

**REQUEST FOR PROPOSALS
FOR 2009-2010
HOUSING AND COMMUNITY DEVELOPMENT**

COMMUNITY SERVICES APPLICATION

ISSUED BY:

**CHESTER COUNTY
DEPARTMENT OF COMMUNITY DEVELOPMENT**

601 WESTTOWN ROAD, SUITE 365
P.O. BOX 2747
WEST CHESTER, PA 19380-0990

PHONE: (610) 344-6900 OR (800) 692-1100
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APRIL 2008

Chester County Board of Commissioners
Carol Aichele, Chair
Terence Farrell
Kathi Cozzone

COMMUNITY SERVICES APPLICATION

- ◆ Section A: Forms and Certifications 1
Includes an application checklist, summary sheet, listing of community support and notification, and certifications. Read and complete each page carefully.

- ◆ Section B: Narrative Summary 9
Seeks information about the need for and benefits of the proposed activity. Be sure to answer each question.

- ◆ Section C: Projected Outcomes..... 12
Seeks estimates about the measurable benefits clients are expected to receive as a result of funded activities. Select from the outcomes listed in the section.

- ◆ Section D: Fiscal Information..... 16
Seeks specific information about the cost of the program and use of the grant. Budget details should be completed on the forms included with the application. Be sure to include a budget narrative and list of funding applied for during the past 12 months and to double check figures and calculations.

If you have any questions about the application, contact DCD at (610) 344-6900 or ccdcd@chesco.org.

SECTION A ~ FORMS AND CERTIFICATIONS

APPLICATION CHECKLIST: Unless otherwise indicated, the following elements are required. Please confirm that all of the required information is included with the application.

- _____ Application Summary Form
- _____ Municipal Notification (required of non-governmental applicants)
- _____ Evidence of Public Hearing (required of municipal applicants)
- _____ Support Letters from Other County Departments (if funded by them)
- _____ Evidence of Community Support
- _____ Certification of Organizational Capacity
- _____ Affidavit of Tax Payment
- _____ Application Certification
- _____ Narrative Summary
- _____ Projected Outcomes
- _____ Budget and Other Funds Narratives
- _____ Budget Form
- _____ Roster of Personnel
- _____ Identification of Other Funds
- _____ Attachments
 - _____ a) List of council members, officers and board members and their affiliations
 - _____ b) Date of most recent audit or financial statements

Type:

- _____ OMB A-133
- _____ Government Auditing Standards (Yellow Book)
- _____ Unaudited Financial Statement

APPLICATION SUMMARY FORM

Organization Name:

Contact Person and Title*:

Address:

Telephone:

Fax:

E-mail address:

Web address:

Amount of funding requested:

Tax Identification Number:

Activity Location:

Total area to be served by activity (*i.e. street addresses, census tract, municipality, or county-wide*):

Activity Description:

Activity will address Consolidated Plan Goal #_____ Objective #_____

If the organization is submitting more than one application, rank them in order of importance. This application is ranked: #

Signature and Title of Authorized Official

Date

* The Contact Person will receive all mailings from the Chester County Department of Community Development, including the final award or rejection letter.

CERTIFICATION OF ORGANIZATIONAL CAPACITY

In completing this page, the applicant is certifying that they have the fiscal and organizational capacity to administer a grant in 2009 and 2010 and have had success in administering grants in the past. Any questions about this certification should be directed to DCD before the application is submitted.

	YES	NO
The applicant has the fiscal capability to operate a program on a cost-reimbursement basis. (Approximate waiting time is 30 days after submission of invoice.)		
The applicant has an adequate financial management system in place to maintain effective control and accountability over all funds, property, and other assets covered by this proposal.		
The applicant has an adequate financial management system in place to produce sufficient backup documenting costs for which reimbursement is sought.		
The applicant has the ability to maintain sufficient books, records, documents, and files to be made available for review and audit.		
The applicant currently has adequate facilities, equipment, and/or staff with the necessary areas of expertise to operate an effective activity.		
The applicant has adequate internal management procedures and separation of duties to prevent fraud and abuse.		
The applicant does not have any outstanding audit deficiencies or disallowed costs from previous programs or activities.		
The applicant has never had to pay back funds to the federal government.		
The applicant or its principals have never been debarred or suspended by the Federal government and the applicant is not the successor organization to one that was.		

