# Sumter County Regional HOME Consortium

# HOME-ARP Supportive Services Application for Funding

**AGENCY INFORMATION**

Organization or Agency Legal Name: ______________________________________________

Street Address: ______________________________________________________________

City:_____________________State:____________________Zip Code:______________________

Universal Entity ID (UEI): _____________________________________________________

FEIN Number. # _______________________________________________________________

**Primary Contact**:____________________________Title:_____________________________

Telephone No:_________________________E-mail:____________________________________

**President/Executive Director**: ______________________________________________

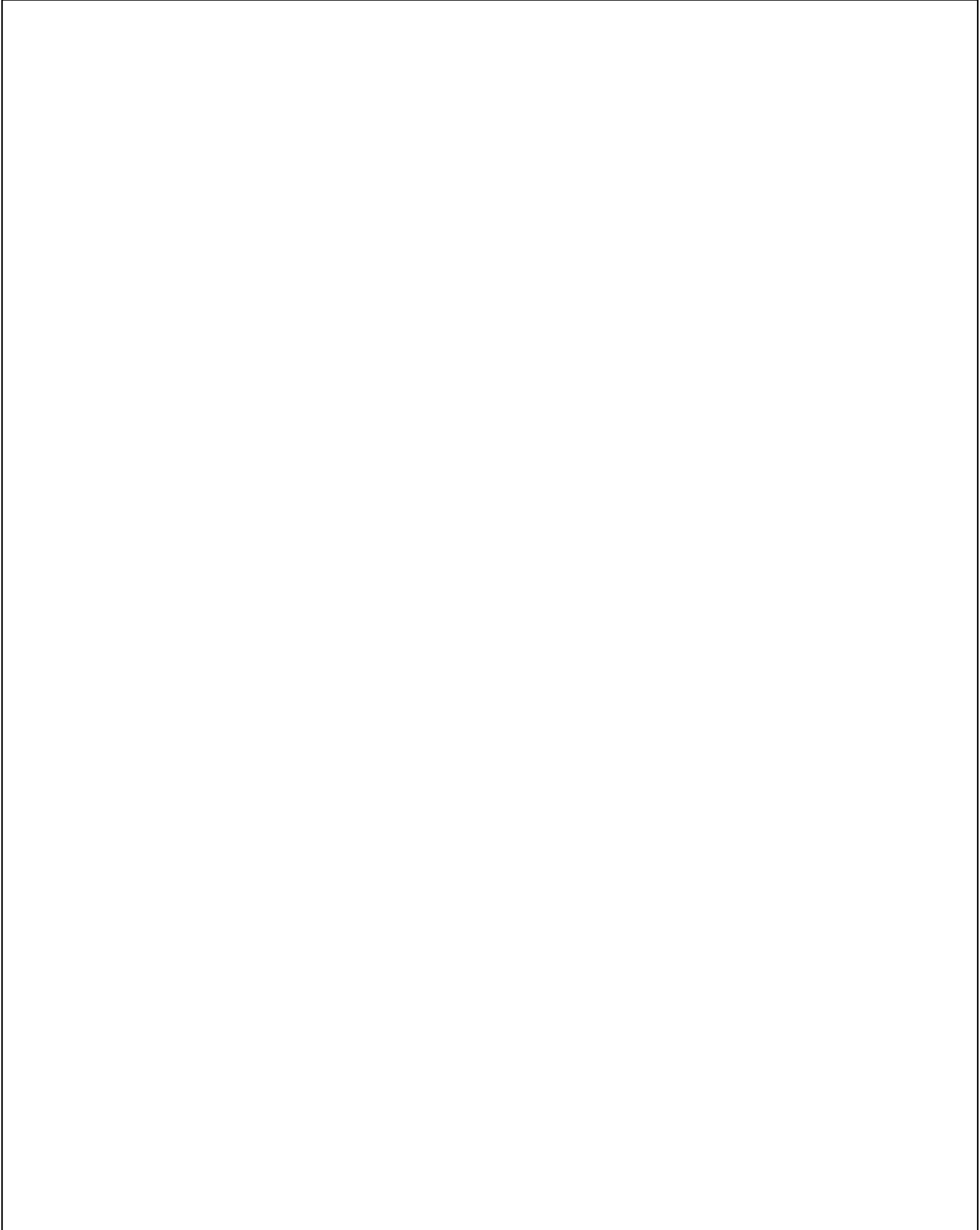
Telephone No:_________________________E-mail:____________________________________

Location of proposed service/program/project (if different than stated above):

