**Lake County Coalition for the Homeless NEW PROJECT Application for**

**FY2018 Continuum of Care Funding**

**Permanent Supportive Housing**

Agency and Program Information:

|  |  |  |
| --- | --- | --- |
| 1. **Agency Name**
 |  | No Points |
| 1. **Program Name**
 |  | No Points |
| 1. **Did your agency attend at least 4 of the past 6 LCCH Board Meetings?**
 | 🞏 Yes🞏 No | Score 1 point if yes.  |
| 1. **Which of the following committee(s) did your agency attend in the last year?**
* **Community Outreach and Engagement**
* **Project Performance and Monitoring**
* **System Coordination and Entry**
* **Homeless Management Information System**
* **Strategic Planning and System Performance**
 |  | Score 1 point if at least one committee is identified.   |
| 1. **What percentage of HMIS Agency Administrator meetings did your agency attend?**
 |  | Score 1 point if greater than 70% |
| 1. **Please indicate the amount of funding you are seeking up to $133,308.**
 |  | No Points  |
| 1. **If the requested amount is reduced, would you pursue funding for a scaled down version of your project?**
 | 🞏 Yes🞏 No🞏 Depends (Please explain in the budget narrative section on page 3) | No points |
| 1. **Proposed Number of Households to be Served**
 |  | Score 2 points for 7 or moreScore 1 point for 6 or fewer |
|  |  |  |
| 1. **Proposed Types of Households to be Served**

**(Check all that apply)** | 🞏 Individuals 🞏 Couples🞏 Families🞏 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score 1 point if proposing to serve more than one type of household |
| 1. **What will be your target population disability? (Check all that apply – Must select at least one)**

**\*Please note: By selecting a disability type, you are affirming that your project will accept someone with that type of disability, with or without any others. For example, if you select all of the disability types, you are affirming that the project will accept someone with any one of the types. If your project requires all participants to have one particular type of disability, only select that one.**  | 🞏 Mental Illness🞏 Substance Abuse (including Alcohol)🞏 Physical Disability🞏 HIV/AIDS🞏 Chronic Health Issue other than HIV, AIDS, or Physical Disability🞏 Developmental  Disability🞏 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Score 1 points if more than one disability is selected |
| 1. **Agency licensed or certified for subpopulation specific services, e.g., SUPR, DMH, Joint Commission, CARF, etc. (Score 1 if yes) 🞏 Yes 🞏No**
 |
| 1. **At least one staff member at agency is licensed or holds certification (Score 1 if yes)**

**🞏 Yes 🞏No** |
| 1. **At least 50% of program staff hold degrees or certification in the subpopulation(s) area or related field. (Score = 1 if yes) 🞏 Yes 🞏No**
 |
| 1. **Current trainings specific to subpopulation(s) are provided by agency or attended by program staff at least annually. (Score = 1 if yes) 🞏 Yes 🞏No**
 |
| 1. **At least one member of subpopulation serves in a policy influencing position, e.g., agency board, advisory group, or staff member. \*Please provide membership list or indicate staff member. (Score = 1 if yes) 🞏 Yes 🞏No**
 |

Budget:

*Please provide a maximum budget for your proposed program. The Continuum of Care cannot guarantee that all new programs will be funded at the maximum amount. Refer to the NOFA regarding eligible costs in each budget category.*

|  |  |  |
| --- | --- | --- |
| 1. **Category**
 | **Amount** |  |
| **Rental Assistance or Leasing**  |  | No Points |
| **Supportive Services** |  | No Points |
| **Operations, Admin, etc.** |  | No Points |
| ***Total Budget*** |  | No Points |
| ***Amount Requested from CoC*** |  | No Points |
| ***Leverage*** |  | 1 point if 25% or more |
| ***Amount of Matching Dollars*** |  | No Points |
| ***Percentage of Matching Dollars*** |  | 2 points for 26% or more1 point for 25% or less |
| **Provide a narrative explaining the budget including match amount and potential sources. (No points for this question.)** |
|  |
| ***Possible Points for this Section = 14*** |

