

March 1, 2025

Ms. Heather Nicholson
Area IV Agency on Aging
Rocky Mountain Development Council
PO Box 1717
Helena, MT 59624-1717

Dear Ms. Nicholson:

Thank you for providing **A Plus Health Care, Inc.** with the opportunity to present our Letter of Intent for the provision of Personal Care Assistance and Skilled Nursing to members of the Lewis and Clark, Broadwater and Jefferson Counties.

To accommodate elevated costs of recruitment and retention caused by the industry-wide workforce shortage of direct care professionals, A Plus Health Care, Inc. as well as stay in compliance with Medicaid Program funding service. The newly billed rates will be as follows:

\$42.00 /hour with a match of \$5.00/hour for Personal Care, Respite, and travel time.
\$61.00/hour with a match of \$5.00/ hour for LPN Skilled Nursing and Nurse travel time.

We take our role as a provider seriously and are committed in our belief that we need to do our part if we are to continue providing these important services to our members.

We look forward to presenting this information to yourself and the rest of the Council in May. Should you have any questions, or if I can be of service to you, please feel free to contact me at 406-443-3866.

Thank you, Ms. Nicholson, for your consideration.

Sincerely,



Teddi Everett, Operations Manager

Cc: Contracting Department
File

LETTER OF INTENT TO APPLY FOR CONTRACT

Under Title III of the Older Americans Act
Fiscal Year July 1, 2025 through June 30, 2026

Summary Sheet

Applicant Agency: A Plus HealthCare Project Director: Amanda Hawley
Mailing Address: 1538 9th Avenue Street Address: 1310 S Main St
City, State, Zip: Helena Montana 59601 City, State, Zip: Kalispell, MT 59901
E-Mail: ahawley@aplushc.com E-Mail: teverett@aplushc.com

Type of Organization:

☐ City ☐ County ☐ Private Non-Profit ☒ Other (specify): _____

Geographic area to be served: Jefferson ,Lewis & Clark

List services to be provided:

Estimated # of unduplicated *persons*
to be served during project period for
each service type:

Estimated # of unduplicated *units* of
service during project period for each
listed service type:

Personal care

16

1000

Nursing

6

100

Applicant agrees that the project described in this Letter of Intent will be operational July 1, 2025 through June 30, 2026 and certifies that to the best of my knowledge and belief, the information in this application is true and correct and the attached conditions will be complied with if the contract is awarded.

Darby Anderson

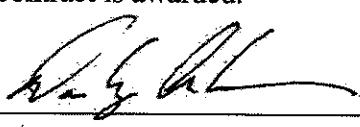
Type or print person authorized to sign

EVP & Chief Government Relations Officer

Title

Amanda Hawley
Type or print person authorized to sign

State Director
Title



Signature

3/24/2025

Date

Amanda Hawley

Signature

3/27/2025

Date

LETTER OF INTENT TO APPLY FOR CONTRACT
Under Title III of the Older Americans Act
Fiscal Year July 1, 2025 through June 30, 2026

Project Description Sheet

(Please fill out a ***Project Description Sheet*** for each service provided. Attach additional pages if necessary to complete the following questions.)

1. Service or Project name:
2. Provide a description of how your program will spend the Title III funding.
3. Statement of how your project will coordinate services with other community programs. (Include a description of referral systems.)

4. Statement of how your project will fulfill the mission of the Older Americans Act. (Include a description of criteria for selection of clients, outreach and targeting activities and how the project fulfills the objectives of the Older Americans Act.)
5. If extra funding was available, what would you do to increase services and how would you plan to spend the money?

