OMB No. 0985-0007

Expiration Date: XX/XX/XXXX

ADMINISTRATION FOR COMMUNITY LIVING

ADMINISTRATION ON AGING

TITLE VI PROGRAM PERFORMANCE REPORT

**Report Period April 1, [year] – March 31, [year]**

**Title VI, Parts A/B and C \_\_\_\_\_\_\_ Title VI, Part A/B only \_\_\_\_\_\_**

Grantee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Part A/B Grant No. \_\_\_\_\_\_\_\_\_ Part C Grant No.\_\_\_\_\_\_\_\_\_\_

**------------------------------------------------------------------------------------------------------------------------------------------**

# TITLE VI, PART A/B REPORT

## STAFFING INFORMATION

Enter the number of staff paid wholly or partly by Title VI, Part A/B funds.

### Full-time staff

| Full-time staff  | Enter number here | Person(s) |
| --- | --- | --- |

### Part-time staff

| Part-time staff  | Enter number here | Person(s) |
| --- | --- | --- |

## NUTRITION SERVICES

### Congregate Meals

| Unduplicated number of eligible persons who received one or more Congregate Meal(s).  | Enter number here | Person(s) |
| --- | --- | --- |
| Total number of Congregate Meals served.  | Enter number here | Meal(s) |

### Home-Delivered Meals

| Unduplicated number of eligible persons who received one or more Home-delivered Meal(s). | Enter number here | Person(s) |
| --- | --- | --- |
| Total number of Home-delivered Meals provided.  | Enter number here | Meal(s) |

### Other Nutrition Services

| Total number of sessions of **Nutrition Education**.  | Enter number here | **Session(s)** |
| --- | --- | --- |
| Total number of persons who received **Nutrition Counseling**.  | Enter number here | **Person(s)** |
| Total number of hours of **Nutrition Counseling**. | Enter number here | **Hour(s)** |

## SUPPORTIVE SERVICES

### Access Services

| Total number of contacts of Information/Assistance. | Enter number here | Contact(s) |
| --- | --- | --- |
| Total number of **Outreach activities**. | Enter number here | Activities |
| Unduplicated number of persons receiving Case Management. | Enter number here | Person(s) |
| Total number of hours of Case Management. | Enter number here | Hour(s) |
| Unduplicated number of persons receiving **Transportation**. | Enter number here | Person(s) |
| Total one-way trips of **Transportation**. | Enter number here | One-way trip(s) |

### In-home Services

| Unduplicated number of persons receiving **Homemaker Services**.  | Enter number here | Person(s) |
| --- | --- | --- |
| Total number of hours of Homemaker Services. | Enter number here | Hour(s) |
| Unduplicated number of persons receiving **Personal Care/Home Health Aid Services**. | Enter number here | Person(s) |
| Total number of hours of **Personal Care/Home Health Aid Service**. | Enter number here | Hour(s) |
| Unduplicated number of persons receiving Chore Services. | Enter number here | Person(s) |
| Total number of hours spent on **Chore Services**. | Enter number here | Hour(s) |
| Total number of contacts of **Visiting**. | Enter number here | Contact(s) |
| Total number of contacts of **Telephoning**. | **Enter number here** | **Contact(s)** |

### Other Supportive Services

| Total number of **Social Events** held. | **Enter number here** | **Event(s)** |
| --- | --- | --- |
| Total number of persons receiving **Health Promotion and Wellness** activities. | **Enter number here** | **Person(s)** |
| Total number of **visits to persons in nursing facilities/homes or residential care communities**.  |  | **Visit(s)** |

Optional space for other supportive services offered that are not listed above (1500 words or less):

## FINANCE

### Part A/B Spending

Optional explanation of elements included in total amount of funds (1500 words or less):

### What other sources of funds help you support your Title VI services:

| Tribal funds | Yes or No |
| --- | --- |
| State funds | Yes or No |
| Title III funds | Yes or No |
| Other grants | Yes or No |
| Donations  | Yes or No |

*This finance section will be an addendum to the 425. This will NOT be used for audits.*

| Total amount of funds spent on Congregate and Home-delivered Meals. | Enter number here | **Dollars** |
| --- | --- | --- |
| Total amount of funds spent on Supportive Services Programming. | Enter number here | **Dollars** |

## STORYTELLING

Please share an example of how your Title VI program has helped an individual or your community (1500 words or less):

\*\*OFFICIAL SIGNATURE\*\* - If only completing Title VI, Part A/B of this report go to page [insert page] to sign and date.

