

City of Bloomington		
Housing & Neighborhood Development	_____	349-3401
401 N. Morton	_____	349-3420
P.O. Box 100		
Bloomington, IN 47402	Fax:	349-3582

Information Sheet

**Social Service Funding Applications for
FY 2017 Community Development Block Grant Program
Fiscal Year June 2017 to May 2018**

Letter of Intent is due October 14, 2016 by 4:00 p.m.
and
Application is due December 2, 2016 by 4:00 p.m.

in the Housing & Neighborhood Development Department

General Instructions:

1. All applications must be typed. Font size shall be at least 12 points.
2. Please respond to each section of the application as clearly and concisely as possible.
3. Please confine your responses to the space provided and provide both narrative and quantitative information in describing your organization/agency and the program for which funding is being sought. Do not attach additional sheets, except requested financial information.
4. Include your DUNS NUMBER on your application.
5. **Submit the original and 10 copies of the completed application.**
6. All applications must be received by the due date. **LATE APPLICATIONS WILL NOT BE ACCEPTED.**

Funding Requirements:

1. In accordance with Federal law, to be considered for funding, the agency must have an affirmative action plan, be incorporated, have an accounting system compatible with Federal Regulations, and eliminate any provision or practices that discriminate or has the effect of

discriminating. Please turn in your affirmative action plan to the City of Bloomington Human Rights Department prior to October 28, 2016. For assistance, please contact Human Rights at 349-3429.

2. Agencies will need to supply HAND with a copy of the most recent Audit, including the Management Letter, prior to the release of any funding. If you are applying for both Social Service and Physical Improvement funds, you need only supply one copy.
3. Only one application for funding per agency for Social Services will be accepted.
4. Community Development Block Grant funds must be used to provide services to income eligible City of Bloomington residents only. Please refer to the CDBG Program Guidelines for Determining Eligibility to ensure that your program can adhere to eligibility requirements.
5. Requests for less than \$5,000.00 will not be considered. Maximum request considered is \$24,999.00.
6. Agencies funded will be required to provide program/client data as required by HUD including monthly program statistics from June 1, 2017 to May 31, 2018.
7. Agency must be registered with System for Award Management. See <https://www.sam.gov>

Application Instructions:

Question 1 – Organization/Agency History and Goals: This question is related to your agency, not the program for which you are requesting funding. Describe your agency, the type of programs your agency administers, the type of clientele provided services under those programs, how long has the agency provided services within the community, and the size of the agency in terms of employees.

Question 2 – Activities: Please briefly describe activities to be completed under this grant. Please be concise and confine your answer to the space provided. Do not use additional space.

Question 3 – Program Need: Your discussion should address how the program serves the needs of the community and its residents, how this need is quantified and documented by citing relevant data. Utilizing the Consolidated Plan 2015-2019 for the City of Bloomington, identify the public service category of your program and the priority need of this category. If applicable address how your program fits into the anti-poverty strategy (p. 108) or other goals and objectives outlined in the Consolidated Plan. Include your organization's capacity to successfully implement this program and why your organization needs financial assistance to implement this program. When applicable, include results achieved as a result of previous CDBG funding.

Question 4 – Evaluation Methodology/Outcome Measurement:

- a. Tell us about your program goal(s).
- b. Describe your evaluation tool for this program.
- c. Tell us about the data you collected using your evaluation tool in 2015.
- d. Tell us what your program benchmarks are.

- e. Tell us about the results of your data collection.
- f. Did you make any changes to your program based on your evaluation? If so, please describe.

Question 5 – Client Data:

Part I. Client History:

1. Please tell us how many clients you served for LAST program year between June 1, 2015 and May 31, 2016.
 - a. What percent were city residents.
 - b. What percent were CDBG eligible based on the 2015 income guidelines (if you were a CDBG recipient that fiscal year, you should have this information from your monthly status reports).
2. Please tell us how many clients you estimate you will serve for THIS program year between June 1, 2016 and May 31, 2017.
 - a. What percent will be city residents.
 - b. What percent will be CDBG eligible.

Part II. Proposed Level of Activity:

1. Estimate how many clients you will serve for NEXT program year June 1, 2017 to May 31, 2018, including non-CDBG eligible.
 - a. What percent do you estimate will be city residents.
 - b. What percent do you estimate will be CDBG eligible.
 - c. Of the city clients, what percent do you estimate will be low-moderate income based on the supplied chart.
 - d. Of the city clients, what percent do you estimate will be low income based on the supplied chart.
 - e. Of the city clients, what percent do you estimate will be extremely low income based on the supplied chart.
 - f. Of the city clients, what percent do you estimate will be female head of household as defined as a single adult female with dependent children.
2. Tell us how these estimates compare to your last year's (June 2015 to May 2016) actual client counts.
3. Tell us your average per client cost for your program. How much does it cost for you to serve one client.
4. Please tell us how you calculated this amount.

Question 6 – Budget Information: Self-explanatory.

Question 7 – Previous Effort: **NEW PROGRAMS ONLY.** You do not need to answer this question if you have received CDBG funding in the past year.

Question 8 – Program Budget: Fill out the budget worksheet showing FY 2015, FY 2016 and proposed FY 2017 budgets. Equipment purchases are not an eligible CDBG expense. In the column titled Amount of CDBG funds per line item, please tell us how much you expect CDBG to pay of each line item.

