



Mid Florida Homeless Coalition, Inc.
Continuum of Care Lead Entity
#RFAMFHC2019

Applicant Information	
Organization Name	Paid Member Yes <input type="checkbox"/> No <input type="checkbox"/>
Mailing Address	Authorized Official Name/Title
City, Zip	Organization Website
Application Contact Name/Title	DUNS Number
Applicant Phone	Federal Tax ID #
Application Contact Email	Applicant Cell Phone
Name of Project Administrator:	
Project Administrator Phone Number:	
Project Administrator Email Address:	
Project/Program Address:	Counties to be Served:
Faith Based Organization <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your participation in the Continuum of Care.	

Organizational Capacity and Experience

What is the background of the person who will administer the project/program and be responsible for all compliance requirements?

Will this be the same person overseeing the day-to-day activities? If no, please indicate who this person will be and their background.

Describe the Federal, State and/or Local Government Grant experience of the Administrator identified above.

Agency Compliance Issues:

Has your organization had any past compliance findings or concerns from monitoring of the funding sources?
If so, funding source?

Has the agency received any other type of compliance findings/concerns from other monitoring agencies?

Have all compliance issues been resolved, if applicable? (Please attach a separate sheet if necessary for responses)

If the organization is faith-based, how will it ensure that you separate the grant related activities from your organization's faith-based activities in the provision of services to clients (i.e., spiritual counseling, worship services, etc.)?

Complete Program Information Form for each Program & Type

Program Information

Program Name:

Funding Source: TANF ESG CHALLENGE **Requested Amount \$**

Indicate below the Project Type for the Proposed Project

TANF: Homeless Prevention

ESG: Street Outreach Rapid Re-housing Emergency Shelter Administration

CHALLENGE: Rapid Re-housing/Homeless Prevention Coordinated Access Housing Location

Total number of unduplicated to be served per month: households _____ persons _____

Total number of households, unduplicated, expected to be served for a one-year period_____

Population to be Served:

Locations (Cities/Counties) to be Served:

Project/Program Schedule/Time Line:

Program Narrative

- Describe what problem this project solves in the effort to end homelessness.
- Describe how this project fits into the CoC's system of care –
 - to prevent homelessness,
 - to end homelessness, and/or
 - to assist those who are homeless.
- Describe the collective impact of the proposed project including:
 - who the project will serve
 - how it will help achieve established goals identified in the CoC Strategic Plan, and
 - how it supports the CoC's efforts to achieve the HUD System Performance Measures.
- Describe how this project is a part of the Coordinated Access System.
- List at least one (1) outcome measure to determine the success of this project.

Program Narrative:

Housing First/Low Barrier Questionnaire

- Will the project require a background screening prior to program entry? Yes No
- Will the project prohibit persons with certain criminal convictions (e.g. violent felonies, arson) from entering your program? Yes No
- Will the project require participants to be clean and sober prior to program entry and/or during program stay? Yes No
- Will the project conduct alcohol/drug tests on participants suspected of being under the influence? Yes No
- Will a positive alcohol/drug test result in termination from the project and/or require participant to participate in substance abuse treatment and/or detox? Yes No
- Will the project require participants to have mental health evaluation prior to program entry? Yes No
- Will the project require program participants who demonstrate mental health symptoms to participate in mental health services (*excluding those who present a danger to self or others*)? Yes No
- Will the project require participants to have income at time of program entry? Yes No
- Will the project require participants to participate in supportive services programs (such as vocational training, employment preparation, budgeting or life skills classes; not including monthly required case management meetings)? Yes No
- Will the project include any requirements, outside of those typically found in a lease agreement or in 'community-living' conduct rules? (*Examples of acceptable 'community-living' rules include agree to be non-violent, agree to no weapons on site, agree to no alcohol/drug consumption on site*) Yes No
- Will the project include curfews and/or required 'lights out' time for all *participants (applicable for facility/project - based emergency shelters, permanent housing)*? Yes No
- Will the project prohibit any children in the household, based on age and/or gender, from remaining with the household at the project (*applicable for facility/project - based emergency shelters, permanent housing for household with children*)? Yes No
- Will 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 (*applicable for facility/project- based emergency shelters, permanent housing*)? Yes No

Every organization has to provide some proof of operating a program like the one for which funding is being requested or a similar type program. Those operating programs within the CoC, information from the Mid Florida Information Network (HMIS) need to be submitted with this application. The exception to rule are domestic violence shelters which will need to submit information from the database that they use at their organization. Those operating or who have operated programs outside the CoC will need to submit data from the HMIS where programs are being operated.

