

**Commonwealth of Virginia
Department of Housing and Community Development
Housing and Homeless Assistance Unit**

**COMBINED APPLICATION:
Funding Application Packet**

Fiscal Year 2006 (July 1, 2005 to June 30, 2006)
covering the following programs:

State Shelter Grant (SSG)
Federal Shelter Grant (FSG)
Child Services Coordinator Grant (CSCG)
Child Care for Homeless Children Program (CCHCP)

Applications Must Be Received By:

April 4, 2005 by 5:00 P.M.

**Department of Housing and Community Development
Housing and Homeless Assistance Office
The Jackson Center
501 North Second Street
Richmond, VA 23219-1321**

HOUSING AND HOMELESS ASSISTANCE

Funding Application Packet

For Fiscal Year 2006

(July 1, 2005 to June 30, 2006)

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Please refer to the Information and Instructions Packet for information regarding program eligibility and requirements, directions for completion of this document, and DHCD contact information for further assistance.

APPLICATION FOR FISCAL YEAR 2006 CHECKLIST

Section	Description	Page Number(s)	Included	Not Applicable
1	Application Checklist	2-3	X <input type="checkbox"/>	
1	Applicant Information	4	X <input type="checkbox"/>	
1	Program Narrative	5	X <input type="checkbox"/>	
1	Facility Information	6	X <input type="checkbox"/>	
1	Attachment A: Certification of Accuracy	7	X <input type="checkbox"/>	
1	Attachment B: Certifications & Assurances	8	X <input type="checkbox"/>	
1	Attachment C: Board Resolution for Nonprofit Applicants (<i>nonprofits only</i>)	9	<input type="checkbox"/>	X <input type="checkbox"/>
1	Attachment D: Governing Body Resolution for Local Governments (<i>local governments only</i>)	10	X <input type="checkbox"/>	<input type="checkbox"/>
1	Attachment E: CoC Participation	11	X <input type="checkbox"/>	
1	Attachment F: FMSI	12	X <input type="checkbox"/>	
1	Supplemental Information: Organization's most recent audit report	5	X <input type="checkbox"/>	
1	Supplemental Information: Organizational chart with all vacancies indicated	5	X <input type="checkbox"/>	
1	Supplemental Information: Position descriptions for all staff positions	5	X <input type="checkbox"/>	
1	Supplemental Information: Current fire inspection for each facility to be assisted with funding from this application	5	X <input type="checkbox"/>	
1	Supplemental Information: Directions to facilities from DHCD	5	X <input type="checkbox"/>	
1	Supplemental Information: Brochures and pamphlets	5	X <input type="checkbox"/>	
2	SSG & FSG Application	13-15	X <input type="checkbox"/>	<input type="checkbox"/>
2	SSG & FSG Narrative	15	X <input type="checkbox"/>	<input type="checkbox"/>
2	SSG & FSG Certification of local Approval	16	<input type="checkbox"/>	X <input type="checkbox"/>
3	CSCG Application	17	<input type="checkbox"/>	X <input type="checkbox"/>

APPLICATION FOR FISCAL YEAR 2006 CHECKLIST (Cont.)

Section	Description	Page Number(s)	Included	Not Applicable
3	CSCG Narrative	17	<input type="checkbox"/>	X <input type="checkbox"/>
3	CSCG Budget Forms	18	<input type="checkbox"/>	X <input type="checkbox"/>
4	CCHCP Application	19	<input type="checkbox"/>	X <input type="checkbox"/>
4	CCHCP Narrative	19	<input type="checkbox"/>	X <input type="checkbox"/>

SECTION 1: APPLICANT INFORMATION

(All applicants must complete this section)

1. Legal Name of Applicant Organization: Arlington County Government
2. Federal Identification Number: 546-0-1123
2. Applicant Type (check one): Nonprofit Local Government
3. Mailing Address: 3033 Wilson Boulevard, Suite 300A
Arlington, VA 22201
Telephone: 703-228-1319 Website: http://www.arlingtonva.us

4. Executive Director: n/a Telephone: n/a
e-mail address: n/a Fax: n/a

Grant Contact Person:

Name: Tony Title: Homeless Coord. Telephone: 703-228-1319
Turnage
e-mail address: tturnage@arlingtonva.us Fax: 703-228-1039