Project Design: *Please attach any relevant policies.*

|  |
| --- |
| 1. **Describe how your program will connect clients to mainstream resources such as Medicaid, ACA, SNAP, Housing Authorities, Energy Assistance, etc. (Score 1 point for clearly defined plan, 1 point for a Policy and 1 point for an assessment form.)**
 |
|  |
| 1. **Describe how your proposed program embodies the Housing First model.**
 |
| 4 points for specific language that clearly reflects housing first model such as housing first,  eliminating barriers, permanent housing, permanent solution, quickly, without conditions, rapid  placement.1 point for general understanding of housing first as applied to permanent housing.0 points for unclear answer or one that does not address the question. |
|  |
| 1. **Describe how your proposed model will incorporate harm reduction principles in terms of housing retention and program exits due to rule violations.**
 |
| 4 points for specific language that clearly reflects harm reduction principles related to housing  services, such as multiple chances for rule violations, therapeutic intervention rather than  termination of services when rule violations occur, moving participants to other locations to  avoid eviction, teaching and assisting clients with identifying ways to reduce harm (such as  wearing headphones to avoid noise complaints, provide coaching about emptying ash trays  regularly to avoid fires, avoiding standing water in apartment to avoid roaches), etc.1 point for general understanding of harm reduction as applied to Substance Abuse treatment only.0 points for unclear answer or one that does not address the question. |
|  |
| 1. **Please indicate what specific supportive services and/or training your agency or a partner agency will provide to prepare participants to successfully live independently:**

**Service Agency Provides Partner Provides Not Provided**Assessment of Service NeedsAssistance with Moving CostsCase ManagementChild CareEducation ServicesEmployment Assistance and Job TrainingFinancial Management or Skills TrainingFoodHIV/AIDS ServicesHousing Search and Counseling ServicesLegal ServicesLife Skills TrainingMental Health ServicesOutpatient Health ServicesOutreach ServicesParenting SkillsSubstance Abuse Treatment ServicesTransportationUtility DepositsScore = 3 points if 10 or more, 2 if 3 -9, 1 if less than 3. |
| 1. **Describe your agency’s past success in executing similar programs or services in Lake County, IL. The inclusion of evidence, performance measures, outcomes, etc. is strongly encouraged.**
 |
| 2 points if clear evidence of success with similar programs |
|  |
| 1. **Use the space provided below for any additional, relevant information that has not been addressed in the previous questions.**
 |
| No Points for This Question |
|  |
| ***Possible Points for this Section = 16***  |
| 1. **Please provide a copy of the following or a clear explanation of why you don’t have one. Please label each item in the top right corner with the corresponding letter.**
 |
| 1. **Tenant Selection or Program Eligibility Criteria**
2. **Client Grievance Procedures and Appeal Process**
3. **Involuntary Termination of Services Policy or Procedure**
4. **Equal Housing / Non-Discrimination Policy or Procedure related to gender and family composition**
5. **Any Policy or Procedure that shows your program’s adoption of Housing First Service Philosophies.**
6. **Any Policy or Procedure that shows your program’s adoption of Harm Reduction Service Philosophies.**
7. **Your Program Budget**
8. **Program Organizational Chart**
9. **Any other policies, procedures or forms that describe your program or your program’s outcomes**

**Score = 3points if A-H are submitted on time. *2pts if submitted on time, but not clearly labeled. 0 pts for missing or late submission***  |
|  ***Possible Points for this Section = 3***  |

By signing below I attest the information above is accurate. I understand that the information on this form will be utilized to make funding decisions and that completing and submitting this form is no guarantee that funding for this program will remain at its current level for the coming fiscal year.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Signature of Authorizing Agent** |  | **Date** |
|  |  |  |
| **Name** |  | **Title** |

**Contact Person for Questions Regarding this Application:**

|  |  |
| --- | --- |
| **Name and Title:** |  |
| **Phone Number:** |  |
| **Email:** |  |

*Completed applications with attachments should be submitted electronically to* *boconnell@lakecountyil.gov* *no later than 5PM on Friday, August 17th.*