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

**Special NOFO to Address Unsheltered Homelessness**

**Supportive Services Only – Other**

SSO-Other projects offer stand-alone support services to individuals and families experiencing homelessness or who have been homeless in the prior 6-months but are now residing in permanent housing (**that is not PSH or RRH**). This means, the recipient is providing supportive services to individuals and families experiencing homelessness for whom the applicant is not also providing housing or housing assistance. Examples of stand-alone supportive services include (1) housing navigation activities for people experiencing homelessness when the applicant is not also providing any ongoing housing assistance (e.g., rental assistance), (2) childcare services to individuals and families experiencing homelessness, (3) drop-in centers that provide supportive services to people experiencing homelessness, and (4) family reunification services to reunite people experiencing homelessness with their families.

**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. Provide a detailed description of the scope of the project including anticipated project outcome(s), coordination with other organizations (e.g., federal, state, nonprofit), and how the CoC Program funding will be used. **(2,000 characters)**.
2. Describe how the proposed project is consistent with the plan described by the CoC in response to Section VII.B.4 of this NOFA **(2,000 characters)**.

2. 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. |

3. 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

4. Describe how the project refers program participants to projects that specifically coordinates and integrates mainstream health, social services, and employment programs for which they may be eligible? (**2,000 characters**)

5. 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**

6. 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)**

7. 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**)

# Supportive Services:

1. Describe how program participants will be assisted to obtain and remain in permanent housing.

(a) The needs of the target population, including challenges to permanent housing (**2,000 characters)**.

(b) A plan that addresses

(i) The types of assistance or support that will be provided by the project applicant, or other partners,

(ii) Pairing of each specific type of assistance or support with the specific challenge it is intended to help program participants to overcome.

(iii) How you will work with program participants to set goals toward either remaining in or moving to other permanent housing once assistance is no longer needed. (**4,000 characters)**.

(c) If you will coordinate with other partners, include their role in meeting this criterion.

2. 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

(a) Assisting program participants with obtaining and increasing employment income that will

lead to successful exits from homelessness (e.g., local employment programs, job training

opportunities, educational opportunities);

(b) The type of mainstream services you will assist program participants with obtaining to increase non-employment income (e.g., SSI; SSDI; Food Stamps, Veterans benefits);

(c) the type of social services you will provide access and help program participants obtain (e.g., childcare, food assistance, TANF, early childhood education). **(3,000 characters)**

3. 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)**

4. 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 | Choose  |[ ]  [ ]  | [ ]  | [ ]  | [ ]  |
| Assistance with Moving Costs | Choose  |[ ]  [ ]  | [ ]  | [ ]  | [ ]  |
| Case Management | Choose  |[ ]  [ ]  | [ ]  | [ ]  | [ ]  |
| Child Care | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Education Services | Choose  | [ ]  |[ ] [ ] [ ] [ ]
| Employment Assistance/Job Training | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Food | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Housing Search/Counseling Services | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Legal Services | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Life Skills | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Mental Health Services | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Outpatient Health Services | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Outreach Services | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Substance Abuse Treatment Services | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Transportation | Choose  |[ ]  [ ]  | [ ]  | [ ]  | [ ]  |
| Utility Deposits | Choose  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

5. Indicate whether the project will include the following activities:

(a) Transportation assistance to clients to attend mainstream benefit appointments, employment training, or jobs? [ ]  **Yes** [ ]  **No**

(b) Annual follow-ups with program participants to ensure mainstream benefits are received and renewed? [ ]  **Yes** [ ]  **No**

6. 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  |

7. 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)**

1. Are/were funding draws from Line of Credit Control System (LOCCS) completed **monthly** for this project? [ ] **Yes** [ ]  **No**
2. 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.

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

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

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

# 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. 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”

|  |  |  |
| --- | --- | --- |
| **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 |
| 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 |

**3. Budget Summary**

|  |  |  |  |
| --- | --- | --- | --- |
| **Line Item** | **Annual CoC Request**  | **Grant Term** | **Total CoC Request for Grant Term** |
| Leased Units |  |  |  |
| Leased Structures |  |  |  |
| Rental Assistance |  |  |  |
| Supportive Services | Click to enter text | 3 Years | Click to enter text |
| Operating |  |  |  |
| HMIS |  |  |  |
| **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 |

**4. 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: Provision of Educational and Related Services Policy