



Powered by ZoomGrants™

YV Conference of Governments
Homeless and Housing Program
YVCOG HP RFP 2018-2020
4/9/2018 deadline

Yakima Neighborhood Health Services Yakima Neighborhood Health Services Coordinated Entry

USD\$ 72,000.00 Requested

Submitted: 4/9/2018 4:49:13 PM (Pacific)

Project Contact

Rhonda Hauff
rhonda.hauff@ynhs.org
Tel: (509) 574-5550

Additional Contacts

none entered

Yakima Neighborhood Health Services

12 South 8th Street, PO Box 2605
PO Box 2605
Yakima, WA 98907
United States

CEO

Anita Monoian
anita.monoian@ynhs.org

Telephone 5095745552
Fax 5095745564
Web www.ynhs.org

Application Questions

PROJECT NARRATIVE

1. PROJECT SUMMARY: Provide a brief description of the proposed project. Describe how the project is aligned with the goals in the Yakima County 5-Year Plan.

The Yakima County 5-Year Plan can be found in the Library tab.

Many years of work has gone into designing a Coordinated Entry (CE) System for Yakima County, wherein all residents seeking assistance with housing or homeless services are greeted, assessed, and referred through a single access point. Yakima Neighborhood Health Services (YNHS) participates in the county's CE as one of those access points and uses a Vulnerability Index (VI-SPDAT) to prioritize the most vulnerable and at risk for eventual housing placement. As an access point for CE, YNHS conducts the majority of the intakes into the system. CE was prompted by funder requirement and community demand. It is not intended to create a single, unified physical access point to services, but a decentralized, standardized process of identifying available resources and allocating them to clients with appropriate service needs. CE intake and referral resources can be accessed through any of the participating access points agencies as part of their standard client intake. Essentially, coordinated entry creates a system with no front door – but also no wrong door.

This request includes the cost of a Coordinated Entry/Eligibility Specialist (CE/ES) to conduct intakes as required by Access points as well as assist homeless clients with applications for benefits including health insurance through Medicaid, Medicare, or the exchange, TANF, SSI/SSDI, TANF, SNAP, etc. Very often the homeless need assistance obtaining documents to qualify for insurance or benefits. The CE/ES assists with obtaining birth certificates, government issued IDs, marriage certificates, divorce decrees, a mailing address, or other necessary documents. YNHS has a grant from the United Way that pays the fees and postage costs for obtaining these documents. The CE/ES will also transport and accompany the client to government offices, translate documents and interpret for Spanish speaking clients, and follow up if documents are not received or the client receives a denial.

This project aligns with the following goals in the 5-Year Plan:

- Goal 1: Utilize a Coordinated Entry, Assessment and Referral System
 - o 1.5 Direct necessary resources to establish and maintain a successful coordinated entry system

- o 1.6 Use Vulnerability Index (VI-SPDAT) to prioritize services (highest need receives top priority)
- o 1.7 Utilize a Coordinated Entry Entity to provide oversight and maintain a coordinated intake, assessment and referral system.
- o 1.9 Improve outreach to identify homeless clients and encourage participation in services through Coordinated entry.
- Goal 5: Expand Permanent Supportive Housing options and prioritize services and housing for chronic homeless families and individuals using Coordinated Entry
- o 5.2 Coordinate services to place individuals into drug and alcohol rehabilitation programs and housing
- o 5.3 Coordinate services to address special needs of veterans into appropriate housing and programs

2. TARGET POPULATION: Describe in detail the target population this project will serve. Include agency's experience working with this particular population and knowledge/understanding of this populations' unique service needs.

Please indicate how serving this population aligns with the 5-Year Plan.

All clients will complete standardized intake information. This may include some of all: a pre-screening form to divert at risk households, an up-to-date HMIS data standards compliant intake form (preferably the coordinated entry HMIS form), and the VI-SPDAT-Single or Family or TAY adaptation adopted for coordinated entry use.

- Chronically Homeless (including chemical dependency and mentally ill) –

- o A person who is “chronically homeless” is an unaccompanied homeless individual with a disabling condition, who has either been continuously homeless for a year or more; or has had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation and/or in an emergency homeless shelter.

- o A disabling condition is defined as a diagnosable substance use disorder, a serious mental illness, a developmental disability, a chronic physical illness, or a disability including the co-occurrence of two or more of the previously mentioned conditions. A disabling condition limits an individual’s ability to work or perform one or more activities of daily living.