Signature and Title of Authorized Official

Date

AFFIDAVIT OF TAX PAYMENT
(Individual)

The undersigned Affiant (hereinafter "Affiant"), being duly sworn, deposes and says that:

1. He/she has applied for funding through the Chester County's Department of Community Development.
2. He/she understands that it is the policy of the County that such funding will not be made available to applicants whose Chester County, school district and/or municipal taxes are delinquent.
3. All of Affiant's County, school district and municipal taxes are now current.
4. He/she understands that this Affidavit is made to induce the County to fund Affiant.
5. He/she understands that this Affidavit is made subject to the provisions of Section 4903 of the Pennsylvania Crimes Code (18 Pa. C.S.A. §4903) and that false statements made herein shall be regarded as false swearing for purposes of criminal prosecution under said section.

Affiant

Sworn to and subscribed
before me this day
of , 200__.

Notary Public

AFFIDAVIT OF TAX PAYMENT
(Corporation/Partnership)

The undersigned Affiant (hereinafter "Affiant"), being duly sworn, deposes and says that:

1. He/she makes this Affidavit as the authorized representative of _____ which has applied for funding through the Chester County's Department of Community Development.
2. He/she understands that it is the policy of the County that such funding will not be made available to applicants whose Chester County, school district and/or municipal taxes are delinquent.
3. All of Affiant's County, school district and municipal taxes are now current.
4. He/she understands that this Affidavit is made to induce the County to fund Affiant.
5. He/she understands that this Affidavit is made subject to the provisions of Section 4903 of the Pennsylvania Crimes Code (18 Pa. C.S.A. §4903) and that false statements made herein shall be regarded as false swearing for purposes of criminal prosecution under said section.

Affiant

Sworn to and subscribed
before me this day
of , 200__.

Notary Public

APPLICATION CERTIFICATION

I certify that the information in this application is, to the best of my knowledge, true and correct.

I recognize that the following actions by Chester County do not constitute a commitment by the County to finance the project:

1. Acceptance of this application.
2. Issuance of a request for a lead-based paint test for construction projects.
3. Issuance of a request for additional information.
4. Initiation of relocation process.

I understand that the County is not responsible for actions taken in reliance upon the prospective financial commitment of the County.

I understand that acceptance of an award of federal, state or county funding creates the obligation to comply with all applicable certifications, comply with record keeping and reporting requirements, and submit timely and accurate invoices with required backup and additional information, as required.

Date

By: _____
(Signature)

Name (Type or Print)

(Title)

Sworn to and subscribed
before me this day
of , 200__.

Notary Public

SECTION B ~ NARRATIVE SUMMARY

**All information included in Section B (*Narrative Summary*)
should be typed.**

Specifically discuss each of the following items in a number by number format, stating the question followed by the response:

1. State the organization's mission.
2. Briefly describe the proposed activity. Explain the Outcomes to be achieved by the activity. How will the program help clients achieve greater independence or stability? What methods/systems will be utilized to track the Outcomes?
3. Describe the need for the activity and how the need was assessed. What is the target population of the program? What are the current trends or changes in local conditions that are increasing the need for this program? Please provide current, local-level data specific to the population that the program is targeting.
4. Explain the planning process involved in assessing the need and selecting this activity.
5. Explain why County funding is necessary for the proposed activity. What other funding sources are committed for this activity? How will this activity move forward if County funding is not awarded?
6. Describe applicant's experience administering this type of activity. Are there available administrative/fiscal resources to manage and complete this activity in a timely manner?
7. Submit a complete address and description of the facility to be used for the program. If no site has been located, the applicant should indicate this fact and supply information on the type of facility being considered.
8. Identify the activity's target population (select all that apply).
 - Single Men
 - Single Women
 - Families
 - Adult-only households
 - Low-income
 - Homeless
 - Near Homeless
 - Chronically Homeless
 - Homeowner
 - Renter
 - Drug/Alcohol dependent
 - Mental Health/Mental Retardation
 - Physically Disabled
 - AIDS/related diseases
 - Veterans

