015	2nd QTR Total	January 2016	February 2016	March 2016	3rd QTR Total	April 2016	May 2016	June 2016	4th QTR Total	Year to Date Total	% of Annual Goal
Program A	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#DIV/0!
Program B	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#DIV/0!
Program C	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#DIV/0!
Program D	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#DIV/0!
Program E	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#DIV/0!

Unduplicated Persons	Unit of Measure	Annual Goal	July 2015	August 2015	September 2015	1st QTR Total	October 2015	November 2015	December 2015	2nd QTR Total	January 2016	February 2016	March 2016	3rd QTR Total	April 2016	May 2016	June 2016	4th QTR Total	Year to Date Total	% of Annual Goal
Program A	0					0				0				0				0	0	#DIV/0!
Program B	0					0				0				0				0	0	#DIV/0!
Program C	0					0				0				0				0	0	#DIV/0!
Program B	0					0				0				0				0	0	#DIV/0!
Program C	0					0				0				0				0	0	#DIV/0!

Waitlist	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
Program A												
Program B												
Program C												
Program B												
Program C												

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

FINANCIAL STATUS REPORT			
Contractor's Name, Address and Program			
Name:	(II) Budget Period: FROM: mm/dd/yyyy	TO mm/dd/yyy	Contract # CT-DCS- 123
Addr:	Reporting Period: FROM: mm/dd/yyyy	TO mm/dd/yyy	
Addr:	Final Report: YES:	No	Contract Amount $ 456
Prog:			

(III) Budget Categories (Cumulative Cash Disbursements Only)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	TOTAL
(a) Personnel										$0.00
(b) Fringe Benefits										$0.00
(c) Equipment										$0.00
(d) Consumable Supplies										$0.00
(e) Travel										$0.00
(f) Consultant Services										$0.00
(g) Raw Food										$0.00
(h) Other Expenses										$0.00
(i) TOTAL DIRECT PROGRAM COST	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

FUNDS	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	TOTAL
Federal Share										$0.00
State Share										$0.00
County Share										$0.00
Program Income										$0.00
NSIP										$0.00
Grantee Portion										$0.00
TOTAL SOURCE OF FUNDS	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

(IV) Cumulative Receipts, Disbursements and Balances	Federal	State	County	Program Income	NSIP	Grantee	Total
A. Resources Received and Contributed	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
B. Disbursements through Report Period							$0.00
C. Cash Balance on Hand	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
D. Unliquidated Obligations							$0.00

Disbursement Percentage	
Federal	#DIV/0!
State	#DIV/0!
County	#DIV/0!
Program Income	#DIV/0!
NSIP	#DIV/0!
Grantee	#DIV/0!

(V) Remarks

(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 of this award.

Signature of Person Authorized

Date

SUBMIT: Original and 3 copies

Form C-11 FEDERAL/STATE

PROGRAM INCOME FINANCIAL STATUS REPORT

Contractor's Name, Address and Program

Name:
Addr:
Addr:
Prog:

(II) Budget Period: FROM: mm/dd/yyyy TO mm/dd/yyy
Reporting Period: FROM mm/dd/yyyy TO mm/dd/yyy
Final Report: YES: _____ No _____

Contract Number: # CT-DCS- 123

Contracted Amount: $ 456

(III) Budget Categories (Cumulative Cash Disbursements Only)	Program Income	Other Gov't	Grantee	TOTAL
(a) Personnel				$0.00
(b) Fringe Benefits				$0.00
(c) Equipment				$0.00
(d) Consumable Supplies				$0.00
(e) Travel				$0.00
(f) Consultant Services				$0.00
(g) Raw Food				$0.00
(h) Other Expenses				$0.00
(I) TOTAL DIRECT PROGRAM COST	**$0.00**	**$0.00**	**$0.00**	**$0.00**

(IV) Cumulative Receipts, Disbursements and Balances	Program Income	Other Gov't	Grantee	TOTAL
A. Resources Received and Contributed	$0.00	$0.00	$0.00	$0.00
B. Disbursements through Report Period	$0.00	$0.00	$0.00	$0.00
C. Cash Balance on Hand	$0.00	$0.00	$0.00	$0.00
D. Unliquidated Obligations				$0.00

(V) Remarks

(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 of this award.

Signature of Person Authorized _____ Date _____

SUBMIT: Original and 3 copies

DEPARTMENT OF COMMUNITY SERVICES

Elderly Affairs Division
In-Kind Contributions Report
(Consolidated)

Contract No. 0 **Contract Amt.** 0
Contractor: Name: Prog:
Address: Addr: Addr:
Report Period: From: mm/dd/yyyy To: mm/dd/yyy

I certify that I personally or the organization or business, **Prog:**
which I represent has furnished the following in-kind services or goods to the above program as in-kind matching to the Department of Community Services, Elderly Affairs Division.

1. **Time and Services**: Total Value $0.00
   Attach list of Service, Hourly Rate, Total Hours per person
   Type of services (planning, accounting, clerical, etc.) contributed.

2. **Travel**: 0 miles of personal car mileage at $0.11 per mile = $0.00
   Bus Fare. $0.00

3. **Office or meeting space:** Total Value $0.00
   Indicate method of calculating space value

. **Equipment or supplies**: List kind of equipment or supplies contributed:
   Total Value $0.00

5. **Publicity**: _____ minutes of radio or TV time at $ _____ per minute = $_____.
   _____ inches of newspaper space at $ _____ per inch = $_____.
   _____ for posters, brochures, etc.

6. **Other contributions**: (specify) $0.00
   $0.00

TOTAL $0.00

Date _____ (Contractor)
Signature of contributor _____
(Contractor)
Signature of Project Director _____

INSTRUCTIONS:

1. 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 ID: Quarterly Report:

AAA Contact: Annual Report for: FY State Federal

PROFILE - HOME DELIVERED MEALS

HOME DELIVERED MEALS	This Quarter	Year-To-Date
1. Volunteers		
a. Total Number of Full & Part-time Volunteers (Any Age)		
b. Total Number of Volunteer Hours		
2. Home-Delivered Meals Information:		
a. Total Number of NSIP Eligible Meals (Sum of 1,2, & 3 below)		
(1) Meals Served: Elderly 60+		
(2) Meals Served: Disabled Under 60		
(3) Meals Served: Volunteer Any Age		
(4) Meals Served: Spouse/Helper (any age)		
b. Number of Home-Delivered (HD) Meals Served According to the Following Categories:		
(1) Regular Meals		
(2) Special Menu Meals		
(a) Modified (Soft, Low Fat, Low Salt, Low Calorie)		
(b) Therapeutic (Prepared Under the Supervision of a Registered Dietician)		
3. Nutrition Education:		
a. Number of Persons Provided with Nutrition Education		
4. Nutrition Counseling:		
a. Number of Persons Who Received Nutrition Counseling Provided by a Qualified Individual		
b. Total Number of Hours of Nutritional Counseling Provided		
5. Nutritional Health Checklist:		
a. Number Screened by All Designated Staff		
b. Number of Persons Assessed as High Nutritional Risk		
c. Total Number of Persons Screened for Body Mass Index (BMI)		
(1) Number of Persons with BMI Less than 22		
(2) Number of Persons with BMI Greater than 27		

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	

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						
• Afro American						
• Cambodian						
• Chinese						
• Filipino						
• Hispanic						
• Indian (Asian)						
• Korean						
• Japanese						
• Laotian						
• Hawaiian/Part Hawaiian						
• Native Alaskan/ American Indian						
• Samoan						
• Tongan						
• Vietnamese						
• White						
• Other Asian						
• Other Pacific Islander						
• Unknown						

(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?