6. Please provide letters of support from other local community-based and/or institutional programs, agencies or organizations involved with older adults.
7. List wage range of all employees funded in full or in part by this contract: \$ _____ to \$ _____.
8. Is this project covered by liability insurance? _____ How much? _____
8. How many years has this project received Title III funds: _____
10. Please provide a **detailed** estimated budget for this Title III service for the fiscal year 2025-2026 as follows (list appropriate estimated resources):

PLEASE FILL IN THE FORM BELOW, YOU MAY SUBMIT ADDITIONAL SUPPORTING DOCUMENTATION IF NECESSARY.
(Your expenses should equal your resources)

Expenses:

Resources:

Personnel and fringe: _____

Supplies: _____

Raw food/meals: _____

Commodities: _____

Communications: _____

Utilities: _____

Repairs/maintenance: _____

Travel/training: _____

Building space: _____

Insurance: _____

Equipment: _____

Contracted services: _____

Audit: _____

Other: _____

TOTAL: \$ _____

Area IV Funds: _____

Project income: _____

Other Resources: _____

Cash in Lieu: _____

Commodities: _____

Match: _____

Other: _____

Other: _____

TOTAL: \$ _____

Application deadline - The electronic application and 2 copies must be received by Rocky before 4 p.m. Friday, March 28, 2025. Applications received after this deadline date will not be considered for funding.

The contractor presentations will be on Zoom again this year.

The date of the Area IV Board Meeting is May 15, 2025 at 9:00am.

**Letter of Intent
Addendum A
2025**

Statement of how your project will coordinate services with other community programs (include a description of referral systems).

Title III Grant funding will serve as a resource for **A Plus Health Care, Inc.** a wholly owned subsidiary of Addus Healthcare, Inc., to provide in home services for clients who do not have access or financial means to obtain needed services to remain safely in their homes. Services that will be provided include personal care, respite care, homemaking, nursing services, shopping, transportation, and medical transportation. Upon admission to our agency, the LPN or RN will assess the ongoing needs of the client in their home and refer to Home Health, Hospice, Medicaid, Medicaid Waiver Programs, Mental Health Program, Senior Companion, Meals on Wheels, Lifeline, and other community services. **A Plus Health Care, Inc.** nursing staff communicates with various entities such as hospital case managers, Medicaid case managers, social workers, physicians, nurses, family, and friends of our community seniors as well as the seniors themselves who live in our community. Referrals from any source will be accepted and assessed for appropriateness to be placed in this program. We will maintain a waiting list when we do not have enough funds to provide assistance to new referrals.

Statement of how your project will fulfill the mission of the Older American Act. (Include a description of criteria for selection of clients, outreach, and targeting activities and how the project fulfills the objective of the Older American Act)

The mission of **A Plus Health Care, Inc.** is to provide the highest quality home health care available so clients may remain safe and comfortable in their own homes. Eligibility criteria include the following:

- 1) 60 or more years of age
- 2) The requested service is not available from family, other programs or funding sources.
- 3) The income is within the sliding scale (see attachment)
- 4) The client is at risk without services, or s/he has extenuating circumstances limiting his/her ability to afford private services.

These criteria will allow **A Plus Health Care, Inc.** to reach clients who are not served by another program due to the custodial nature of their medical condition, excessive income, or no available resources for entitlement program, eligibility, or other program eligibility criteria. **A Plus Health Care, Inc.** can offer a continuum of services while they are negotiating through the Medicaid eligibility process for the Personal Assistance Service Program, waiting for a Medicaid Waiver slot, or awaiting placement in a supportive living setting.

Recipient's eligibility is re-evaluated yearly or upon a significant break in services due to hospitalization or nursing home admission. Based on the sliding income scale some clients contribute toward the cost of their services. The ability to contribute towards their services, foster feelings of self-reliance and freedom from total dependency on public assistance.