- Survivors of domestic violence
- Other _____

9. If requesting funding for renewal of an activity currently under contract, were there any significant changes in the activity since the last funding approval? Check all that apply:

- Number of persons served: from _____ to _____
- Location of activity sites: _____
- Line item or cost category budget changes more than 10%
- Change in target population
- Other:

Please explain changes:

10. Indicate how many people were served by the proposed activity in the last 12 months, AND how many people will benefit from the proposed activity during Program Year 2009, if funding is awarded.

Number of persons assisted, Previous 12 –months (select one Outcome Indicator):

- A. with new access to a service: _____
- B. with improved access to a service: _____
- C. who no longer have access to a substandard service: __

Number of persons assisted, Projected Program Year 2009 (select one Outcome Indicator):

- A. with new access to a service: _____
- B. with improved access to a service: _____
- C. who no longer have access to a substandard service: _____

Household Income at time of entry into Activity		
Population	Actual Number Assisted Previous 12-months	Projected Number Assisted Program Year 2009
Number of persons with incomes below 30% of AMI		
Number of persons with incomes between 31% and 50% of AMI		
Number of persons with incomes between 51 and 80% of AMI		
Number of persons with incomes 81% of AMI and greater		
Total persons served (must agree with Outcome Indicators listed above)		

11. Explain how eligibility – especially income eligibility – will be documented. Please be specific about the methodology for documentation, and how eligibility records will be maintained.

12. Are services available and accessible to persons with disabilities? If not, describe your plan to accommodate persons with disabilities.
13. Is this activity providing client and service level data to the Chester County Client Information Management System (CCCIMS)?
14. If the answer to Question 13 is NO, when does the agency anticipate providing client and service level data to the CCCIMS? (mm/yyyy) If not applicable, briefly explain.
15. If the answer to Question 13 is YES, are you collecting client level data on 100% of the persons served by this activity?
16. If the answer to Question 15 is NO, what percentage of persons served are entered into the CCCIMS? Explain why 100% of persons served are not entered in the system.
17. What percentage of services offered by your organization have been entered into the CCCIMS?
18. If the activity involves coordination with other organizations, describe the relationship with the other organizations and the type and extent of coordination. Letters of commitment must relate to the proposed activity and include the services to be provided by each party, the conditions for service, and eligibility criteria.

NOTE:

The questions below are intended to assist you in your response to #18:

Does your agency routinely make referrals or coordinate activities with other organizations?

If so, to which organizations do you make referrals or coordinate activities?

For what purpose do you make referrals or coordinate activities?

How often do you make referrals or coordinate activities?

SECTION C ~ PROJECTED OUTCOMES

SELECT UP TO FIVE PRE-DEFINED OUTCOMES from the list on the following pages that will measure how the **proposed activity** is expected to benefit clients and complete the “projected # to receive” and “the projected # to achieve” columns.

Successful applicants will be required to submit quarterly and end-of-year reports detailing how many clients actually achieved the outcomes and to maintain backup documentation in client files.

