

Big Bend Continuum of Care

STATE of FL ESG 2016/17 Project Application

1. APPLICANT INFORMATION

Name: _____

Mailing Address: _____

City _____ County: _____

Zip Code: _____ Telephone #: _____

Applicant's E-mail Address: _____

Organization's Web Address: _____

Federal Tax Identification: _____

DUNS Number: _____

***Please include a copy of your organization's 990 in your application.**

2. PROJECT ADMINISTRATOR

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

3. CONTACT PERSON FOR THE APPLICATION

Name: _____

Phone: _____

Email: _____

4. TARGET GROUP (check all that apply):

- ___ Single adults
- ___ Adult couples with no children in the households
- ___ Families with at least one child under age 18
- ___ Chronically homeless adults
- ___ Chronically homeless families with children
- ___ Unaccompanied youth under age 18
- ___ Youth ages 18-24
- ___ Parenting youth ages 18-24
- ___ Domestic violence survivors
- ___ Persons with substance abuse history
- ___ Persons with serious persistent mental illness
- ___ Veterans
- ___ Other (specify): _____

5. CoC AREA _____

COUNTY(IES) AND CITY TO BE SERVED: _____

6. Proposal includes FAITH BASED ORGANIZATIONS? YES NO

7. TOTAL ESG PROJECT FUNDS REQUESTED: \$ _____

Street Outreach \$ _____

Shelter Activities (Essential Services + Operations) \$ _____

Prevention \$ _____

Rapid Re-Housing \$ _____

HMIS \$ _____

Administration \$ _____

MATCHING FUNDS:

\$ _____

TOTAL PROGRAM COST

\$ _____

To the best of my knowledge, I certify that the information in this application is true and correct and that the document has been duly authorized by the governing body of the applicant. I will comply with the program rules and regulations if assistance is approved. I also certify that I am aware that providing false information on the application can subject the individual signing such application to criminal sanction.

Executive Director, or Board Chair of Organization:

Signature: _____

Typed Name: _____

Title: _____

Date: _____

Organization/Agency Profile

- 1. Is your organization actively participating in the Big Bend CoC Coordinated Intake and Assessment? YES NO
- 2. If Yes, how is your organizing utilizing the Coordinated Intake and Assessment System?
- 3. Has your agencies received referrals through the Coordinated Intake and Assessment System? YES NO

of Accepted Referrals from 11/1/15-4/30/16: _____

of Declined Referrals from 11/1/15-4/30/16: _____

Reasons for declined referrals:

Are you making housing placements through the Coordinated Intake and Assessments System? YES NO

Number of successful housing placements made through Coordinated Intake and Assessment System from 11/1/15 to 4/30/16: _____

Provide HMIS Client ID #s for all clients successfully housed through Coordinated Intake and Assessment from 11/1/15-4/30/16:

- 4. Does your agency consult and coordinate with the Big Bend CoC to provide input on policy and planning from the homeless or formerly homeless in your area?
 Yes No

Please list any CoC committees you or your organization have actively participated in:

- 5. Describe any prior experience with Federal or other grant funding, particularly grant funding from Department of Children and Families.

If you have had Federal grant funding in the past, were you able to meet your deliverables and the requirements of the grant? Please explain.

- 6. Describe your organizations current participation with the Homeless Management Information System (HMIS). Include number of users and programs using HMIS with your organization.

- 7. Does your proposal include funding any faith-based project or program? If yes, how will you ensure they separate ESG related activities from the agency's faith-based activities in the provision of services to clients (i.e., spiritual counseling, worship services)?

Proposed Activities – Street Outreach

1. Describe how the Coordinated Intake procedure will be used to assess participants needs and coordination with other service providers in your region:
2. Is assisting clients to transition into permanent housing part of the proposal? What steps are taken to accomplish this?
3. Are their Emergency Shelter services available in the county you intend to conduct outreach in (including motel/hotel vouchers paid for by an agency or organization) ___YES ___NO
If Yes, what is the capacity of the shelter and motel vouchers and how many individuals can those services accommodate?

If No, Is there a plan to have new resources in that county available for Emergency Shelter services? Explain.

4. How will your organization follow-up with clients served through outreach and measure client outcomes.
5. Describe activities proposed to be conducted under Street Outreach:
6. How many clients will be served under Street Outreach and objectives of program:

Proposed Activities – Emergency Shelter

1. Describe how the Coordinated Intake procedure will be used to assess participants needs and coordinate with other service providers:
2. Is assisting clients to transition into permanent housing part of the proposal? What steps are taken to accomplish this?
3. Are there already existing Emergency Shelter resources available in this county? Explain the current capacity for these existing services and your plan to expand on these services.
4. Describe the procedure that will be used to follow-up on clients who were served and then exited the program:
5. What was the average length of stay for clients in your existing Emergency Shelter project?

