**IA-502 Des Moines/Polk County CoC**

**Special NOFO to Address Unsheltered Homelessness**

**PH-PSH and PH-RRH**

**To qualify as a new project and submit an application, at least one staff member from your agency must have attended the**

**Open Meeting on August 24, 2022, at 2:00 p.m.**

**Application submission:** Please submit this application form and required attachments by emailing an electronic application packet to Angie Arthur at aarthur@homewardiowa.org no later than

**September 9, 2022 at 5:00 p.m.** in order to be considered.

**Organization:** Click here to enter text **Contact Name:** Click here to enter text. **Email:** Click here to enter text.

**Contact telephone #:** Click here to enter text.

**Project Name:** Click here to enter text.

**Project Type:** Choose an item.

**Requested amount:** Click here to enter text.

**GRANT TERM: 3 years**

**Applicants are STRONGLY URGED to review**

* ***Section V. Eligibility Information* of the** [**Special NOFO to Address Unsheltered and Rural Homelessness**](https://www.hud.gov/sites/dfiles/CPD/documents/CoC/Unsheltered-and-Rural-Homelessness-NOFO-FR-6500.pdf) **beginning on page 17, before starting their application.**
* **First time applicants for HUD’s CoC funding are also STRONGLY URGED to review** [**24CFR 578 Subpart D and Subpart F**](https://www.govinfo.gov/content/pkg/CFR-2017-title24-vol3/xml/CFR-2017-title24-vol3-part578.xml) **before completing Sections III through VIII of this application.**

**PLEASE NOTE:** The wording of questions in this project application may not be the exact wording found in comparable questions of Exhibit 2 when it is uploaded to e-SNAPS. Therefore, read the questions in Exhibit 2 carefully before using the answers provided in this application.

# Centralized Intake System

* 1. Will the project for which you are requesting funding take referrals ONLY from the Polk County Centralized intake? [ ]  **Yes** [ ]  **No**

# If “NO”, your project is not eligible for HUD CoC funding

# Housing First

All applicants, except those seeking funding for HMIS and SSO-**CI** projects, **must operate as a Housing First model**. Please complete the checklist below by checking the box in front of each of the criteria that applies to your project.

* 1. Will/Does the project require a background screening prior to project entry (excluding sexual offender check for site-based projects with legal requirements)?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project prohibit persons with certain criminal convictions from entering your project (excluding registered sexual offender for site-based projects with legal requirements)?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project require participants to be clean and sober prior to project entry and/or during project stay?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project require alcohol/drug tests on participants suspected of being under the influence?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does a positive alcohol/drug test result in termination from the project and/or require participant to participate in substance abuse treatment and/or detox to resume project services?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project require participants to have a mental health evaluation prior to project entry?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project require project participants who demonstrate mental health symptoms to participate in mental health services and/or medication compliance *(excluding those who present a danger to self or others*) as a condition of services?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project require participants to have income at time of project entry?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project require participants to obtain an income as a condition of remaining in the project?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project require participants to participate in supportive services (such as vocational training, employment preparation, budgeting or life skills classes; not including required case management meetings) as a condition of continued services?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project require participants to be ‘progressing’ in their goals in order to remain in the project?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project require participants to sign a services plan agreement to receive your services? *(Please note a service plan is not the same as a housing plan.)*

 [ ]  **Yes** [ ]  **No**

* 1. Will/Does the project exclude or refuse project entry based on race, color, religion,

national origin, disability, sex, sexual orientation, gender identity and/or gender expression?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project include any requirements, outside of those typically found in a lease Agreement in Polk County[ ]  **Yes** [ ]  **No**
	2. Will/Do project participants have to travel to the agency’s office(s) to receive the majority of their services, including case management, after they are housed

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project exclude any dependent children in the household, based on age and/or gender, from remaining with the household at the project

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project prohibit any member(s) of a household *(as defined by the household),* based on age, gender, biological relationship and/or marital status, from residing together at the project?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does the project exclude any family composition type: single dad, single mom, same gender couples, opposite-gender couples, multi-generational, and non-romantic groups who present for services as a family?

[ ]  **Yes** [ ]  **No**

* 1. Will/Does project require project participants to be “placed” in accordance with their sex assigned at birth and/or “perceived” gender; and/or require participant to “prove” their gender identity prior to receiving services?

[ ]  **Yes** [ ]  **No**

* 1. Will/Do the project exclude participants who do not have a form of identification?