<i>OUTCOME</i>	Projected # of Households to Receive the Service	Projected # of Households to Achieve the Outcome
1. Obtained Employment/Self-Employment For Unemployed Persons		
a) Obtained part-time employment – <u>less</u> than 25 hours per week, at minimum wage or above (or its equivalent if employment includes tips/etc.), without health insurance benefits.		
b) Obtained part-time employment – <u>equal to</u> or <u>greater than</u> 25 hours per week, at minimum wage or above (or its equivalent if employment includes tips/etc.), without health insurance benefits.		
c) Obtained full-time employment – number of hours as defined by employer; at minimum wage, without benefits.		
d) Obtained full-time employment – above the minimum wage and could include benefits.		
2. Obtained New/ Better Employment For Persons Already Employed and Receiving Services		
a) Obtained part-time employment – <u>less</u> than 25 hours per week, at minimum wage or above (or its equivalent if employment includes tips/etc.), without health insurance benefits.		
b) Obtained part-time employment – <u>equal to</u> or <u>greater than</u> 25 hours per week, at minimum wage or above (or its equivalent if employment includes tips/etc.), without health insurance benefits.		
c) Obtained full-time employment – number of hours as defined by employer; at minimum wage, without benefits.		
d) Obtained full-time employment – above the minimum wage and could include benefits.		
3. Maintained Employment for at Least 90 days.		
a) Increased Earned Income from Previous Reporting Period.		
4. Increased Total Household Resources – Increase in Total Financial Resources From All Non-Employment Sources.		
a) Obtained Federal Earned Income Tax Credit.		
b) Obtained Federal Child Tax Credit.		
c) Homeowners realize an increase in assessed value of their home as a result of rehabilitation.		
5. Increased Ability to Manage Income and Accumulate Assets to Achieve Self-Sufficiency.		
a) Demonstrated ability to complete and maintain a budget for over 90 days.		
b) Opened IDA/FSA or other savings account and increased savings.		

<u>OUTCOME</u>	<u>Projected # of Households to Receive the Service</u>	<u>Projected # of Households to Achieve the Outcome</u>
c) Decreased debt and maintained budget and savings plans for over one year.		
d) Capitalized small business.		
e) Begins post-secondary education due to their accumulated savings.		
6. Obtained Adequate, Safe, Affordable, Permanent Housing.		
a) Purchased home, mobile home or condo ownership.		
b) Obtained permanent rental housing of choice.		
7. Eliminated/Reduced Barriers to Employment and Self Sufficiency.		
a) Obtained work experience as a non-paid volunteer and developed measurable identified skill(s).		
b) Demonstrated a measurable increase in identified skills/competencies required for employment.		
c) Completed training program and received certificate or diploma required for employment.		
d) Completed ABE/GED and obtained certificate or diploma in order to acquire or maintain employment.		
e) Completed post-secondary education program and obtained certificate or diploma in order to acquire or maintain employment.		
f) Enrolled children in “before/after” school program, in order to acquire/maintain employment.		
g) Obtained care for child or other dependent, in order to acquire/maintain employment.		
h) Obtained drivers license and/or reliable transportation in order to acquire/maintain employment.		
i) Resolved other issue(s)/barrier(s) to employment. Explain in Narrative Comments below.		
j) Received case-management services; developed a plan and completed self-sufficiency goals on their plan.		
k) Maintained independence, etc. You may define the nature of the increased stability, or identify the specific area of concern, such as “remain drug free”, in the Narrative Comments. You may break out individuals by age or other characteristics in the Narrative Comments.		
l) Moved “up” at least one step as measured by an increase/decrease in identified areas on a family scale (Attach a copy of scale used.)		
8. Increased Education/Skills		
a) Adults achieve educational or life skill goals.		
b) Adults improve academic skills, and/or prepare to move on to other educational/training programs.		
c) Adults complete ABE and obtain certificate or diploma.		
d) Adults complete GED and obtain certificate or diploma.		
e) Youth complete ABE and obtain certificate or diploma.		
f) Youth complete GED.		