HMIS report as July 1, 2016 through December 31, 2018

HUD Reports: [HUDX-228] ESG CAPER [Oct 2018]

Element	Question	RRH	SO	HP	CAS
	HL				
• Data Quality	Q6a-6e	x	x	x	x
• Households Served	Q8a	x	x	x	x
• Number of Persons Contacted	Q9a	-	x	-	-
• Number of Persons Engaged	Q9b	-	x	-	-
• Living Situation	Q15	x	x	x	x
• Length of Participation	Q22a2	x	x	x	x
• Time Between Entry & Move-In Date	Q22c	x	-	-	-
• Exit Destination	Q23a & 23b	x	-	-	-
• Exit Destination	Q23c	-	x	x	x
• HP Housing Assessment at Exit	Q24	-	-	x	-
• Chronically Homeless	Q26b	x	x	-	x

HUD Reports:[HUDX-226} Annual Performance Report [2017]

Element	Question	RRH	SO	HP
• Income at Entry	APR 2018 Q16	x	-	x
• Income Change	APR 2016 Q19a3	x		

RRH – Rapid Rehousing, SO –Street Outreach, HP - Homeless Prevention, CAS – Coordinated

Complete Project/Program Budget Form for each Program & Type

Project/Program Budget

Project/Program Title:

Revenue

Amount of Grant Request?

Other Funds Supporting Program (Cash & In-Kind – List by Source and Amount):

Source	Other Cash	In-Kind
MFHC Grant	\$	\$
Government Grants ()	\$	\$
Foundation/Private Grants	\$	\$
In-Kind Support	\$	\$
Volunteers/Interns	\$	\$
Contributions	\$	\$
Interest/Investment	\$	\$
Other - itemize	\$	\$
Other - itemize	\$	\$
Total Other Cash & In-Kind:	\$	\$

Grand Total of Revenue (cash, in-kind & grant) | \$

Expenses

PROGRAM EXPENSES – breakdown of expenses specific to the program for which you seek funding	AMOUNT	TO BE PAID BY*
Salaries (Program Staff)	\$	
Contract Labor	\$	
Benefits/Taxes	\$	
Professional Fees	\$	
Supplies	\$	
Travel	\$	
Communication	\$	
Occupancy/Utilities	\$	
Major Property, Equipment, Acquisition, Rental or Maintenance	\$	
Conference/Training	\$	
Postage, Shipping, Printing	\$	
Other - Itemize	\$	
Other - itemize	\$	
Total Expenses:	\$	

Grand Total of Program Expenses: | \$

***G = GRANT or GIK = GIFT IN KIND/VOLUNTEER HOURS or OC = OTHER CASH**

**COMPLETE A BUDGET AND BUDGET NARRATIVE
FOR EACH PROGRAM NAME AND ACTIVITY TYPE**

Budget Narrative For each proposed activity, the subrecipient must provide a detailed budget narrative answering the following criteria.

- Description of the proposed Personnel Costs, including Fringe Benefits
- Justification for the proposed Personnel Costs, including Fringe Benefits
- Description of the proposed Client Financial Assistance Costs
- Justification for the proposed Client Financial Assistance Costs
- Description of the proposed Other Program Operation Costs
- Justification for the proposed Other Program Operation Costs
- Description of the proposed Administrative Costs
- Justification for the proposed Administrative Costs

Financial Documentation

This section provides a listing of financial documents applicant organizations are required to submit. These documents are reviewed to determine whether: (1) applicant organization is solvent; (2) has the cash flow needed to complete the project/program within the time allowed; and; (3) financial management procedures are adequate to manage federal, state and/or local government grant funds.

Attach

1. Most current signed copy of Agency’s Audit (if applicable)
– OR -
2. Organization’s most recently submitted Federal Form 990
3. Your organization’s Leverage letter
4. Leverage letter from other organization(s) – **Extra points will be awarded for leverage letters from other organizations (We need other organizations to provide match letters to improve our scoring opportunity.)**
5. Certification for Contracts, Grants, Loans, and Cooperative Agreements Certification Regarding Lobbying

Other Certification

I certify that the information contained in this application is true and correct and that it contains no misrepresentations, falsifications, intentional omissions, or concealment of material facts. I further certify that no contracts have been awarded, funds committed or construction begun on the proposed project, and that **no action will be taken prior to issuance of official authorization to proceed by MFHC.** I further certify that I am authorized to submit this application and have followed all policies and procedures of my agency regarding grant application submissions.

_____ Signature of Authorized Official	_____ Title
_____ Name of Authorized Official	_____ Date