What is your overall success rate (%) for placing clients from your Emergency Shelter program to Permanent Housing?

Rehabilitation or Conversion Projects

1. Briefly describe your renovation project including the address of the building, the specifications for the proposed renovations, the cost estimate for the renovations and total project cost. Please attach a work write-up or estimates to this application.
2. Provide documentation of ownership and age of building:
3. Provide the property's current market value and the date the building was constructed.
4. If applicable, has the lead-based paint inspector identified? If yes, please provide documentation of the inspector's qualifications (Appendix L).

Essential Services Projects

1. Describe activities proposed for Essential Services and/or Operations:
2. Provide a physical description and capacity of the shelters funded under this project. Include number of beds available and operation hours.
3. If applicable, list all persons, position titles, percentage of time and salaries of personnel that will be billed under Essential Services and/or Operations for all shelters:
4. List number of clients to be served monthly and objectives of all programs:

Proposed Activities – Prevention and Re-housing

1. Describe how the Coordinated Intake procedure will be used to assess participants needs and coordination with other service providers in your region:
2. Describe the procedures that will be in place to assist transitioning into permanent housing:
3. Describe the procedure that will be used to follow-up on clients who were served and then exited the program:
4. How will you ensure housing placements meet minimum habitability standards when rental assistance funds are used to place a homeless household into housing, or move a household to different housing? Who will conduct necessary inspections?
5. How will you assure that rent reasonableness tests are conducted for each unit rented?
6. Explain the assessment process for determining the duration of financial assistance to be provided. If applicable, how will you document that Prevention program participants receiving medium-term rent assistance (3 to 9 months of assistance) be certified for eligibility at least once every 3 months or at re-certification?
7. List all position titles and salaries of personnel that will be billed under Housing Relocation and Stabilization Services (Prevention and/or Rapid Re-Housing). Include salary, percentage of time billed to ESG and indicate whether the position is full- or part-time.
8. For Prevention activities *only*, how will you ensure documentation of proof of income eligibility for program participants?
9. Provide brief, but detailed summary of all proposed services funded under this grant:
10. Total number of clients to be served monthly and objectives of program:

Street Outreach ONLY:

1. If applicable, based upon the CoC HMIS System, during February 1, 2015 and January 31, 2016, the applicant has achieved the following outcomes for housing permanency in the planning area:
 - (a) For Outreach clients assisted, _____% of clients who received emergency health services on an outpatient basis by licensed medical professionals.
 - (b) For Outreach clients assisted, _____% of clients who received emergency mental health services on an outpatient basis by licensed medical professionals.
 - (c) For Outreach clients assisted, _____% of clients who were sheltered as a result of referral from the applicant's street outreach program to community housing applicants.

Emergency Shelter ONLY:

1. If applicable, based upon the CoC HMIS System, during February 1, 2015 and January 31, 2016, the applicant has achieved the following outcomes for housing permanency in the planning area:
 - (a) For Shelter Facilities clients housed, _____% of clients exited the facility to permanent housing.
 - (b) For Shelter Facilities clients housed, _____% of clients left the facility with employment income.
 - (c) If applicable, the applicant's outcomes achieved with its' DCF 2014 shelter award furthered the goals and objectives of the CoC.

Yes _____ No _____

Prevention and Rapid Re-housing ONLY:

1. Based upon the CoC HMIS System, or comparable database for domestic violence (dv) applicants, during February 1, 2015 and January 30, 2016, the applicant has achieved the following outcomes for housing permanency in the planning area:
 - (a) For Prevention clients assisted, _____% of the clients remained in their permanent housing as of ninety (90) days following the last date of assistance provided by the applicant's program.
 - (b) For Rapid Re-Housing clients assisted, _____% of the clients remained in permanent housing provided as of ninety (90) days following the last date of assistance provided by the applicant's program.

OVERALL PROJECT BUDGET AND MATCH FORM

	<u>Grant Activity/Project</u>	<u>\$ Requested</u>	<u>\$ Match Amount</u>	Agency Provider Name	Existing Service	New Service	Number of Persons Homeless To Be Served
1	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____	_____
TOTAL GRANT							_____
		\$_____	\$_____				_____
							Total Persons To Be Served

Instructions

Please list your grant projects on the above chart. The maximum grant for the entire Big Bend CoC shall be \$250,000 in FY2016-17. *At least 40% of the total project budget for the Big Bend CoC must be allocated to prevention and re-housing activities.*

1. Grant Activity / Project

Please use the same title or description used in the narrative. Be sure to identify and list each activity to be funded, if more than one is proposed for funding.