g) Youth demonstrate improved academic performance.		
h) Youth demonstrate improved behavior at school.		
OUTCOME	Projected # of Households to Receive the Service	Projected # of Households to Achieve the Outcome
9. Increased Families' Skills and Strengthened Families		
a) Improve behavior/family functioning as a result of counseling.		
b) Parents/caregivers improve family functioning due to classes and/or support services.		
c) Child(ren) at-risk of out-of-home placement remain with family due to improved family functioning.		
d) Non-Custodial fathers increase time spent with child.		
e) Non-Custodial fathers who are behind in child support payments make payments against new payment schedule.		
10. Increased Ability to Manage Income		
a) Become financially stable due to budget counseling.		
b) Operates within established budget for 90 days.		
c) Decrease energy usage due to Weatherization services.		
d) Decrease debt.		
11. Increased/Maintained Safe, Affordable Housing		
a) Achieve safe/stable-housing arrangements. Include victims of domestic violence, families in transitional housing, etc.		
b) Maintain safe/stable housing for at least 90 days.		
c) Households have home safety hazards ameliorated.		
d) Households improve home environmental safety through installation of new heating and/or air conditioning system.		
e) Complete necessary forms for subsidized housing.		
f) Complete steps toward first home purchase.		
12. Increased Nutrition – Address Nutritional Needs		
a) Senior congregate meal program.		
b) Children congregate meal program (Head Start, child care after school).		
c) WIC (Women Infant Children).		
d) Meals on Wheels		
13. Reduced an Emergency Need		
a) Receive emergency/supplemental food from food pantry.		
b) Receive clothing.		
c) Receive emergency shelter.		
d) Avoid utility termination or fuel crisis through agency payment.		
e) Avoid eviction for at least 30 days as a result of emergency rent or mortgage payment.		
f) Avoid eviction for at least 60 days as a result of emergency rent or mortgage payment.		
g) Households have other emergency needs ameliorated.		
14. Obtained Linkages		
a) Receive information regarding available services to meet need.		

b) Report ability to access services independently.		
c) Obtain/maintain necessary services with assistance.		
d) Maintain family stability resulting from access to affordable care of minor child or other dependent.		
OUTCOME	Projected # of Households to Receive the Service	Projected # of Households to Achieve the Outcome
e) Maintain health and independence by utilizing shared-ride transportation.		
15. Increased/Maintained Physical or Behavioral Health		
a) Improve and/or maintain desired health status/ behavior for at least three months.		
b) Demonstrate increased knowledge regarding how to avoid at-risk behavior.		
c) Avoid at-risk behavior for at least six months.		
d) Remain drug and alcohol free for at least six months.		
16. Youth Participate in Services that Support their Growth and Development		
a) Youth improve physical health and development.		
b) Youth improve social/emotional development.		
c) Youth avoid at-risk behavior for at least three months.		
d) Youth have reduced involvement with the criminal justice system.		
e) Youth participate in before/after school activities to increase academic, athletic or social skills for school success.		
f) Children participate in pre-school activities to develop school readiness skills.		
g) Children who participate in pre-school activities are developmentally ready to enter kindergarten.		
17. Senior Citizens Participate in Services that Support Active, Independent Living		
a) Senior Citizens remain active in their communities through support services (including Senior Centers, RSVP, Senior Employment, Foster Grandparent, etc.).		
b) Senior Citizens maintain independent living status for at least 90 days through support services (including home delivered meals, home health or homemaker services, etc.).		
c) Senior Citizens avoid institutionalization through support services.		

