**Monmouth County Homeless System Collaborative**

**HUD Continuum of Care Program**

**2016 Renewal Project Application**

|  |  |
| --- | --- |
| **Project Name:** |  |
| **Project Grantee:**  |  |
| **Project Sponsor:** |  |  |  |
| **Contact:**  |  | **Title:** |  |
| **Address:** |  |
| **City:** |  | **State:** |  | **Zip:** |  |
| **Telephone:** |  | **Fax:** |  |
| **E-mail:** |  |

**Type of Funding** (double click the appropriate box and select “checked”)**:**

**[ ]** Permanent Supportive Housing **[ ]** Rapid Re-Housing **[ ]** Transitional Housing

|  |  |
| --- | --- |
| **Total Project Cost:** | $  |
| **Total HUD CoC Request:** | $ |
| **Number of unduplicated people to be served by project:** |  |
| **Population to be served:**  |  |
| **Project location address:** |  |
| **Expiring Grant Number:** |  | **Program Operating Year:** |  |
| **Date of most recent APR Submission:** |  |

**Project Description:** Briefly describe the activity for which you are requesting funds. If there are any changes to your program please explain.

1. Please describe the program’s target population. If your project prioritizes those within the target population based on severity of need please identify the criteria used and discuss how severity of need is assessed.

The following charts will provide information about beds for the chronically homeless population. Please see the HUD Exchange FAQs for more information on the difference between dedicated and prioritized beds or follow this link:

<https://www.hudexchange.info/faqs/1888/what-is-the-difference-between-a-dedicated-permanent/>

|  |
| --- |
| 1. Please identify the total number of beds available in your project
 |
| Household Type | Units | Beds |
| Individuals |  |  |
| Families |  |  |

|  |
| --- |
| 1. Please identify the total number of beds currently dedicated to the chronically homeless population
 |
| Household Type | Units | Beds |
| Individuals |  |  |
| Families |  |  |

|  |
| --- |
| 1. Of the beds not currently dedicated to the chronically homeless, please identify the number of beds that will become **dedicated** to the chronically homeless at turnover
 |
| Household Type | Units | Beds |
| Individuals |  |  |
| Families |  |  |

|  |
| --- |
| 1. Of the beds not currently dedicated to the chronically homeless, please identify the number of beds that will be **prioritized** to the chronically homeless at turnover
 |
| Household Type | Units | Beds |
| Individuals |  |  |
| Families |  |  |

1. Will the project follow a Housing First model? If yes, please describe in what ways the project is housing first.
2. Program Accessibility:

|  |
| --- |
| Please identify if any of the criteria below would make a potential participant ineligible for your program. (answer y/n for each option below) |
| Having too little or no income |  |
| Active substance abuse or history of substance abuse |  |
| Criminal record with exceptions for state-mandated restrictions |  |
| History of domestic violence (e.g. lack of a protective order, period of separation from abuser, or law enforcement involvement) |  |

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| --- |
| Please identify if any of the criteria below would be cause for termination from your program. (answer y/n for each option below) |
| Failure to participate in supportive services |  |
| Failure to make progress on a service plan |  |
| Loss of income or failure to improve income |  |
| Being a victim of domestic violence |  |
| Any other activity not covered in a lease agreement typically found in the project’s geographic area |  |

1. Please identify any significant changes in the project.
2. Has your project been monitored by HUD in the last 3 years? If yes, please discuss any open/unresolved monitoring findings.
3. Please identify the amount of unspent program funds that have been returned to HUD in the last 3 years.

|  |  |  |
| --- | --- | --- |
| Program Operating Year | Total Amount of Funding Awarded | Unspent Funds Returned to HUD |
|  |  |  |
|  |  |  |
|  |  |  |

1. Please describe the services currently available to program participants. Within your description indicate if services are provided by grantee or partner agency, types of services provided, frequency of services and accessibility of services.
2. Please describe your capacity to serve the chronically homeless population. If your project has beds that are not currently dedicated to the chronically homeless, please describe your ability to serve additional chronically homeless households. Identify how your current service structure enables you to effectively serve a high needs population.
3. Please complete the leveraging chart indicating the source of leveraging, type of leveraging (specify activities), level of commitment (formal agreement in place, informal agreement, no agreement/general community service) and value of the leveraged activities.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Leveraging type (in-kind/cash) | Source | Activity leveraging supports | Level of commitment | Amount |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. Please provide a copy of your most recent close-out certification
2. Please provide a copy of your most recently completed audit and 990
3. Please provide a copy of your most recently submitted APR