References

Roberta Lapier, Consumer
Betty Cole, Consumer
Jane Shelley, Consumer
Mary Phillips, Consumer

2023 Sliding Scale Grant Client Contribution Guidelines

Persons in Household		48 Contiguous States and D.C. Poverty Guidelines (Monthly)								
	100%	133%	150%	200%	250%	300%	400%			
1	\$1,133	\$1,506	\$1,699	\$2,265	\$2,831	\$3,398	\$4,530			
2	\$1,526	\$2,029	\$2,289	\$3,052	\$3,815	\$4,578	\$6,103			
3	\$1,919	\$2,552	\$2,879	\$3,838	\$4,798	\$5,758	\$7,677			
4	\$2,313	\$3,076	\$3,469	\$4,625	\$5,781	\$6,938	\$9,250			
5	\$2,706	\$3,599	\$4,059	\$5,412	\$6,765	\$8,118	\$10,823			
6	\$3,099	\$4,122	\$4,649	\$6,198	\$7,748	\$9,298	\$12,397			
7	\$3,493	\$4,645	\$5,239	\$6,985	\$8,731	\$10,478	\$13,970			
8	\$3,886	\$5,168	\$5,829	\$7,772	\$9,715	\$11,658	\$15,543			
For each person over 8 add:	\$393	\$524	\$590	\$786	\$983	\$1,180	\$1,573			

Sliding Scale Grant Clients Contributions

Client pays ____%	100%	100%	75%	50%	25%	0%	0%
of total Billing							

Info found on : <https://www.payingforseniorcare.com/federal-poverty-level>



CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
05/29/2024

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services Southwest, Inc. Dallas TX Office 5005 Lyndon B Johnson Freeway Suite 1500 Dallas TX 75244 USA	CONTACT NAME: PHONE (A/C. No. Ext): (866) 283-7122 FAX (A/C. No.): (800) 363-0105 E-MAIL ADDRESS:														
INSURED Addus HealthCare, Inc. and its subsidiaries 2300 warrenville Road Downers Grove IL 60515 USA	<table><tr><th>INSURER(S) AFFORDING COVERAGE</th><th>NAIC #</th></tr><tr><td>INSURER A: Hartford Fire Insurance Co.</td><td>19682</td></tr><tr><td>INSURER B: Arch Specialty Insurance Company</td><td>21199</td></tr><tr><td>INSURER C:</td><td></td></tr><tr><td>INSURER D:</td><td></td></tr><tr><td>INSURER E:</td><td></td></tr><tr><td>INSURER F:</td><td></td></tr></table>	INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A: Hartford Fire Insurance Co.	19682	INSURER B: Arch Specialty Insurance Company	21199	INSURER C:		INSURER D:		INSURER E:		INSURER F:	
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INSURER D:															
INSURER E:															
INSURER F:															

Holder Identifier :