# TITLE VI, PART C REPORT

## STAFFING INFORMATION

Enter the number of staff paid wholly or partly by Title VI, Part C funds.

### Full-time staff

| Full-time staff | Enter number here | Person(s) |
| --- | --- | --- |

### Part-time staff

| Part-time staff | Enter number here | Person(s) |
| --- | --- | --- |

## TOTAL CAREGIVERS SERVED

*Caregivers served by the Title VI program are informal, unpaid providers of in-home and community care. Caregivers may be family members, neighbors, friends, or others.*

| Unduplicated number of caregivers to Elders or individuals of any age with Alzheimer’s disease and related disorders. | Enter number here | Person(s) |
| --- | --- | --- |
| Unduplicated number of Elder caregivers caring for children under the age of 18. | Enter number here | Person(s) |
| Unduplicated number of Elder caregivers providing care to adults 18-59 years old with disabilities.  |  | Person(s) |

## CAREGIVER SUPPORT SERVICES

### Services for Caregivers

| Total number of activities of **Information Services** provided. |  | Activities |
| --- | --- | --- |
| Total number of contacts of **Information and Assistance** provided. |  | Contact(s) |
| Unduplicated number of caregivers receiving **Counseling** (e.g. formal and/or informal counselors). | Enter number here | Person(s)  |
| Total number of hours of **Counseling**. | Enter number here | Hour(s) |
| Total number of sessions of **Support Group**. | Enter number here | Session(s) |
| Unduplicated number of caregivers served in **Caregiver Training**. | Enter number here | Person(s)  |
| Total number of hours of **Caregiver Training**. | Enter number here | Hour(s) |

**Supplemental Services**: (report on units provided, unduplicated caregivers served, service category)

| **Service Category** | **Description of Service** | **Unduplicated Caregivers** |
| --- | --- | --- |

There will be a dropdown menu of service categories: **Home Modification/Repairs, Consumable Items, Lending Closet, Homemaker/Chore/Personal Care Service, Financial Support, Other**.

### Respite Care for Caregivers

*Respite care is a service for informal caregivers, not Elders or children. Respite care refers to allowing caregivers time away to do other activities by having an Elder, person with a disability, or child cared for by someone else.*

| Unduplicated number of **caregivers of Elders** provided **Respite Care**. | Enter number here | Person(s) |
| --- | --- | --- |
| Total number of hours of **Respite Care for caregivers of Elders**. | Enter number here | Hour(s) |
| Unduplicated number of **caregivers of children** under the age of 18 provided **Respite Care**. | Enter number here | Person(s) |
| Total number of hours of **Respite Care for caregivers of children under the age of 18**. | Enter number here | Hour(s) |
| Unduplicated number of **caregivers of adults** 18-59 years old with disabilities provided **Respite Care**. | Enter number here | Person(s) |
| Total number of hours of **Respite Care for caregivers of adults 18-59 years old with disabilities**. | Enter number here | Hour(s) |

## FINANCE

### Part C Spending

*This finance section will be an addendum to the 425. This will NOT be used for audits.*

| Total amount of funds spent on the Caregiver Program.  | **Enter number here** | Dollars |
| --- | --- | --- |
| Total amount of funds spent on Respite Care.  | **Enter number here** | Dollars |

Report Certified By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Tribal Official or other authorized personnel)

Report Prepared by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Submitted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number (OMB 0985-0059). Public reporting burden for this collection of information is estimated to average 3.5 hours per response, including time for gathering and maintaining the data needed and completing and reviewing the collection of information. The obligation to respond to this collection is required to retain the statutory authority for the Older Americans Act Amendments of 2006, P.L. 114-144. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Administration for Community Living, U.S. Department of Health and Human Services, 330 C Street, SW, Washington, DC 20201-0008, Attention Kristen Hudgins, or email Kristen.Hudgins@acl.hhs.gov.