[ ]  **Yes** [ ]  **No**

# INCLUDE WITH THIS APPLICATION ONE COPY OF YOUR ADMITTANCE POLICY, ONE COPY OF YOUR TERMINATION POLICY AND ONE COPY OF YOUR TERMINATION APPEAL PROCESS.

1. **Project Description**
	1. Describe the target population(s) to be served and the plan for addressing the identified needs/issues of the target population(s). Rapid rehousing applicants: indicate the maximum length of assistance provided; Transitional housing exclusively serving homeless youth: maximum program length **(2,000 characters)**.
2. If this project will have a specific subpopulation focus, place an “x” in the blank before each criterion that applies to your proposed project:

[ ]  Chronic Homeless [ ]  Veterans [ ]  Youth (under 25)

[ ]  Families with Children [ ]  Domestic Violence (recent or past)

[ ]  Substance Abuse [ ]  Mental Illness [ ]  HIV/ AIDS

[ ]  Households with No Minor Children

1. Residence Prior to Homelessness (Select ALL that apply):

[ ]  Literally homeless (emergency shelter or place not meant for human habitation)

[ ]  Transitional housing for homeless persons

2. Does the project deny admission to or separate family members when they enter, including serving all family members together and in accordance with each family member’s self-reported gender? (If “No”, please describe the location of this policy in the admissions policy attached to this application.)

[ ]  **Yes** [ ]  **No**

3. Does the project use a harm-reduction model for drugs and/or alcohol use?

[ ]  **Yes** [ ]  **No**

If you answered “Yes”, please provide a specific example (without identifying anyone) illustrating a time when a harm-reduction model was used. If answered “No”, please explain why not. (**2,000 characters)**

4. Does the project have specific policies and procedures that work to prevent evictions (If “Yes”, please attach copy of the policies and procedures to your application)?

[ ]  **Yes** [ ]  **No**

Please explain your response (**2,000 characters**)

5. Is your organization a victim service provider as defined in 24CFR 578.3 and uses a comparable HMIS database? [ ]  **Yes** [ ]  **No**

If YES, describe how the project improves the safety of the DV survivors being served. (**2,000 characters**)

6. For each primary project location, or structure, enter the number of days from the execution of the grant agreement that each of the following milestones will occur if this project is selected for conditional award. If your project includes multiple structures, you will complete one column for each structure. Non-applicable fields can remain blank, or you can enter “0” or “NA.”

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Project Milestone** | **Days to Execution of Grant Agreement** | **Days to Execution of Grant Agreement** | **Days to Execution of Grant Agreement** | **Days to Execution of Grant Agreement** |
|  | **A** | **B** | **C** | **D** |
| **Begin hiring staff or expending funds** | Click here to enter text | Click here to enter text | Click here to enter text | Click here to enter text |
| **Begin program participant enrollment** | Click here to enter text | Click here to enter text | Click here to enter text | Click here to enter text |
| **Program participants occupy leased or rental assistance units or structure(s), or supportive services begin** | Click here to enter text | Click here to enter text | Click here to enter text | Click here to enter text |
| **Leased or rental assistance units or structure, and supportive services near 100% capacity** | Click here to enter text | Click here to enter text | Click here to enter text | Click here to enter text |
| **Closing on purchase of land, structure(s), or execution of structure lease** | Click here to enter text | Click here to enter text | Click here to enter text | Click here to enter text |
| **Start rehabilitation** | Click to enter a date. | Click to enter a date. | Click to enter a date. | Click to enter a date. |
| **Complete rehabilitation** | Click to enter a date. | Click to enter a date. | Click to enter a date. | Click to enter a date. |
| **Start new construction** | Click to enter a date. | Click to enter a date. | Click to enter a date. | Click to enter a date. |
| **Complete new construction** | Click to enter a date. | Click to enter a date. | Click to enter a date. | Click to enter a date. |

# Project Quality (Please answer questions based on applicant type):

* 1. Based on your answers to questions in section III(1)(a & b), Please describe how your project meets the following project quality criteria:
1. How the type of housing and number and configuration of units will fit the needs of the program participants (e.g., 2 or more bedrooms for families) (**2,000 characters)**
2. How the type of the supportive services that will be offered to program participants will

ensure successful retention or help to obtain permanent housing–this includes all supportive services, regardless of funding source (e.g., childcare for families with children, case management, life skills, drug counseling) (**2,000 characters)**

1. How accessible are basic community amenities (e.g., medical facilities, grocery store, recreation facilities, schools, etc.) to the participants’ housing?