SECTION D ~FISCAL INFORMATION

1. Complete the following fiscal forms:
 - a. **Budget Form (Page 17):** Enter estimated costs for the activity for a one-year period beginning January 1st. The *Budget Form* should reflect the costs of operating the proposed activity, not the entire agency unless the agency runs only one program.
 - b. **Roster of Personnel (Page 18):** List all of the positions, including those not funded out of the grant, that the applicant will assign to work on the activity. The positions should include support or administrative staff whose work contributes to the completion of the activity. Do not include fringe benefits on this form.
 - c. **Identification of Matching Funds (Page 19):** Indicate other sources of funding for the activity. If funding is secured, attach a confirmation letter. If funding is denied, attach the denial letter stating the name of the source, the date funds were sought, and the reason for the denial.
 - d. **Budget Narrative (Page 20-21):** Describe each line item for which you are requesting funding.
 - Indicate the current fringe benefit percentage used to determine the benefit costs.
 - Miscellaneous costs must be detailed.
 - In-kind contributions should be detailed and should be reasonably valued and justifiable. The estimated hourly rate for volunteer time in 2006 was \$19.51 (Independent Sector, 2007). The value of volunteer time is based on the average hourly earnings of all production and non-supervisory workers on private non-farm payrolls (as determined by the Bureau of Labor Statistics). Independent Sector takes this figure and increases it by 12 percent to estimate for fringe benefits.

Please make sure that information provided on the two fiscal forms (*Budget*, *Roster*) is correct and consistent. In particular, check that the following areas correspond:

The "Salaries/Wages" line in the "County Funds" column on the Budget Form	=	The total of the "Amount of Salary Funded Through Grant" column on the Roster of Personnel .
The "Salaries/Wages" line in the "Total" column on the Budget Form	=	The total of the "Total Amount of Salary Allocated to Activity" column on the Roster of Personnel .

2009 BUDGET FORM

AGENCY: _____ ACTIVITY: _____

	<u>County Funds</u>	Other Funds	In-Kind	Total
PERSONNEL:				
Salaries/Wages				
Fringe Benefits				
OPERATING:				
Rent				
Communications				
Insurance				
Legal Service/Audits				
Supplies				
Staff Travel				
Overhead				
Systems Consultant				
Miscellaneous				
CLIENT SERVICES:				
Food				
Rent Assistance				
Security Deposits				
Utilities				
Mass Shelter (nights)				
Purchased Service				
Transportation				
Outreach				
Education				
Other				
TOTAL				

1. "County Funds" salaries/wages should equal the total of column D on the *Roster of Personnel*.
2. "Total" salaries/wages should equal the total of column C on the *Roster of Personnel*.
3. The total of the "Other Funds" column should equal the "Total of Other Funds" row on the *2008 Identification of Matching Funds*.

ROSTER OF PERSONNEL

AGENCY: _____

ACTIVITY: _____

Position	Annual Salary	% of Time Allocated to Activity	Amount of Salary Allocated to Activity	Amount of Salary in Column C To Be Funded Through Grant
(List all of the positions, including those not funded out of the grant, which will work on the activity.)	(A)	(B)	(C=A x B)	(D is less than or equal to C)
TOTAL				

1. The total of column C should equal the total of "Salaries/Wages" in the last column (Total) on the *Budget Form*. It does not include "Fringe Benefits".

2. The total of column D should equal the "Salaries/Wages" line in the first column (County Funds) of the *Budget Form*.

2009 IDENTIFICATION OF MATCHING FUNDS

APPLICANT: _____ ACTIVITY: _____

Identify funds other than those requested in this application for the proposed activity in 2009 and 2010.

SOURCE OF FUNDS	AMOUNT (ESTIMATE OR ACTUAL)	USE OF FUNDS	STATUS OF REQUEST: SECURED, PENDING OR DENIED*
<u>FEDERAL</u>			
FEDERAL FUNDS SUBTOTAL:			
<u>STATE/COUNTY</u>			
STATE/COUNTY FUNDS SUBTOTAL:			
<u>LOCAL/PRIVATE</u>			
LOCAL/PRIVATE FUNDS SUBTOTAL:			
TOTAL OF OTHER FUNDS:			

*The total of other funds should equal the total of the "Other Funds" column on the *Budget Form*.

If funding is secured, attach a confirmation letter. If funding is denied, attach the denial letter stating the name of the source, the date funds were sought, and the reason for the denial.