Financial Contact Person:

Name: Lynn Barak Title: Admin. Officer Telephone: 703-228-1318
e-mail address: lbarak@arlington.va Fax: 703-228-1039

5. List all cities and counties in your service area: Arlington County, VA

6. Does your organization impose requirements other than experiencing homelessness as criteria for receiving housing and services, i.e. victim of domestic violence, substance abuser, release from a correctional facility, previous residency status?
 Yes No

If yes, provide an explanation of these requirements _____

SECTION 1: PROGRAM NARRATIVE – Please see attached.

a. Statement of Problem/Need:

Describe the problem or need your agency’s program(s) is/are intended to address.

b. Program Description:

Describe your program(s), and the services to be provided and who will be providing those services, including any partnerships with other agencies. Describe how you intend to reach your target population.

SECTION 1: FACILITY INFORMATION

Complete the table on page 7 (“Facility Information”) for each facility to be assisted with State Shelter Grant, Federal Shelter Grant, Child Services Coordinator Grant, and/or Child Care for Homeless Children Program funds. **You must include the address to each facility. DHCD will maintain the confidentiality of each address given.** (Attach additional copies of the table if needed.)

SECTION 1: ATTACHMENTS

- Attachment A: Certification of Accuracy
- Attachment B: Certifications and Assurances
- Attachment C: Board Resolution for Nonprofit Applicants
- Attachment D: Governing Body Resolution for Local Governments
- Attachment E: Active Participation in local Continuum of Care Planning Group Assurances
- Attachment F: Financial Management System Information

SECTION 1: SUPPLEMENTAL INFORMATION

- Organization’s most recent audit report
- Organizational chart with all vacancies indicated
- Position descriptions for all staff positions
- Current fire inspection for each facility you are requesting funding
- Directions to your facilities from DHCD
- Brochures and pamphlets

SECTION 1: FACILITY INFORMATION

Name of Facility	Street Address (Please indicate if this is a confidential location or address)	Location (indicate City, County or Town where facility is located, not mailing address)	Enter type of facility (see key below)	Populations served in facility (see key below)	Max length of stay (see key below)	Number of Beds in Facility used for homeless persons	Program(s) applying for			
							SSG	FSG	CSCG	CCHCP
Emergency Winter Shelter (EWS)	2015 N. 15 th Street Arlington, VA 22201	Arlington County	Facility WS	UAM, UAW	B	40	X <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Facility				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Facility				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Facility				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Facility				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Facility				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

KEY:

Enter type of facility using the following abbreviations

ES (<i>full-year emergency shelter</i>)	TH (<i>transitional housing</i>)
WS (<i>winter or seasonal emergency shelter</i>)	DS (<i>day shelter with no overnight accommodations</i>)
DVES (<i>full-year emergency shelter serving victims of domestic violence</i>)	

Enter the letter that corresponds to the maximum length of stay at facility

- No overnight accommodations
- less than 6 months
- 6 months to 24 months

Enter populations served in each facility using the following abbreviations

UAM (<i>Unaccompanied Adult Men</i>)	UAW (<i>Unaccompanied Adult Women</i>)
UMY (<i>Unaccompanied Male Youth</i>)	UFY (<i>Unaccompanied Female Youth</i>)
SPF (<i>Single-Parent Families</i>)	TPF (<i>Two Parent Families</i>)
ACWC (<i>Adult Couples without Children</i>)	OFC (<i>Other Family Composition</i>)

ATTACHMENT A

Certification of Accuracy

I, Lynda Schoenbeck, Chief, Economic Independence Division,

Duly authorized to act on the behalf of:
Arlington County Government

Certify that by signing this document:

1. *I have read and understood the Application for Fiscal Year 2006 Funding and have answered the questions to the best of my ability;*
2. *I understand that in order for DHCD to execute a grant agreement between my agency and theirs, at least one representative from my agency must attend a mandatory Implementation Session. However, I understand that one representative for each program our agency is awarded funding for is recommended to attend (please see page 4 of the Information and Instruction packet for more information).*

<u>Tony Turnage, Homeless Coord.</u>	and <u>Linda Coats, Director EWS</u>
<i>(Name and Title)</i>	<i>(Name and Title)</i>

will attend the following session (please check):