Question 9 – List all sources of income . . . : Please list all of the sources of income you have for THIS program for the fiscal years designated.

Question 10 – List other grants . . . : Please list all of the funds your agency will apply for that will contribute to the cost of running THIS program. FY 2016 and FY 2017.

Question 11 – List any fundraising . . . : Please list all fundraising activities for THIS program. You may also want to include fundraising activities that are very well known that are used for other programs and explain. June 1, 2015 to May 31, 2016.

Question 12 – List any current fundraising . . . : Please list any current or future fundraising activities your agency is/will be undertaking for THIS program. June 1, 2016 to May 31, 2017.

Question 13 – List all staff . . . : Please list all staff for THIS program by title, not name. Please indicate full time (FT) or part time (PT), how many hours per week is charged to this program by this staff member, the amount of salary charged to this program for those hours, and whether or not any portion of this will be covered by CDBG funds.

CDBG Program Guidelines for Determining Eligibility

Eligible social service programs must be run by a 501(c)3 organization or a governmental entity. The following outlines the documentation and reporting requirements:

If the program provides emergency **food** provisions/services **and** is located in a qualified census block group **or** if the program/service is located in a public housing authority facility:

1. Provide an unduplicated count of clients served who are city residents by race.
 - a) If you are a direct services provider, clients will need to fill out the attached direct service provider race form. Please also provide information on Female Head of Household defined as adult female with no male significant other **with** dependents.
 - b) If you serve other agencies, each agency located in the city limits must provide unduplicated client count by race and Female Head of Household.
 - c) If your per unit reimbursement is not based on number of people served, information on clients must be provided at least bi-annually (or when ½ the funding is expended and when the entire amount of funding has been expended).

If your program does not fit the above described category:

1. Provide an unduplicated count of clients who are city residents broken down by:
 - a) Race (see attached information on racial categories).
 - b) Female Head of Household defined as adult female with no male significant other **with** dependents.
 - c) Income at or below 30% area median income; between 30-50% area median income; and between 50-80% area median income. See attached income guidelines. Acceptable income documentation is as follows:
 - i. Proof of public housing residency (i.e. Crestmont)
 - ii. Letter verifying Section 8 assistance from BHA
 - iii. Copy of TANF or food stamp card or other benefit program
 - iv. Copy of two month's worth of pay check stubs
 - v. Copy of Social Security Benefit Amount letter or Social Security Verification form (see attached)
 - vi. Employment Verification form (see attached)
 - vii. Copies of **signed** federal or state tax forms or print out from IRS or Department of Revenue regarding last year's tax forms
 - viii. Copies of W2's
 - d) Client Profile reports must be filed monthly with claims.

Verification of Social Security Benefits

The person identified below has requested assistance through _____. The individual has authorized your release of the requested information. The information you provide will be used only for the purpose of determining the family's eligibility for this program. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience. If you have any questions, please feel free to contact _____, at _____. Thank you.

Part I. Applicant Information (To be completed by applicant)

Name of Applicant: _____ SSN: _____

Address of Applicant: _____

Part II. Social Security Data (To be completed by Agency)

Client Name: _____ Date of Birth: _____

Monthly Payments from this Agency:

Gross Monthly \$ _____

Supplemental Security Income \$ _____

Other (Specify) _____ \$ _____

_____ \$ _____

Total Amount Received Monthly: \$ _____

Start Date: _____

Closing Date: _____

Do you expect any change in payments in the near future? Yes No

If yes, please explain.

Additional Comments: (e.g., any special situations, etc.)

Completed by: Name: _____
Title: _____
Signature: _____
Date: _____
Tele. No.: _____

Warning: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

Verification of Employment

The person identified below has requested assistance through _____. The individual has authorized your release of the requested information. The information you provide will be used only for the purpose of determining the family's eligibility for this program. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience. If you have any questions, please feel free to contact _____, at _____. Thank you.

Part I. Applicant Information (To be completed by applicant)

Name of Applicant _____

Address of Applicant _____

Part II. Employer Information (To be completed by applicant)

Name of Employer _____

Address of Employer _____

Part III. Employment Information (To be completed by employer)

1. Date of Employment: _____ Position/Occupation: _____

2. Date of Termination (if applicable): _____

3. Current Rate of Regular Pay \$_____ per _____ (hour, week, month, year, etc.)

4. Current Rate of Overtime Pay \$_____ per _____ (hour, week, month, year, etc.)

5. Do you anticipate any change in the employee rate of pay in the near future?
o Yes o No. If yes: Revised Rate _____ Effective Date _____

6. Number of hours/weeks employee normally works _____

7. Do you anticipate any change in the number of hours the employee works: o Yes o No
If yes, explain under #14 below.

8. Anticipated average amount of overtime/week _____

9. Gross **annual** earnings you anticipate for this employee for the next twelve months.
(Gross amount including all tips, bonuses, overtime, commissions) \$ _____

10. Does this employee receive vacation with pay? o Yes o No

11. Does this employee receive sick leave pay? o Yes o No

12. If the employee's work is seasonal or sporadic, indicate lay-off periods: _____

13. Does this employee receive an earned income tax credit? o Yes o No

14. Additional Comments: _____

Completed by: Name: _____
Title: _____
Signature: _____
Date: _____
Tele. No.: _____

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