- Homeless Veterans
- Homeless Families with Children (including victims of Domestic Violence)
- Homeless Elderly over the age of 62

YNHS has extensive experience working with this particular population. Founded in 1975, YNHS began providing health services to the homeless in 2005 when Health Care for the Homeless funding was first received, and has grown to become the largest provider of homeless services in Yakima county. They currently provide outreach and basic needs assistance, medical respite care, and permanent supportive housing. YNHS is a community health center operating seven clinics located throughout the county. They provide integrated medical, dental, behavioral health and substance use services to the low-income residents of Yakima County. To ensure access for the homeless, YNHS operates a medical and dental clinic located at Triumph Treatment Services in the downtown area. YNHS also operates a clinic located at Comprehensive Healthcare, which serves the chronically mentally ill.

Yakima Neighborhood Health Services has staff trained in Trauma Informed Care as well as various staff trained to respond to behavioral and mental health needs as indicated. Nursing Case managers are also trained to provide services to those with disabilities and other identified special needs.

3. SERVICES/ACTIVITIES: Describe the services/activities proposed in a specific and detailed manner. Include a description of how the services/activities will be implemented and the frequency/duration of services.

Please indicate how the proposed services align with the 5-Year Plan.

A coordinated entry assessment and system generated referral from the Active Client List are required for ALL program entries at participating agencies, except for domestic violence and other victim service providers and some shelter programs that admit on a per-night basis with limited or no entry criteria. Nightly shelters will be encouraged to adopt vulnerability over first come first served access but will not be required to comply.

Clients must provide consent before beginning the intake and assessment process using the Client Informed Consent form. If client consent is collected orally via call in, the consent must be collected when the first contact is made with a physical provider. Client informed consent documentation is secured in a HIPPA approved system. Consent is to be secured prior to generating a referral unless only oral consent is currently available.

All clients will complete standardized intake information. This may include some of all: a pre-screening form to divert at risk households, an up-to-date HMIS data standards compliant intake form (preferably the coordinated entry HMIS form), and the VI-SPDAT-Single or Family or TAY adaptation adopted for coordinated entry use. All VI-SPDAT assessments will use the same script during the assessment.

ALL intake and assessment data is entered into HMIS system within 24 hours. If the system is not currently available for some reason, it may be held on paper until the system access is restored.

This project aligns with the following activities in the 5-Year Plan Action Plan:

- Goal 1: Utilize a Coordinated Entry, Assessment and Referral System
- o 1.5 Direct necessary resources to establish and maintain a successful coordinated entry system
- o 1.6 Use Vulnerability Index (VI-SPDAT) to prioritize services (highest need receives top priority)

- o 1.7 Utilize a Coordinated Entry Entity to provide oversight and maintain a coordinated intake, assessment and referral system.
- o 1.9 Improve outreach to identify homeless clients and encourage participation in services through Coordinated entry.
- Goal 5: Expand Permanent Supportive Housing options and prioritize services and housing for chronic homeless families and individuals using Coordinated Entry
- o 5.2 Coordinate services to place individuals into drug and alcohol rehabilitation programs and housing

4. LOCATION: In what City or Cities will your project be located? Describe how the services will be available and accessible.

Is this location near a public transit line and/or will your services include client transportation, if necessary.

All intakes are done in the main offices within the Cities of Yakima and Sunnyside.

5. LINK TO NEED: Describe how the proposed services/activities, including the location, meet the needs of the target population and fill any gaps in services. How do the proposed services meet the need in the community without duplicating efforts?

Indicate whether the service delivery model to be used is best practice, and provide detailed information to support that the project design is: a) evidence based, or b) introduces an innovation that improves the services provided.

CE was prompted by funder requirement and community demand to create a single, unified physical access point to services, but a decentralized, standardized process of identifying available resources and allocating them to clients with appropriate service needs. The two models that have informed the design of the generalize intake process as well as the design of CE; Housing First and Trauma Informed Care. These are both evidence-based practices (more rigorously studied than best-practices) and are National models.

- Housing First – The National Alliance to End Homelessness defines Housing First as a homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed. This approach prioritizes client choice in both housing selection and in-service participation. Specific Activities include:

- o A focus on helping individuals and families access and sustain permanent rental housing as quickly as possible;
- o A variety of services delivered to promote housing stability and individual well-being on an as-needed and entirely voluntary basis; and

- o A standard lease agreement to housing – as opposed to mandated therapy or services compliance.

- o While all Housing First programs share these elements, program models vary significantly depending upon the population served. For people who have experienced chronic homelessness, long-term services and support may be needed.

- Trauma Informed Care (TIC) – This Best Practice recognizes life progress at the smallest level, and builds on that progress to achieve greater successes in self-sufficiency and improved health. YNHS uses TIC as it's model for case management and outreach in their work with medically fragile patients, mental health clients, homeless clients, and clients in supportive housing. The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified the Six Key Principles of Trauma Informed Care:

- o Safety - Throughout the organization, staff and the people they serve feel physically and psychologically safe.