 [ ]  Very accessible

[ ]  Somewhat accessible

[ ]  Not accessible

1. A specific plan for ensuring that program participants will be individually assisted to obtain the benefits of the mainstream health, social, and employment programs for which they are eligible to apply (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education) and which meets the needs of the program participants as well as annual follow-ups with program participants to ensure mainstream benefits are received and renewed (**3,000 characters)**; and
2. How program participants are assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., allows the participant the mobility to access needed services, case management follow-up, additional assistance to ensure retention of permanent housing) (**2,000 characters)**.

# Leveraging Housing Resources:

1. Applicant is using one of the following sources of funding? [ ]  **Yes** [ ]  **No** If YES:

(a) Place an “x” in front of the funding source being used.

 [ ]  Private organizations

 [ ]  State or local HOME funding

 [ ]  State or local American Rescue Plan funding

 [ ]  Other state or local funding

 [ ]  Public Housing Agencies

 [ ]  Federal programs other than the CoC or ESG programs

(b) Applicant demonstrate housing units will (place an “x” next to the appropriate option) [ ]  For PSH, provide at least 25% of the units included in the project for the targeted

 population described in this application

 [ ]  For RRH, serve at least 25% of the program participants anticipated to be served by the

 project

**Applicant must attach letters of commitment, contracts, or other formal written documents that clearly demonstrate the number of subsidies or units being provided to support the project.**

# Leveraging Healthcare Resources:

1. Project is utilizing healthcare resources? [ ]  **Yes** [ ]  **No** If YES:

(a) Place an “x” in front of the healthcare resource being used.

 [ ]  Direct contributions from a public or private health insurance provider or project

 (e.g., Medicaid)

[ ]  Provision of healthcare services by a private or public organization (e.g., Ryan White

 funded organization) tailored to the program participants of the project

[ ]  Other healthcare resource

(b) Applicant demonstrates (place an “x” next to the appropriate option):

[ ]  The value of the assistance being provided is at least an amount equivalent to 25% of the funding being requested for the project which will be covered by the healthcare

organization, or

[ ]  In the case of substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who qualify and chose those services

# Applicant must attach a written commitment from a health care organization, including organizations that serve people with HIV/AIDS

# Supportive Services:

* 1. Support Services and Frequency

|  |
| --- |
| For all supportive services available to participants, indicate who will provide, how they will be accessed and how often they will be provided **regardless of the resources that will be used to pay for the services**. Please include all Medicaid services whether provider by the applicant or through partnerships with other organizations that provide Medicaid funded services.*For Provider, indicate:* ***“Applicant”*** *if the applicant will provide the service directly;* ***“Partner”*** *if an organization with whom a formal agreement or memorandum of understanding (MOU) has been signed will provide the service directly; or,* ***“Non- Partner”*** *to if a specific organization with whom no formal agreement has been established regularly provides the service to clients.* |
|  |  | **Frequency – select one per service type** |
| **Supportive Service** | **Provider** | **Daily** | **Weekly** | **Bi- Monthly** | **Monthly** | **Does Not Apply** |
| Assessment of Service Needs | Click to enter text |[ ]  [ ]  | [ ]  | [ ]  | [ ]  |
| Assistance with Moving Costs | Click to enter text |[ ]  [ ]  | [ ]  | [ ]  | [ ]  |
| Case Management | Click to enter text |[ ]  [ ]  | [ ]  | [ ]  | [ ]  |
| Child Care | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Education Services | Click to enter text | [ ]  |[ ] [ ] [ ] [ ]
| Employment Assistance/Job Training | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Food | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Housing Search/Counseling Services | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Legal Services | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Life Skills | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Mental Health Services | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Outpatient Health Services | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Outreach Services | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Substance Abuse Treatment Services | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Transportation | Click to enter text |[ ]  [ ]  | [ ]  | [ ]  | [ ]  |
| Utility Deposits | Click to enter text | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

2. Describe efforts to identify and enroll all Medicaid-eligible participants. Describe opportunities for Medicaid-financed services, including case management, tenancy supports, behavioral health services and mental health supports**. (2,000 characters)**

3. The project has staff (or contract with another agency who has staff) who participated in a SOAR training? [ ]  **Yes** [ ]  **No**