COVERAGES**CERTIFICATE NUMBER:** 570105879591**REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS												
B	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> <input type="checkbox"/> GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER:			FLP005514611	06/01/2024	06/01/2025	<table><tr><td>EACH OCCURRENCE</td><td>\$1,000,000</td></tr><tr><td>DAMAGE TO RENTED PREMISES (Ea occurrence)</td><td>\$100,000</td></tr><tr><td>MED EXP (Any one person)</td><td>\$5,000</td></tr><tr><td>PERSONAL & ADV INJURY</td><td>\$1,000,000</td></tr><tr><td>GENERAL AGGREGATE</td><td>\$8,000,000</td></tr><tr><td>PRODUCTS - COMP/OP AGG</td><td>\$8,000,000</td></tr></table>	EACH OCCURRENCE	\$1,000,000	DAMAGE TO RENTED PREMISES (Ea occurrence)	\$100,000	MED EXP (Any one person)	\$5,000	PERSONAL & ADV INJURY	\$1,000,000	GENERAL AGGREGATE	\$8,000,000	PRODUCTS - COMP/OP AGG	\$8,000,000
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A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			46 AB S28207 46 CSE S28206	06/01/2024 06/01/2024	06/01/2025 06/01/2025	<table><tr><td>COMBINED SINGLE LIMIT (Ea accident)</td><td>\$2,000,000</td></tr><tr><td>BODILY INJURY (Per person)</td><td></td></tr><tr><td>BODILY INJURY (Per accident)</td><td></td></tr><tr><td>PROPERTY DAMAGE (Per accident)</td><td></td></tr></table>	COMBINED SINGLE LIMIT (Ea accident)	\$2,000,000	BODILY INJURY (Per person)		BODILY INJURY (Per accident)		PROPERTY DAMAGE (Per accident)					
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PROPERTY DAMAGE (Per accident)																			
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input checked="" type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input type="checkbox"/> RETENTION			FLP005514611	06/01/2024	06/01/2025	<table><tr><td>EACH OCCURRENCE</td><td>\$10,000,000</td></tr><tr><td>AGGREGATE</td><td>\$10,000,000</td></tr></table>	EACH OCCURRENCE	\$10,000,000	AGGREGATE	\$10,000,000								
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AGGREGATE	\$10,000,000																		
A	<input checked="" type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N Y	N/A	46WNS28204	06/01/2024	06/01/2025	<table><tr><td><input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER</td><td></td></tr><tr><td>E.L. EACH ACCIDENT</td><td>\$1,000,000</td></tr><tr><td>E.L. DISEASE-EA EMPLOYEE</td><td>\$1,000,000</td></tr><tr><td>E.L. DISEASE-POLICY LIMIT</td><td>\$1,000,000</td></tr></table>	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER		E.L. EACH ACCIDENT	\$1,000,000	E.L. DISEASE-EA EMPLOYEE	\$1,000,000	E.L. DISEASE-POLICY LIMIT	\$1,000,000				
<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER																			
E.L. EACH ACCIDENT	\$1,000,000																		
E.L. DISEASE-EA EMPLOYEE	\$1,000,000																		
E.L. DISEASE-POLICY LIMIT	\$1,000,000																		
B	Miscellaneous Medical Professional Liab			FLP005514611 Prof Liab - Claims Made	06/01/2024	06/01/2025	<table><tr><td>Each Incident</td><td>\$1,000,000</td></tr><tr><td>Aggregate</td><td>\$8,000,000</td></tr></table>	Each Incident	\$1,000,000	Aggregate	\$8,000,000								
Each Incident	\$1,000,000																		
Aggregate	\$8,000,000																		

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER**CANCELLATION**

Addus HealthCare, Inc. dba Addus HomeCare 2300 warrenville Rd. Downers Grove IL 60515 USA	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE <i>Aon Risk Services Southwest, Inc.</i>
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Certificate No : 570105879591

2/12/25

To whom it may concern,

My name is Roberta Latier and I am on the grant program that you offer.

I really appreciate what you are doing for me. The extra help has done wonder in the way that I can keep my house much cleaner now.

The woman that comes to help me with everything is a jewel. She does everything that I ask her to do for me.

I don't think I would get any help if it wasn't for your program, so thank you very much

Roberta Latier

2-17-25

To whom it may concern
I use the program a lot and
I'm happy that there for me. They
help me with my shower and house
cleaning. If it wasn't for them
I don't know what I'd do

Thank You
my R

Betty Cole

Year Grant Committee;

2/25/2025

Thank you for the services I received through grant. I am legally blind AND have insulin dependent diabetes. The PCA who helps me assures I can stay in my home. This is helping me maintain my health AND well being. The nurse assists w/ my medicines AND the PCA assists w/ maintaining housekeeping chores.

Thank-You

X- Betty L Cole

3-5-25

At I am sorry I only have
scrap paper to write on.

I want the Power's that be
to know how grateful I am
for this service.

Without the help of my caretaker
I could not live alone.

with my severe case of Bamboo
spine, nearly every joint in my
body is fused. My pelvic & thoracic
girdle are calcified and I have very
little mobility. My ribs have 0
expansion. Walking just a few feet
causes several minutes of trying
to breathe. Seated I can do some
chores. I have to wait for Ellie to
come over to do the chores I am not
capable of. I have several other
medical issues. However lack of

Mobility is the most de-
bilitating;

I thank you all
for allowing me
to receive this
privilege and help.

Joe R. Shelley
Lincoln, Mo.

Ph. 406-362-4064