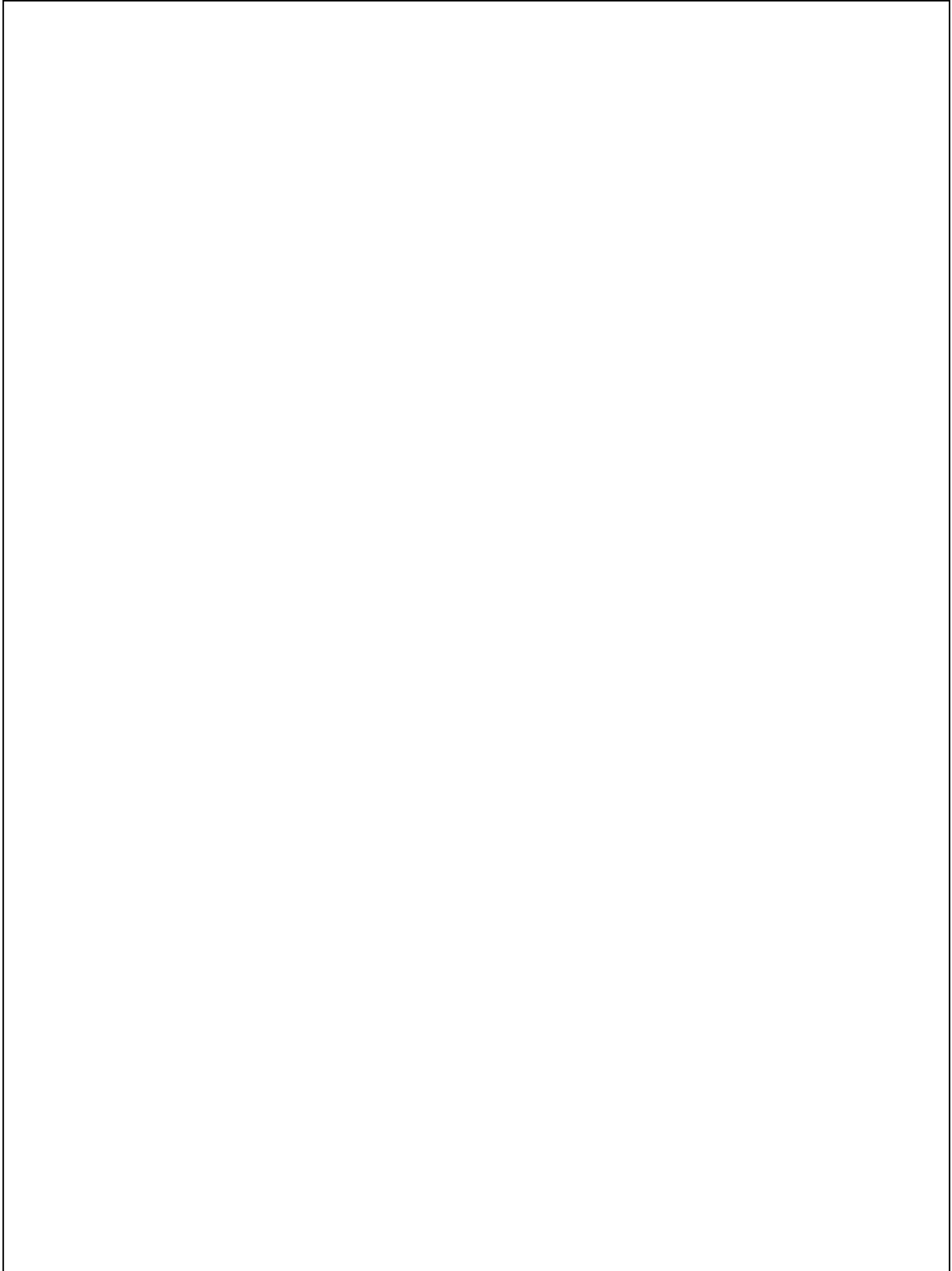
Street Address: ______________________________________________________________

City:_____________________State:____________________Zip Code:______________________

**1.** Describe in detail the organization's mission, types of programs and services currently offered, need or problem the program seeks to address, and how HOME-ARP Supportive Services programs will fit within its mission.