**F. Project Budget**

*The project Budget should reflect the full HUD request, any cash match requirements and the total project leveraging (HUD Cash Match and Other Cash/In-Kind Match or Leveraging columns sources should match the leveraging chart above)*

|  |  |
| --- | --- |
| **Component Type (**please double click appropriate box and select checked)**[ ]  [ ]  [ ]  [ ]  [ ]** **PSH RRH TH SSO HMIS**  | **Grant Term (**please double click appropriate box and select checked)**[ ]  [ ]  [ ]  [ ]  [ ]** **1 yr 2 yrs 3 yrs 5 yrs 15 yrs** |
| Proposed CoC Activities | **CoC Dollars Requested**  | **HUD Cash Match** | **Other Cash/in-Kind Match or Leveraging** | **Total Project** **Budget** |
| 1. **Real Property Leasing**
 |  |  |  |  |
| 1. **Rental Assistance**
 |  |  |  |  |
| 1. **Supportive Services**

From Supportive Services Budget Chart |  |   |  |  |
| 1. **Operations**

From Operating Budget Chart  |  |  |  |  |
| 1. **HMIS**
 |  |  |  |  |
| 1. **Subtotal**

**(lines 4 through 9)** |  |  |  |  |
| 1. **Administrative Costs**

**(Up to 7% of line 10)** |  |  |  |  |
| 1. **Total CoC Request**

**(Total lines 10 and 11)** |  |  |  |  |

Definitions:

HMIS Homeless Management Information System

PSH Permanent Supportive Housing

RRH Rapid Re-housing

SSO Supportive Services Only

TH Transitional Housing

Please note there is a 25% match requirement based on the total HUD request minus any Leasing funds. The 25% match may be fulfilled in any of the above line items and does not have to correspond to the specific category in which HUD funds are requested.

**Supportive Services Budget**

|  |  |  |
| --- | --- | --- |
| Eligible Costs | Quantity & Description | Annual HUD Assistance Requested |
| 1. Assessment of Service Needs
 |  |  |
| 1. Assistance with Moving Costs
 |  |  |
| 1. Case Management
 |  |  |
| 1. Child Care
 |  |  |
| 1. Education Services
 |  |  |
| 1. Employment Assistance
 |  |  |
| 1. Food
 |  |  |
| 1. Housing/Counseling Services
 |  |  |
| 1. Legal Services
 |  |  |
| 1. Life Skills
 |  |  |
| 1. Mental Health Services
 |  |  |
| 1. Outpatient Health Services
 |  |  |
| 1. Outreach Services
 |  |  |
| 1. Substance Abuse Treatment Services
 |  |  |
| 1. Transportation
 |  |  |
| 1. Utility Deposits
 |  |  |
| 1. Operating Costs (
 |  |  |
| Total Annual Assistance Requested |  |  |
| Grant Term |  |  |
| Total Request for Grant Term |  |  |

**Operating Budget**

|  |  |  |
| --- | --- | --- |
| Eligible Costs | Quantity & Description | Annual HUD Assistance Requested |
| 1. Maintenance/Repair
 |  |  |
| 1. Property Taxes and Insurance
 |  |  |
| 1. Replacement Reserve
 |  |  |
| 1. Building Security
 |  |  |
| 1. Electricity, Gas, and Water
 |  |  |
| 1. Furniture
 |  |  |
| 1. Equipment (lease, buy)
 |  |  |
| Total Annual Assistance Requested |  |  |
| Grant Term |  |  |
| Total Request for Grant Term |  |  |

**Rental Assistance/Leasing Budget**

|  |  |
| --- | --- |
| **b. Component Types (Check only one box)** **[ ]  [ ]  [ ]  [ ]**  TRA SRA PRA Leasing  **[ ]** Short-term Rental Assistance (1 – 3 months) **[ ]** Medium-term Rental Assistance (3 – 24 months) |  **c. Grant Term** **(Check only one box)** |
| **[ ]  [ ]  [ ]  [ ]  [ ]**  **1 yr 2 yrs 3 yrs 5 yrs 15 yrs** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Size of Units** | **Number****Of Units** | **FMR or****Actual Rent** | **Number of Months** | **Total** |
| SRO | x | x | = | $ |
| 0 Bedroom | x | x | = | $ |
| 1 Bedroom | x | x | = | $ |
| 2 Bedrooms | x | x | = | $ |
| 3 Bedrooms | x | x | = | $ |
| 4 Bedrooms | x | x | = | $ |
| 5 Bedrooms | x | x | = | $ |
| 6 Bedrooms | x | x | = | $ |
| Other: ­­­­­\_\_\_\_ | x | x | = | $ |
| **i. Totals:** | x | x | = | $ |

The current FMR is listed below:

|  |  |
| --- | --- |
| SRO | * 678
 |
| 0 Bedroom | * 904
 |
| 1 Bedroom | * 1,124
 |
| 2 Bedrooms | * 1,417
 |
| 3 Bedrooms | * 1,928
 |
| 4 Bedrooms | * 2,245
 |