Location	Date	Session Times	
Prince William Co.	June 3, 2005	<input checked="" type="checkbox"/> A: 9:00-12:00	<input type="checkbox"/> B: 1:00-4:00
Hampton	June 7, 2005	<input type="checkbox"/> A: 9:00-12:00	<input type="checkbox"/> B: 1:00-4:00
Roanoke	June 9, 2005	<input type="checkbox"/> A: 9:00-12:00	<input type="checkbox"/> B: 1:00-4:00
Richmond	June 14, 2005	<input type="checkbox"/> A: 9:00-12:00	<input type="checkbox"/> B: 1:00-4:00

3. *I agree to submit all Quarterly Reports timely;*
Due: Quarter 1: October 10, 2005
Quarter 2: January 10, 2005
Quarter 3: April 10, 2006
Quarter 4: July 10, 2006

 Signature of Authorized Representative

 Date

Chief, Economic Independence Division
 Title
Arlington County Government
 Name of Organization

ATTACHMENT B

CERTIFICATIONS AND ASSURANCES

I, Lynda Schoenbeck , authorized representative of Arlington County Government, on behalf of the organization do hereby certify that, if an award is received, the organization will conform to all programmatic regulations, guidelines and requirements set forth in the Application for Fiscal Year 2006 Funding, in Grant Agreements, and in Operations Manuals while conducting grant activities for the programs funded.

To this end, I certify/assure the following:

1. Buildings/structures rehabilitated or physically improved with grant funds, if allowable under the program guidelines, will remain in use as homeless facilities for a period of at least five years;
2. All services/programs supported by grant funds will be delivered on a non-discriminatory basis consistent with the Fair Housing Act of 1988 and the Virginia Fair Housing Law;
3. The facility(s) is is not (check one) owned by a church or other primarily religious organization, and if the organization is operating in a facility owned by a religious organization, the funds will not be used for physical improvements to the building/structure;
4. The organization does /does not (check one) require a fee or donation as a condition for receiving emergency shelter or related services;
5. The organization operates in a facility that is in compliance with applicable State and local health, building, and fire safety codes, meeting the U. S. Department of Housing and Urban Development's Housing Quality standards and Habitability Standards as a minimum, or agrees to make necessary improvements/repairs for code compliance;
6. The organization shall maintain and operate under a standardized set of procurement procedures designed to assure efficient and proper expenditure of grant funds;
7. The organization will administer a policy to ensure each homeless facility is free from the illegal use, possession or distribution of drugs or alcohol by its employees and/or beneficiaries;
8. The organization will maintain and operate under a standardized conflict of interest procedure for employees and members of the board;
9. The organization will insure the confidentiality of victims of domestic violence;
10. The organization (unless a unit of local government) was incorporated under Virginia law on _____; and
11. The organization (unless a unit of local government) has received Federal tax-exempt status under Section 501 (c) of the U. S. Internal Revenue Code.

Signature of Authorized Representative

Date

Lynda Schoenbeck, Director, Economic Independence Division

Title of Authorized Representative (*print or type*)

ATTACHMENT C-Not Applicable

BOARD RESOLUTION FOR NONPROFIT APPLICANTS

- I. WHEREAS, the Commonwealth of Virginia, Department of Housing and Community Development, has issued a Notice of Funding Availability and requested applications under the Application for Fiscal Year 2006 Funding.
- II. WHEREAS, assistance is needed to effectively and adequately address the needs of homeless persons, including families, individuals, and/or children, to be served by *(enter name of organization)* in our service area(s) of *(list all jurisdictions in service area)*.
- III. WHEREAS, an application for a grant(s) under the Application for Fiscal Year 2006 Funding has been prepared.
- IV. WHEREAS, *(enter name of organization)* agrees, if an award is received, to provide coordination of safe and sanitary shelter and/or supportive services to homeless persons in conformance with the regulations and guidelines of any program(s) funded.
- V. WHEREAS, *(enter name and title)* may act on behalf of *(enter name of organization)* and will sign all necessary documents required to complete the grant transaction.
- VI. WHEREAS, any required match under the program guidelines will be provided.
- VII. NOW, THEREFORE, BE IT RESOLVED THAT the Board of Directors of *(enter name of organization)* hereby authorizes *(enter name)* to apply for and accept a grant award under the programs indicated above (see IV.) and enter into a Grant Agreement with the Department of Housing and Community Development and perform any and all actions and responsibilities in relation to such Agreement.