2. Briefly describe expected project goals and anticipated results with HOME-ARP Supportive Services.



3. Describe the organization's intake process to ensure individuals and families meet Qualified Population requirements.

4. Has the organization adopted a Housing First Policy?
   - Yes
   - No

5. Is the organization an active member of the Continuum of Care?
   - Yes
   - No

6. Does the organization currently use HMIS?
   - Yes
   - No

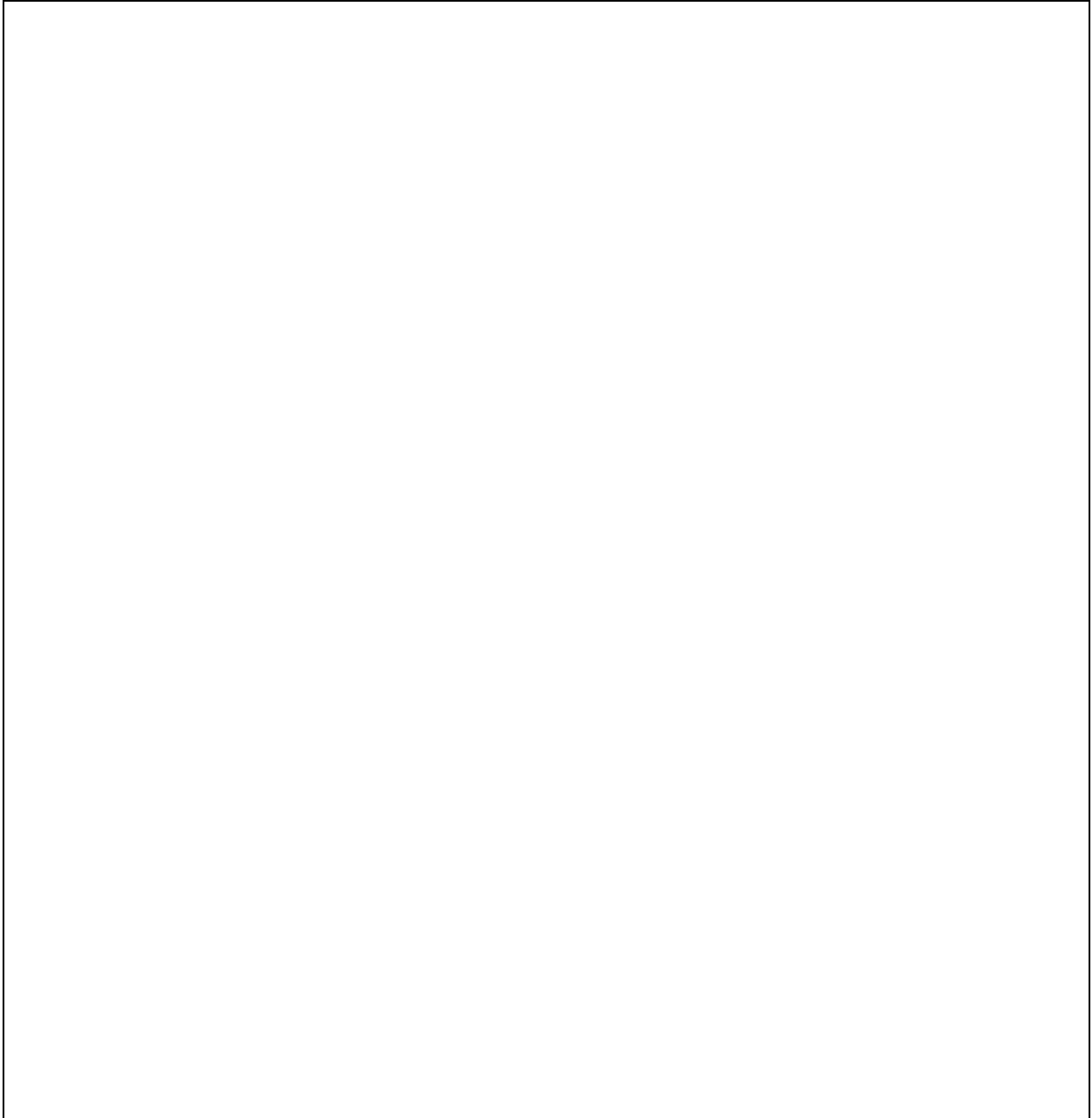
7. If a victim service provider, does the organization utilize a comparable database?
   - Yes
   - No

8. If HMIS or comparable database is not utilized, how will the organization track reporting requirements for households served?

9. Does this organization participate in the Continuum of Care Coordinated Entry Process?
   - Yes
   - No

10. Describe the Applicant's method of receiving referrals. (CE, Hotline, Walk-in, Outreach, etc.)

11. Summarize the professional expertise of project-relevant staff members responsible for implementation of this project in their ability to manage or provide program services and grant management experience. If a staff member does not have prior experience in providing the proposed service, please indicate experience and successes carrying out similar programs. Remember to attach all project-relevant staff resumes to this application.



12. Proposed budget details for the HOME-ARP Supportive Services Activities:

| | **Estimated Project Cost** | **HOME-ARP Request** | **Description** |
|---|---|---|---|
| Salaries: | | | |
| Services: | | | |
| Other: | | | |
| Total: | | | |

13. Required Documents:
    a. Financial Statement: Attach proof of your organization's financial heath, such as a yearend financial statement or certified audit (if you have provided a copy of your most recent audit, please note date of submission).
    b. IRS 501(c)(3) Status Letter
    c. Form 990
    d. Unique Entity Identifier (SAM.gov Registration Confirmation)
    e. SC Secretary of State Business/Incorporation information
    f. List of Current Board Members
    g. By laws
    h. Resumes of Executive Director, Fiscal Officer, Program Administrator, Program Staff, copies of certifications, and consultant contract (if applicable).
    i. Proof of General Liability Coverage

APPLICANT CERTIFICATION

THE UNDERSIGNED CERTIFIES THAT:
a) The information contained in this document is complete and accurate;
b) The proposed program/project described in this application will meet the requirements of HOME-ARP,
c) The applicant shall comply with all Federal, State and City laws, and HOME-ARP Program requirements;

________________________________________ _________________________

Signature of Authorized Applicant Representative     Date