 If yes, please complete the following table for each SOAR-trained staff person.

|  |  |  |
| --- | --- | --- |
| Staff Person | Title | Year |
| Click to enter text |  Click to enter text  |  Click to enter text  |
|  Click to enter text  |  Click to enter text  |  Click to enter text  |
| Click to enter text |  Click to enter text  |  Click to enter text  |

#

4. Collaboration with Local School Districts:

(a) For projects serving families with dependent children and single adults 21 years old or younger, does the applicant have policies and practices that are consistent with, and do not restrict the exercise of rights provided under subtitle B of title VII of the Act (42

 U.S.C. 11432, et seq.) and other laws relating to the provision of educational and related services to individuals and families experiencing homelessness? [ ]  **Yes** [ ]  **No**

 **ATTACH A COPY OF YOUR POLICY TO THE APPLICATION**

(b) For projects serving families with dependent children and single adults 21 years old or younger, does the applicant have a designated staff person responsible for ensuring that children are enrolled in school and connected with the appropriate services with the community, including early childhood education programs such as Head Start, Part C

of the Individuals with Disabilities Act, and subtitle B of title VII of the Act (42 U.S.C.

 11432, et seq.) services? [ ]  **Yes** [ ]  **No**

 Name: Click or tap here to enter text. Title: Click or tap here to enter text.

# Project Administration:

1. Describe your organizations experience in effectively utilizing federal funds and performing the activities proposed in your application. (**2,000 characters)**

2. Describe the organization’s experience in leveraging Federal, State, local and private sector funds. (**2,000 characters)**

3. Describe the organization’s financial management structure. (**2,000 characters)**

4. Applicants with a history of HUD CoC/ESG Project Administration:

1. Does the applicant have any existing/history of HUD CoC or ESG grants with any monitoring or audit findings (A-133 or general accounting-level audit) in the **last three years?** [ ] **Yes**  [ ] **No**

If yes, please explain each finding and any applicable corrective action that has been or will be taken. (**2,000 characters)**

(b) Are/were funding draws from Line of Credit Control System (LOCCS) completed **monthly** for this project? [ ] **Yes** [ ]  **No**

(c) Did you have unspent HUD funds at the expiration of grant terms in any of the pervious years listed below? [ ]  **Yes** [ ]  **No**

 If yes, how much? (Enter zero if all funds were spent & N/A if it does not apply)

 2020 – 2021 (ended in 2021): Click here to enter text.

 2019 – 2020 (ended in 2020): Click here to enter text.

 2018 – 2019 (ended in 2019): Click here to enter text.

 2017 – 2018 (ended in 2018): Click here to enter text.

(d) Is/did the applicant participate in HMIS or DVIMS? [ ]  **Yes** [ ]  **No**

5. Will it be feasible for the project to be under grant agreement by September 15, 2024?

 [ ]  **Yes** [ ]  **No**

1. **Project Evaluation/Client Input**
	1. Describe the evaluation plan for this project. Also, describe how your agency incorporates outcome data into a quality improvement process for this project and for the agency. **(2,000 characters)**
	2. Will the program conduct anonymous client satisfaction surveys or alternative methods of anonymous feedback? [ ]  **Yes** [ ]  **No**
	3. Will the program provide an opportunity for feedback from all clients at exit regardless of reason for leaving? [ ]  **Yes** [ ]  **No**
	4. Will the program present customer feedback to the Board of Directors?

[ ]  **Yes**[ ]  **No**

* 1. Is there a person with lived experience involved in your agency’s decision-making process?

[ ] **Yes** [ ] **No**

If yes, please describe **(2,000 characters)**

#  Housing Type and Location

[ ]  Single Structure [ ]  Scattered site

Click to enter text. Total Number of Units Click to enter text. Total Number of Beds

**If scattered-site leasing**, describe strategies that will be used to develop a network of landlords willing to lease homeless individuals, youth or families. How will you mitigate the reluctance of landlords to lease households with potential credit issues, histories of evictions or legal issues? **(2,000 characters)**

# Project applicants must enter an address for all proposed and existing properties. If the location is not yet known, enter the expected location of the housing units. For Scattered-site and Single-family home housing, or for projects that have units at multiple locations, project applicants should enter the address where the majority of beds will be located or where the majority of beds are located as of the application submission. Where the project uses tenant-based rental assistance in the RRH portion, or if the address for scattered-site or single-family homes housing cannot be identified at the time of application, enter the address for the project’s administration office. Projects serving victims of domestic violence, including human trafficking, must use a PO Box or other anonymous address to ensure the safety of participants.

|  |  |  |  |
| --- | --- | --- | --- |
| Street | City | State | Zip Code |
| Click to enter text | Click to enter text | Click to enter text | Click to enter text |

# Program Participants – Households

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Households with at Lease One Adult and One Child | Adult Households without Children | Households with Only Children | Total |
| Number of Households |  | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
|  |  |  |  |  |  |
| Characteristics |  | Persons in Households with at Least One Adult and One Child | Adult Persons in Households without Children | Persons in Households with Only Children | Total |
| Persons over age 24 |  | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Persons ages 18-24 |  | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Accompanied Children under age 18 |  | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Unaccompanied Children under age 18 |  | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Total Persons |  | Click to enter text | Click to enter text | Click to enter text | Click to enter text |

# Project Participants – Subpopulations

# Persons in Households with at Least One Adult and One Child

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | CH (Not Vet) | CH Vet | Vet | Chronic SA | HIV/ AIDS | Severely MI | DV | Phys. Disabled | Dvlpmntl. Disabled | Persons Not Listed |
| Persons over age 24 | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Persons ages 18-24 | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Children under age 18 | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Total Persons | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |

# Persons in Households without Children

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | CH(Not Vet) | CH Vet | Vet | Chronic SA | HIV/ AIDS | Severely MI | DV | Phys. Disabled | Dvlpmntl. Disabled | Persons Not Listed |
| Persons over age 24 | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Persons ages 18-24 | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Total Persons | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |

# Persons in Households with Only Children

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | CH (Not Vet) | CH Vet | Vet | Chronic SA | HIV/ AIDS | Severely MI | DV | Phys. Disabled | Dvlpmntl. Disabled | Persons Not Listed |
| Accompanied Children under age 18 | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Unaccompanied Children under age 18 | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |
| Total Persons | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text | Click to enter text |

# Budget/Cost Effectiveness

* 1. Will funds requested in this new project application replace state or local government funds? ☐ **Yes** ☐ **No**
	2. (PH-PSH only) Will this project include replacement reserves in the Operating budget? ☐ **Yes** ☐ **No**
	3. **Rental Assistance** (enter number of units by unit type; the applicable Fair Market Rent (FMR) level or HUD Paid Rent, multiply units times rent amount times 12 (1 year grant) and enter totals. (DO NOT use “HUD Paid Rent (Actual Rent)” column unless previously approved).

Indicate the Type of Rental Assistance:

* + Project Based ☐ Tenant Based ☐ Sponsor Based

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Unit Size** | **No. of Units** | **FMR** | **HUD Paid Rent (Actual Rent)** | **Term (months)** | **Total** |
| Efficiency | Click or tap here to enter text. | **$658** | $Click here to enter | 12 | Click here to |
| 1 Bedroom | Click here to | **$770** | $Click here to enter | 12 | Click here to |
| 2 Bedroom | Click here to | **$935** | $Click here to enter | 12 | Click here to |
| 3 Bedroom | Click here to | **$1,284** | $Click here to enter | 12 | Click here to |
| 4 Bedroom | Click here to | **$1,357** | $Click here to enter | 12 | Click here to |
| **Total** | Click here to |  |  |  | Click here to |

# Operating Costs

Enter the quantity and total budget request for each operating cost. The request entered should be equivalent to the cost of one year of the relevant operating costs. When including staff costs, please include title, salary and FTE.

|  |  |  |
| --- | --- | --- |
| **Operating Costs** | **Quantity Description** | **Annual Assistance** **Requested** |
| Maintenance and repair | Click to enter text | Click to enter text |
| Property Tax and Insurance | Click to enter text | Click to enter text |
| Replacement Reserve | Click to enter text | Click to enter text |
| Building Security | Click to enter text | Click to enter text |
| Electricity, Gas and Water | Click to enter text | Click to enter text |
| Furniture | Click to enter text | Click to enter text |
| Equipment (lease, buy) | Click to enter text | Click to enter text |
| **Total** |  | Click to enter text |

1. **Supportive Services:** Enter the quantity and total budget request for each supportive services cost in the chart below. The request entered should be equivalent to the cost of one year of the relevant supportive service. Enter the quantity in detail (e.g., 1 FTE Coordinated Entry Specialist Salary + benefits) for each supportive service activity for which funding is being requested. Please note that simply stating 1FTE is NOT providing “Quantity AND Detail”

**Applicants for SSO-CI** projects should only request funds in eligible cost categories that are specifically relevant for the expansion of the CoC’s coordinated entry process. Please also note that the only cost category not included on this screen is “Direct provision of services.” The project applicant should include those costs under one of the other applicable eligible costs when specifically relevant for coordinated entry.

|  |  |  |
| --- | --- | --- |
| **Eligible Costs** | **Quantity Description** | **Annual Assistance Requested** |
| Assessment of Service Needs | Click to enter text | Click to enter text |
| Assistance with Moving Costs | Click to enter text | Click to enter text |
| Case Management | Click to enter text | Click to enter text |
| Child Care | Click to enter text | Click to enter text |
| Education Services | Click to enter text | Click to enter text |
| Employment Assistance | Click to enter text | Click to enter text |
| Food | Click to enter text | Click to enter text |
| Housing/Counseling Services | Click to enter text | Click to enter text |

|  |  |  |
| --- | --- | --- |
| **Eligible Costs** | **Quantity Description** | **Annual Assistance Requested** |
| Legal Services | Click to enter text | Click to enter text |
| Life Skills | Click to enter text | Click to enter text |
| Mental Health Services | Click to enter text | Click to enter text |
| Outpatient Health Services | Click to enter text | Click to enter text |
| Outreach Services | Click to enter text | Click to enter text |
| Substance Abuse Treatment Services | Click to enter text | Click to enter text |
| Transportation | Click to enter text | Click to enter text |
| Utility Deposits | Click to enter text | Click to enter text |
| Operating Costs | Click to enter text | Click to enter text |
| **Total** |  | Click to enter text |

1. **Budget Summary**

|  |  |  |  |
| --- | --- | --- | --- |
| **Line Item** | **Annual CoC Request**  | **Grant Term** | **Total CoC Request for Grant Term** |
| Leased Units | Click to enter text | 3 Years | Click to enter text |
| Leased Structures | Click to enter text | 3 Years | Click to enter text |
| Rental Assistance | Click to enter text | 3 Years | Click to enter text |
| Supportive Services | Click to enter text | 3 Years | Click to enter text |
| Operating | Click to enter text | 3 Years | Click to enter text |
| HMIS | Click to enter text | 3 Years | Click to enter text |
| **CoC Request (subtotal lines 1-6)** |  |  | Click to enter text |
| Administration (up to 10% of CoC Request) |  |  | Click to enter text |
| **Total Request Plus Admin (subtotal lines 7 & 8)** |  |  | Click to enter text |
| Cash Match |  |  | Click to enter text |
| In-Kind Match |  |  | Click to enter text |
| **Total Match** |  |  | Click to enter text |
| **Total Budget** |  |  | Click to enter text |

1. **Cash and/or In-Kind Match (Must be >25% of total grant request, with the exception of leasing costs.)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type** | **Source** | **Name of Source** | **Amount** |
| Choose | Choose  | Click to enter text | Click to enter text |
| Choose | Choose  | Click to enter text | Click to enter text |
| Choose | Choose  | Click to enter text | Click to enter text |
| Choose | Choose  | Click to enter text | Click to enter text |
| Choose | Choose  | Click to enter text | Click to enter text |
| Choose | Choose  | Click to enter text | Click to enter text |
| Choose | Choose  | Click to enter text | Click to enter text |

# Submit your match letters and in-kind MOU agreements, no later than October 12, 2022 at 5:00 p.m. to Angie Arthur at aarthur@homewardiowa.org.

**Application submission:** Please submit this application form and required attachments by emailing an electronic application packet to Angie Arthur at aarthur@homewardiowa.org no later than **September 9, 2022 at 5:00 p.m.** in order to be considered.

# SUBMISSION SUMMARY

 2022 UnshelteredProject Application

 Attachment: Admittance Policy

 Attachment: Termination and Termination Appeal Policy

 Attachment: Policies and Procedures to Prevent Eviction

 Attachment: Provision of Educational and Related Services Policy

 \_\_\_\_\_\_Attachment: Leveraged Housing Resources

\_\_\_\_\_\_Attachment: Leveraged Healthcare Resources