Signature of Authorized Board Member

Date

Name and Title of Authorized Board Member *(print or type)*

ATTACHMENT D

GOVERNING BODY RESOLUTION FOR LOCAL GOVERNMENTS

- I. WHEREAS, the Commonwealth of Virginia, Department of Housing and Community Development, has issued a Notice of Funding Availability and requested applications under the Application for Fiscal Year 2006 Funding.
- II. WHEREAS, assistance is needed to effectively and adequately address the needs of homeless persons, including families, individuals, and/or children in Arlington County, Virginia.
- III. WHEREAS, an application for a grant(s) under the Application for Fiscal Year 2006 Funding has been prepared.
- IV. WHEREAS, Arlington County/Department of Human Services agrees, if an award is received, to provide coordination of safe and sanitary shelter and/or supportive services to homeless persons in conformance with the regulations and guidelines of any program(s) funded.
- V. WHEREAS, Lynda Schoenbeck, Division Chief, Economic Independence may sign all necessary documents required to complete the grant transaction, on behalf of Arlington County, VA.
- VI. WHEREAS, any required match under the program guidelines will be provided, subject to appropriation.
- VII. NOW, THEREFORE, BE IT RESOLVED THAT the Board of Supervisors, City Council, or other authorizing governmental body of Arlington County hereby authorizes Lynda Schoenbeck to apply for and accept a grant award under the programs indicated above (see IV.) and enter into a Grant Agreement with the Department of Housing and Community Development and perform any and all actions and responsibilities in relation to such Agreement.

Signature of Authorized Local Government Official

Date

Jay Fiset, Chairman Arlington County Board
Name and Title of Authorized Board Member

ATTACHMENT E

Active Participation in local Continuum of Care Planning Group Assurances

DHCD working definition: An active member agency/organization/service provider of a local Continuum of Care attends at least 51% (fifty-one percent) of the overall Coalition meetings, serves on at least one committee and contributes work hours and staffing in the Continuum of Care application process by writing sections, proof reading, and/or researching, etc.

DHCD acknowledges that Continua of Care are unique organizations, specifically tailored to fit the needs and available resources within a community. For this reason, if your Continuum of Care uses a different definition to describe “active member agency/organization,” rank the organization in question according to that definition. If using an alternate definition, please type it here:

Applicant Information:

Name: Homeless Services Coordination Committee
Continuum of Care Group:
Arlington County

Address: 3033 Wilson Boulevard, Suite 300A
Arlington, VA 2201

My signature below attests that this agency/organization:

- 1. Is an active participant, of the above named Continuum of Care, according to

DHCD’s working definition or another stated definition:

X Yes No

If “no,” please provide an explanation:

- 2. Is filling a gap, or the lack of this established program would cause hardship for homeless individuals and/or families, in our community’s continuum of services by providing services and/or shelter through their programs

X Yes No

Signature of Continuum of Care Chairperson*
Tony Turnage, Homeless Program Coordinator
Printed Name, Title

Date
Arlington County/DHS
Agency

***Conflict of interest statement:** if the chair for your agency’s Continuum of Care is an employee or volunteer at your agency, you must have another Continuum of Care member in a leadership position certify this assurance.

ATTACHMENT F

FINANCIAL MANAGEMENT SYSTEM INFORMATION (FMSI)

Information must be completed by all applicants.

1. Does your organization do its own financial accounting? Yes No

If no, who does your organization's financial accounting? JNVP

2. In your financial accounting system, are the following books of account used?

A. General Ledger Yes No

B. Cash Disbursements (Check Register) Yes No

C. Cash Receipts (Deposits Received) Yes No

D. Fixed Asset Yes No

Are financial records maintained by computer? Yes No

If yes, provide answers to the following:

What accounting software is used? Quickbooks

Who has access to accounting records? Accounting Services, Financial Manager

Are passwords used to access records? Yes

Is there an off-site back-up system? Yes

3. List the title of the staff person responsible for the following tasks

A. Opens mail: Addressee-Executive Director, Executive Assistant

B. Deposits checks/funds: Executive Director

C. Reconciles checkbook with bank statement: Accounting Service

D. Posts cash receipts: Accounting Service

4. Do checks require two signatures? Yes No

Whose signatures are required? (Titles) Executive Director or designated Program Director