2. \$ Requested

List the amount of ESG Funds requested for each activity or use separately and the total amount of the Emergency Solutions Grant requested.

3. \$ Match Amount

List the amount of matching funds that will be submitted for invoicing purposes.

4. Existing or New Service

Specify whether the activity or use to be funded will support an existing service or use, or whether the funded activity is a new service to fulfill an unmet need.

5. Number of Homeless Persons Served

For each activity, identify the estimated number of homeless persons to be served.

BUDGET AND MATCH FORM

Prevention and Re-Housing

<u>Service Provider:</u>		Grant \$	Match \$
1.	Rapid Re-Housing		
A.	Rental Assistance	\$	\$
B.	Housing Relocation and Stabilization		
	i. Financial Assistance Costs	\$	\$
	ii Services Costs	\$	\$
2.	Homeless Prevention		
A.	Rental Assistance	\$	\$
B.	Housing Relocation and Stabilization		
	i. Financial Assistance Costs	\$	\$
	ii Services Costs	\$	\$
3.	HMIS		
A.	Lead Agency	\$	\$
B.	Sub-providers		
4.	Administrative Costs [Cap 5%]		
A.	Lead Agency	\$	\$
B.	Sub-provider	\$	\$
TOTAL BUDGET		\$	\$

Attach a detailed list of the sources of the required match, including the breakdown by amount of cash match, and/or in-kind services and valuation of such in-kind match.

Applicant: _____

MATCH SOURCES:

BUDGET AND MATCH FORM
Emergency Shelter Facilities

Service Provider:		Grant \$	Match \$
1.	Essential Services (list activities)		
	A.	\$	\$
	B.	\$	\$
	i.	\$	\$
	ii	\$	\$
2.	Shelter Operations (list activities)		
	A.	\$	\$
	B.	\$	\$
	i.	\$	\$
	ii	\$	\$
3.	Hotel or Motel Vouchers		
	A. ONLY if there is no emergency shelter available or appropriate for a homeless family or individual	\$	\$
4.	Renovations	\$	\$
5.	HMIS	\$	\$
	A. Lead Agency		
	B. Sub-providers		
6.	Administrative Costs [Cap 5%]		
	A. Lead Agency	\$	\$
	B. Sub-providers	\$	\$
TOTAL BUDGET		\$	\$

Attach a detailed list of the sources of the required match, including the breakdown by amount of cash match, and/or in-kind services and valuation of such in-kind match.

Applicant: _____

MATCH SOURCES:

BUDGET AND MATCH FORM
Street Outreach Program

Service Provider:		Grant \$	Match \$
1.	Engagement	\$	\$
2.	Case Management	\$	\$
3.	Outpatient Health Services by licensed professionals	\$	\$
4.	Outpatient Mental Health Services by licensed professionals	\$	\$
5.	Transportation of outreach workers or unsheltered persons to services	\$	\$
6.	Services for special populations (youth, victim services, persons with HIV/AIDS)	\$	\$
	HMIS	\$	\$
A.	Lead Agency		
B.	Sub-providers		
	Administrative Costs [Cap 5%]		
A.	Lead Agency	\$	\$
B.	Sub-providers	\$	\$
	TOTAL BUDGET	\$	\$

Attach a detailed list of the sources of the required match, including the breakdown by amount of cash match, and/or in-kind services and valuation of such in-kind match.

Applicant: _____

MATCH SOURCES:

***INCLUDE A COPY OF YOUR ORGANIZATION'S 990**

**Certification of Local Government Approval
For Nonprofit Organizations – Emergency Shelter Only
Required by 25 C.F.R. § 576.202**

I, _____ duly authorized to act on behalf of the
(Name and Title)

_____ hereby approve the submission of the
(Name of City or County Government) following

ESG Application proposed by _____
Name of Agency

which will serve persons
living in _____
(Name of City or County)

This certification solely warrants that the jurisdiction has agreed to allow the nonprofit organization to seek the grant to be able to serve citizens in need who reside in this jurisdiction. This certification places no responsibility or liability upon the local government jurisdiction related to the nonprofit's performance of grant-funded activities in our jurisdiction.

By: _____
(Name) (Title)

(Signature)

(Date)

*This form **MUST BE** signed, dated and returned with the grant application in order for the application to be considered for funding. All applications and supporting materials should be submitted to*