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

**2023 Continuum of Care Application**

**Letter of Interest – Renewal Project**

**OVERVIEW**

The LOI process will assist Homeward in understanding the expenditure rate and budgetary needs of existing projects and whether they will request renewal funding.

If your organization is planning to renew an existing Homeless Management Information System (HMIS), Permanent Supportive Housing (PSH), Rapid Rehousing (RRH), Rapid Rehousing-TH (RRH-TH), Supportive Services Only-CI (SSO-CI), or Youth Homeless Demonstration Program (YHDP) project you must submit a *non-binding* LOI by email to **Angie Arthur at** [aarthur@homewardiowa.org](mailto:aarthur@homewardiowa.org) **no later than**  **May 26th at 12:00 PM.** LOI’s submitted after this deadline **WILL NOT** be accepted and the organization **WILL NOT** be considered for submitting a full project application for 2023 HUD CoC funds.Projects will be prioritized and ranked as described in the *2023 CoC Program Competition Priorities and Ranking.*

**ORGANIZATION**

Name: Click here to enter text.

Grant Contact Person: Click here to enter text.

Phone: Click here to enter text. Email:Click here to enter text.

**PROJECT INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **HUD Project Name** | **HUD Grant #** | **Program Type**  (PSH, RRH  TH-Y,  SSO-CI, HMIS) | **Expiration Date**  (mm/dd/yyyy) | **Total Grant Amount** | **Amount Drawn Down** | **Date of Last Draw** (mm/dd/yyyy) |
| Project Name | Grant # | Choose an item. | Click here for calendar | $0 | $0 | Click here for calendar |
| Project Name | Grant # | Choose an item. | Click here for calendar | $0 | $0 | Click here for calendar |
| Project Name | Grant # | Choose an item. | Click here for calendar | $0 | $0 | Click here for calendar |
| Project Name | Grant # | Choose an item. | Click here for calendar | $0 | $0 | Click here for calendar |

**MODIFICATIONS**

Have there been or will there be any significant changes in the project(s) listed above since the last funding approval?  **Yes**  **N**o

If yes, enter in the chart below, the grant number(s) of the grant(s) where changes have been/will be made and check all that apply for each grant listed.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HUD Grant #** | **Number of persons served** | **Number of units** | **Number of beds** | **Location of project sites** | **Supportive Services budget line-item changes <10%** | **YHDP Replacement Grant¹** | **Grant Expansion** | **Grant Consolidation** |
| Grant # |  |  |  |  |  |  |  |  |
| Grant # |  |  |  |  |  |  |  |  |
| Grant # |  |  |  |  |  |  |  |  |
| Grant # |  |  |  |  |  |  |  |  |
| Grant # |  |  |  |  |  |  |  |  |
| Grant # |  |  |  |  |  |  |  |  |

¹ *If included in the 2023 CoC Program Competition NOFO. Grantees wishing to pursue this option must meet with Homeward and City of Des Moines staff to discuss prior to completing the DSM/Polk CoC local program application.*

**Please explain, in detail, any change(s) and why the change(s) are being made:**

**For “Supportive Services budget line-item changes <10%” -** Complete the attached budget form.

**Person completing the Letter of Interest:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Signature Title

*I certify, on behalf of my organization, that all information contained in this Letter of Interest is accurate and true to best of my knowledge and belief and is consistent with my organization’s records. I understand and acknowledge that presenting false information or failing to provide accurate and complete information as required could have a negative impact on my organization’s application potentially including, but not limited to, rejection of my organization’s grant application.*

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Executive Director/CEO/President Date

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Subrecipient Name:** |  |  |  |  |
| **Project Name:** |  |  |  |  |
| **Grant Number:** |  |  |  |  |
|  |  |  |  |  |
| **Supportive Service Budget - Amended** | | | | |
| **Eligible Costs** | **Quantity Description (For Amended Amount Requested)** | **Reason for Changing the Amount** | **Original Amount Requested** | **Amended Amount Requested** |
| Assessment of Service Needs |  |  |  |  |
| Assistance with Moving Costs |  |  |  |  |
| Case Management |  |  |  |  |
| Child Care |  |  |  |  |
| Education Services |  |  |  |  |
| Employment Assistance |  |  |  |  |
| Food |  |  |  |  |
| Housing/Counseling Services |  |  |  |  |
| Legal Services |  |  |  |  |
| Life Skills |  |  |  |  |
| Mental Health Services |  |  |  |  |
| Outpatient Health Services |  |  |  |  |
| **Eligible Costs** | **Quantity Description (For Amended Amount Requested)** | **Reason for Changing the Amount** | **Original Amount Requested** | **Amended Amount Requested** |
| Outreach Services |  |  |  |  |
| Substance Abuse Treatment Services |  |  |  |  |
| Transportation |  |  |  |  |
| Utility Deposits |  |  |  |  |
| Operating Costs |  |  |  |  |
| **Total Requested** |  |  | **$** | **$** |