2009 BUDGET NARRATIVE

APPLICANT: _____ **ACTIVITY:** _____

Describe each line item for which you are requesting funding:

PERSONNEL

Salaries/Wages:

Fringe Benefits:

OPERATING:

Rent:

Communications:

Insurance:

Legal Service/Audits:

Supplies:

Staff Travel:

Overhead:

Systems Consultant:

Miscellaneous:

2009 BUDGET NARRATIVE – cont.’

CLIENT SERVICES

Food:

Rent Assistance:

Security Deposits:

Utilities:

Mass Shelter (nights):

Purchased Service:

Transportation:

Outreach:

Education:

Other:

2010 BUDGET FORM

AGENCY: _____ ACTIVITY: _____

	<u>County Funds</u>	Other Funds	In-Kind	Total
PERSONNEL:				
Salaries/Wages				
Fringe Benefits				
OPERATING:				
Rent				
Communications				
Insurance				
Legal Service/Audits				
Supplies				
Staff Travel				
Overhead				
Systems Consultant				
Miscellaneous				
CLIENT SERVICES:				
Food				
Rent Assistance				
Security Deposits				
Utilities				
Mass Shelter (nights)				
Purchased Service				
Transportation				
Outreach				
Education				
Other				
TOTAL				

1. "County Funds" salaries/wages should equal the total of column D on the *Roster of Personnel*.
2. "Total" salaries/wages should equal the total of column C on the *Roster of Personnel*.
3. The total of the "Other Funds" column should equal the "Total of Other Funds" row on the *2008 Identification of Matching Funds*.

ROSTER OF PERSONNEL

AGENCY: _____

ACTIVITY: _____

Position	Annual Salary	% of Time Allocated to Activity	Amount of Salary Allocated to Activity	Amount of Salary in Column C To Be Funded Through Grant
(List all of the positions, including those not funded out of the grant, which will work on the activity.)	(A)	(B)	(C=A x B)	(D is less than or equal to C)
TOTAL				

1. The total of column C should equal the total of "Salaries/Wages" in the last column (Total) on the *Budget Form*. It does not include "Fringe Benefits".

2. The total of column D should equal the "Salaries/Wages" line in the first column (County Funds) of the *Budget Form*.

2010 IDENTIFICATION OF MATCHING FUNDS

APPLICANT: _____ ACTIVITY: _____

Identify funds other than those requested in this application for the proposed activity in 2009 and 2010.

SOURCE OF FUNDS	AMOUNT (ESTIMATE OR ACTUAL)	USE OF FUNDS	STATUS OF REQUEST: SECURED, PENDING OR DENIED*
<u>FEDERAL</u>			
FEDERAL FUNDS SUBTOTAL:			
<u>STATE/COUNTY</u>			
STATE/COUNTY FUNDS SUBTOTAL:			
<u>LOCAL/PRIVATE</u>			
LOCAL/PRIVATE FUNDS SUBTOTAL:			
TOTAL OF OTHER FUNDS:			

*The total of other funds should equal the total of the "Other Funds" column on the *Budget Form*.

If funding is secured, attach a confirmation letter. If funding is denied, attach the denial letter stating the name of the source, the date funds were sought, and the reason for the denial.

2010 BUDGET NARRATIVE

APPLICANT: _____ **ACTIVITY:** _____

Describe each line item for which you are requesting funding:

PERSONNEL

Salaries/Wages:

Fringe Benefits:

OPERATING:

Rent:

Communications:

Insurance:

Legal Service/Audits:

Supplies:

Staff Travel:

Overhead:

Systems Consultant:

Miscellaneous:

2010 BUDGET NARRATIVE – cont.’

CLIENT SERVICES

Food:

Rent Assistance:

Security Deposits:

Utilities:

Mass Shelter (nights):

Purchased Service:

Transportation:

Outreach:

Education:

Other: