APPENDIX B

STATEMENT OF WORK EXHIBITS

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EXHIBITS

EXHIBIT 1

CONTRACT DISCREPANCY REPORT

TO:

FROM:

DATES: **Prepared:** _____

Returned by Contractor: _____

Action Completed: _____

DISCREPANCY PROBLEMS: _____

_____

_____

_____ _____

Signature of County Representative Date

CONTRACTOR RESPONSE (Cause and Corrective Action): _____

_____

_____

_____ _____

Signature of Contractor Representative Date

COUNTY EVALUATION OF CONTRACTOR RESPONSE: _____

_____

_____

_____ _____

Signature of Contractor Representative Date

COUNTY ACTIONS: _____

_____

_____

CONTRACTOR NOTIFIED OF ACTION:

County Representative's Signature and Date _____

Contractor Representative's Signature and Date _____

EXHIBIT 2

PERFORMANCE REQUIREMENTS SUMMARY CHART

The Performance Requirements Summary (PRS) Chart is a listing of the minimum required services and performance that will be monitored during the Contract term. The PRS chart also lists examples of the types of documents that will be used during monitoring, as well as the standards of performance and the acceptable quality level of performance.

All listings of required services or standards used in this Performance Requirements Summary Chart are intended to be completely consistent with the terms and conditions of the Contract (Appendix C of the RFP) and the Statement of Work (Exhibit A to the Contract and Appendix A of the RFP) and are not meant in any case to create, extend, revise, or expand any obligation of the Subrecipient beyond that defined in the terms and conditions of this Contract and Statement of Work. In any case of apparent inconsistency between required services or Standards as stated in the terms and conditions of the Contract, the Statement of Work, and this Performance Requirements Summary (PRS) Chart, the terms and conditions of the Contract and the Statement of Work (SOW) will prevail.

Performance Outcomes	Standards	Acceptable Quality Level	Data Source	Remedies For Non-Compliance
Number of one-way trips provided by New Freedom Door-Assistance Transportation Program.	Subrecipient will accurately track all trips provided through program.	100%	Case Management System	If Subrecipient performance does not meet the Acceptable Quality Level, the County will have the option to apply the following remedies: 1) Corrective Action Plan; 2) Suspension of Payment; 3) Suspension of Contract; 4) Reduce and reallocate funds; and 5) Termination of Contract.
Provision of scheduled trips.	Subrecipient will pick up/drop off client on scheduled date and time.	95%	Case Management System	
Provide timely escort driver transportation service.	Subrecipient shall provide Door-to-Door or Door through Door service within 15 minutes of scheduled time and shall inform the Client of any possible time delay.	95%	Client Case Files and Reports	
Begin timely services once a client is determined eligible	Subrecipient shall provide Program services within two (2) weeks of initial assessment	95%	Case Management System	

EXHIBIT 3 - APPLICATION

WDACS
WORKFORCE DEVELOPMENT
AGING & COMMUNITY SERVICES

New Freedom: Door Assistance Transportation Program

SERVICE PROVIDERS: _____

DISTRICT 1☐ DISTRICT 2 ☐ DISTRICT 3 ☐ DISTRICT 4 ☐ DISTRICT 5 ☐

APPLICANT INFORMATION

PERSONAL

Last Name	First Name	Middle Initial	Date of Birth

Home Address *(Number/Street/Apt No.)*	City	State	Zip Code

Home Phone	Cell Phone	E-mail Address

Preferred Method of Contact
☐ Home ☐ Cell ☐ E-mail

Gender
☐ Male ☐ Female ☐ Transgender ☐ Decline to State

Mailing Address *(If different from home address)*	City	State	Zip Code

Employment Status
☐ Full or Part-time ☐ Retired ☐ Unemployed ☐ Decline to State

DEMOGRAPHICS

Client Race
☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hawaiian or Pacific Islander Japanese
☐ Black or African American ☐ Multiple Race ☐ Decline to State ☐ Other Race (Specify) _____

Client Ethnicity
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to State

Primary Language Spoken/Used
☐ American Sign Language ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ Chinese ☐ English
☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog
☐ Thai ☐ Vietnamese ☐ Other (Specify) _____

Translation needed ☐ Yes ☐ No

EMERGENCY CONTACT

Contact Last Name	First Name	Middle Initial

Address *(Number/Street)*	City	State	Zip Code

Home Phone	Cell Phone	Relationship to Client

REFERRAL SOURCE

How did you hear about the programs?

☐ Senior Center ☐ Community Based Organization ☐ Outreach Event

☐ Department Website ☐ Case Manager/Social Worker ☐ Other (Specify) _____

ADL / IADL RISK FACTORS

MOBILITY INFORMATION

Please state your level of assistance needed with the following daily activities:

Activities of Daily Living *(ADL)*

	Independent	Verbal Assistance	Some Human Help	A lot of Human Help	Dependent	Decline to State
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living *(IADL)*

	Independent	Verbal Assistance	Some Human Help	A lot of Human Help	Dependent	Decline to State
Meal preparation	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Medical Management	☐	☐	☐	☐	☐	☐
Money Management	☐	☐	☐	☐	☐	☐
Using Phone	☐	☐	☐	☐	☐	☐
Heavy Housework	☐	☐	☐	☐	☐	☐
Light Housework	☐	☐	☐	☐	☐	☐

DISABILITY FACTORS

Do you have a disability?

☐ Yes ☐ No

If yes, please check the type(s) of disability.

☐ Visually Impaired ☐ Hearing Impaired

☐ Speech Impaired ☐ Physically Impaired

☐ Memory Impaired ☐ Cognitively Impaired

Types of mobility aid(s) used

☐ Wheelchair ☐ Scooter ☐ Walker ☐ Cane

☐ Oxygen Tank ☐ Crutches ☐ Service animal

☐ None ☐ Other (Specify) _____

MOBILITY

Current means of transportation (Check all that apply)

☐ Family ☐ Friends ☐ Neighbor

☐ Personal vehicle ☐ Public Transit

☐ ACCESS ☐ Dial-A-Ride

☐ Uber/Lyft/Taxicab ☐ Other (Specify) _____

Most frequent trips made (Check all that apply)

☐ Medical facility ☐ Dental facility ☐ Pharmacy

☐ Personal ☐ Grocery Store ☐ Employment

☐ Place of Worship ☐ Senior Center

☐ Other (Specify) _____

MOBILITY MANAGEMENT

MOBILITY SURVEY

1) How would you rate your current overall quality of life?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2) Do you currently have difficulty accessing transportation?

☐ Yes ☐ No

If yes, please indicate why:

☐ Cost ☐ Disability ☐ Available services unknown ☐ Lack of services in your area

☐ Other (Specify) _____

3) Please indicate the impact access to transportation has on your quality of life:

☐ Negative ☐ Somewhat Negative ☐ Neutral ☐ Somewhat Positive ☐ Positive

4) In the past 6 months, how many medical and/or dental appointments have you missed due to a lack of transportation?

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ 11-15 ☐ More than 15

5) In the past 6 months, how many personal appointments have you missed due to a lack of transportation?

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ 11-15 ☐ More than 15

6) On average, how long does it take to travel to your medical and/or dental appointments?

☐ Less than 10 minutes ☐ 11-20 minutes ☐ 21-30 minutes ☐ More than 30 minutes

7) On average, how many times per month do you use public transit services?

☐ Zero ☐ 1-5 times ☐ 6-10 times ☐ 11-15 times ☐ More than 15 times

8) On average, how many days per month do you engage in social activities outside of your home?

☐ Zero ☐ 1-5 days ☐ 6-10 days ☐ 11-15 days ☐ More than 15 days

CERTIFICATION

ACKNOWLEDGEMENT

(To be completed by Interviewer and signed by Client)

I certify that the information on this form, provided to me by the client, is accurate and true to the best of my abilities. I also certify that I have informed the Client that this information may be shared with other providers for the purpose of providing services. Client signature establishes agreement to services.

	Completed by *(Print)*	Phone
	Signature	Date
	Client Name *(Print)*	
	Client Signature	Date

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