5. Are individuals who handle the organization's funds bonded? Yes No

6. How many years are records retained? Ten

7. Is an annual audit completed by an independent accountant? Yes No

If no, how often is an audit completed or what other methods are used to ensure fiscal accountability? _____

Section 2: State Shelter Grant (SSG) and Federal Shelter Grant (FSG)
APPLICATION

Please check which grant(s) your agency is applying for by marking one or both boxes:

X State Shelter Grant (SSG) Federal Shelter Grant (FSG)*

*Applicants in the U. S. Department of Housing and Urban Development (HUD) designated entitlement cities of Norfolk, Portsmouth, Richmond, Roanoke and Virginia Beach and entitlement counties of Arlington, Fairfax, and Prince William are not eligible for FSG funding.

A. Emergency Shelter Programs

1. Number of beds, as approved by the local building official, which are available to the homeless on *July 1, 2005*: 40
2. Number of months your facility will be used to house homeless persons in fiscal year 2006: Five (5)
3. If applicable, average number of beds for which per diem payments from a third-party were received in the first two quarters of fiscal year 2005 (*July 1, 2004 through December 31, 2004*): n/a
4. If applicable, number of beds set-aside under a purchase of service contract in fiscal year 2006 (*July 1, 2005 through June 30, 2006*): n/a
5. Total number of persons sheltered in your facilities during the first two quarters of FY 2005 (*July 1, 2004- December 31, 2004*): 186
6. Number of bed nights for all persons sheltered in the first two quarters of fiscal year 2005 (*count each time a bed was occupied for the night by any homeless individual as a bed night*): 2,214
7. Total number of those persons who were under the age of 18: n/a
8. Number of bed nights for persons under the age of 18 in first two quarters of fiscal year 2005 (*count each time a bed was occupied for the night by a child as a bed night*):
n/a
9. Number of households staying in your facility(s) in first two quarters of fiscal year 2005:
186

B. Transitional Housing Programs – Not Applicable

1. Number of beds, as approved by the local building official, which are available to the homeless on *July 1, 2005*:
2. Number of months your facility will be used to house homeless persons in fiscal year 2006 (*July 1, 2005 through June 30, 2006*):
3. If applicable, average number of beds for which per diem payments from a third-party were received in the first two quarters of fiscal year 2005 (*July 1, 2004 through December 31, 2004*):
4. If applicable, number of beds set-aside under a purchase of service contract in fiscal year 2006 (*July 1, 2005 through June 30, 2006*):
5. Total number of persons sheltered in your facilities during the first two quarters of FY 2005 (*July 1, 2004- December 31, 2004*):
6. Number of bed nights for all persons sheltered in the first two quarters of fiscal year 2005 (*count each time a bed was occupied for the night by any homeless individual as a bed night*):
7. Total number of those persons who were under the age of 18:
8. Number of bed nights for persons under the age of 18 in first two quarters of fiscal year 2005 (*count each time a bed was occupied for the night by a child as a bed night*):
9. Number of households staying in your facility(s) in first two quarters of fiscal year 2005:
10. Does your transitional housing program receive:
 - ✓ HUD Supportive Housing Program grant for operations? Yes No
 - ✓ Section 8 Program rental subsidy? Yes No
 - ✓ another governmental rental subsidy? Yes No

If yes, list facilities by address:

C. Day Shelter Programs – Not Applicable

1. Average daily attendance of homeless persons during the first two quarters of fiscal year 2005 (July 1, 2004-December 31, 2004): n/a
2. Describe the methodology used to count and track the number of people using the facility daily, and the person/position responsible for ensuring an accurate count. n/a
3. What method is used to verify the housing status or lack of housing of participants?
n/a

SECTION 2: NARRATIVE – Please see attached

All SSG and FSG Applicants:

1. How long has your organization provided a shelter facility for homeless families and individuals and how has the organization changed focus and tactics in response to changing needs? (*no longer than 2 pages*)
2. Please provide a narrative (*no longer than 2 pages*) explaining the supportive services that your organization provides that do not supplant or duplicate existing services in the area.

Not applicable.

Section 2: State Shelter Grant (SSG) and Federal Shelter Grant (FSG)
CERTIFICATION OF LOCAL APPROVAL FOR NONPROFIT APPLICANTS

State Shelter Grant and Federal Shelter Grant Only

I, *(enter name and title)*, duly authorized to act on behalf of *(enter name of jurisdiction)* _____,
hereby approve the following project(s) proposed by *(enter name of nonprofit organization)*
_____ which is (are) located in *(enter name of all applicable jurisdictions)* _____.

Signature of Authorized Local Government Official

Date

Name and Title of Authorized Local Government Official

Section 3: Child Services Coordinator Grant (CSCG)
APPLICATION

Statistical information (based on first two quarters of FY 2005, July 1-December 31, 2004)

Total number of new children admitted (for emergency shelters only)	
Average number of children in residence on a monthly basis (TH programs only)	

Narrative:

No longer than 10 (ten) pages, cumulatively.

This information will be used to in several ways.

- a) It may be used to make a funding decision.
 - b) The information provided will be used during a site visit. Any comments made in the narrative could be checked for completeness during an on-site review.
-
1. Describe your agency's programs and how they impact the well being of homeless children.
 2. Explain the strategies that will be used to ensure all school aged children, who enter the program during the school year) are enrolled in school and how their school performance will be monitored.
 3. Explain your agency's working relationship with the Project HOPE staff.
 4. Explain the strategies that will be used to ensure all children will receive a health care assessment and referrals when necessary.
 5. Explain the strategies that will be used to ensure all children over the age of five receive a mental health assessment and referrals if necessary.
 6. Explain other services the agency intends to provide for children and their parent(s).
 7. Explain how the Child Services Coordinator will be supervised and how his/her performance monitored.
 8. Explain what other agency or community resources will be used to enhance the work or provide salary support for the Child Services Coordinator.
 9. Provide any additional information about the programs and services that will better explain the quality of care the children will receive.

Section 3: Child Services Coordinator Grant (CSCG)

BUDGET FORMS

Staff/Salary Breakdowns

Please show all staff positions regardless of funding source, which relate to the Child Services Coordinator Grant including the amount for fringe benefits. If multiple staff members have the same position/title, list separately, e.g., Counselor 1, Counselor 2.

Position Title	Is this a current or proposed position?	Annual Salary	Annual Fringe Benefits	Total Annual Salary	X	% Time Spent on Program	=	Total Position Cost
ex: Child Services Coordinator	Current	\$25,000	\$5,000	\$30,000		75		\$22,500

In-kind and Leveraging Explanation Form

List the proposed leveraging sources for FY 2006. Please check the appropriate box for In-Kind or Cash.

Entity/Proposed Source	Type	Annual Project Value in \$	In-Kind	Cash
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
TOTAL DOLLAR VALUE			<input type="checkbox"/>	<input type="checkbox"/>

**Section 4: Child Care for Homeless Children Program (CCHCP)
APPLICATION**

1. Does your shelter program impose a deadline for obtaining employment to continue residence in your facility: Yes No

If "Yes", how much time is allowed for obtaining employment? _____

2. Does your facility provide on-site child care? Yes No
 If "Yes", is the child care center licensed? Yes No
 Are parents required to use the on-site child care? Yes No

3. Please provide the name and telephone number, including area code, of your contact for child care activities at the local department of social services: _____

4. Amount Requested for child care services: \$_____

5. Statistical information (based on first two quarters of FY 2005, July 1-December 31, 2004)

Total number of children served (birth – 13)	
number of children ages birth – 4 years of age (pre-school)	
number of children ages 5 – 13	

Narrative

No longer than 5 (five) pages, cumulatively.

- 1) List all the ways child care is provided (please answer for each type of shelter facility).
- 2) What is the process for referrals to off-site child care? (Please answer for each type of shelter facility)?
- 3) Describe how you determined how much money you anticipate being able to use in FY 06.
- 4) Describe how the assistance will be made available to the parents.
- 5) Describe how the funds will be managed and who will be responsible for disbursing them.
- 6) Describe your agency's working relationship with the local DSS staff and eligible child care provider staff.