- o Trustworthiness and transparency - Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

- o Peer support and mutual self-help - These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

- o Collaboration and mutuality - There is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.

- o Empowerment, voice, and choice - Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary. The organization aims to strengthen the staff's, clients', and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach. This includes a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.

- o Cultural, historical, and gender issues - The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

6. ACCESSABILITY: Describe in detail how the proposed project will be accessed by the targeted population.

How will this project coordinate with the Coordinated Entry System?

YNHS will continue to use the current outreach approaches being utilized in the form of Street Outreach program, Depot Services, health care for the homeless services, and the no wrong door approach. This will be in addition to intake and assessment in order to identify service and housing needs and provide a link to the appropriate level of both as indicated. The intended audience for this outreach is homeless individuals and families.

YNHS is an access point for coordinated entry, and as a result, works with all agencies who are participating in coordinated entry to identify the most vulnerable in the community in order to prioritize them for housing. A Coordinated Entry/Eligibility Specialist (CE/ES) assists homeless clients with applications for benefits including health insurance through Medicaid, Medicare, or the exchange, TANF, SSI/SSDI, TANF, SNAP, etc. Very often the homeless need assistance obtaining documents to qualify for insurance or benefits. The CE/ES assists with obtaining birth certificates, government issued IDs, marriage certificates, divorce decrees, a mailing address, or other necessary documents. YNHS has a grant from the United Way that pays the fees and postage costs for obtaining these documents.

Individuals have eligibility and risk determined through participation through the Coordinated Entry system which includes administration of the Vulnerability Index (VI-SPDAT) to prioritize services (highest need receives top priority). The following methods are utilized to determine and document eligibility based on their current circumstances:

- Street (Those who are permanently camping; do not have a home; those who state they live on the street or in their cars; those living in abandoned buildings or other structures not meant for human habitation)
 - o Signed and dated statements validating situation on letterhead from outreach workers and/or organizations that assisted the person in the recent past OR
 - o Written verification signed and dated on letterhead from referring social service organization or outreach worker providing information regarding where the person has been residing OR
 - o Verification from Homeless Network member known by YNHS staff with first-hand knowledge of client situation.
 - o Documentation already verified in Yakima County HMIS System.
- Literally Homeless (Continually Homeless 1 Year or 4 Episodes in 3 Years that add up to 1 year):
 - o Verification signed and dated on shelter letterhead.
 - o Shelter's bed-night roster.
 - o Verification from Homeless Network member known by YNHS staff with first-hand knowledge of client situation.
 - o Documentation already verified in Yakima County HMIS System.
- From Transitional Housing:
 - o Written verification from Transitional Housing provider, showing date client entered transitional housing and verifying client was previously homeless.
 - o Verification from Homeless Network member known by YNHS staff with first-hand knowledge of client situation.
 - o Documentation already verified in Yakima County HMIS System.
- Institutions / Treatment Centers: (must have been homeless prior to being institutionalized):
 - o Written, signed and dated verification on letterhead from institution's staff that participant is being discharged without housing and lacks resources to obtain housing.
 - o Verification from Homeless Network member known by YNHS staff with first-hand knowledge of client situation.
 - o Documentation already verified in Yakima County HMIS System.

7. HOUSING SEARCH AND STABILIZATION: For Rapid Rehousing/Rental Assistance Projects ONLY. Describe the agency's experience in working with area landlords and/or property managers and detail the project's planned liaison efforts.

Describe your agency's approach to maintaining strong relationships with landlords and providing tenants with knowledge of their responsibilities as a tenant.

This is not a Rapid Rehousing/Rental Assistance Project

8. COMPLEMENTARY SERVICES and COORDINATION: Describe other services, projects, and agencies that will provide services or resources to project participants that help meet needs and promote movement toward permanent housing.

Describe in detail any formal agreements or history of partnerships (i.e. education, employment, life skills, mental health, substance abuse) that your agency has with partnering agencies and UPLOAD signed MOU's/agreements in the Documents Tab.

In addition to being an access point for CE - YNHS collaborates with many agencies in most programs and projects including, but not limited to; Yakima Housing Authority, private landlords, etc. for housing needs. For support services, YNHS rely on the expertise of Triumph Treatment Services and the YWCA of Yakima for clients with Chemical Dependency and Domestic Violence issues. YNHS also collaborates with the workforce, housing, and transportation systems to make employment an essential component of their supportive housing programs and projects.

As an access point for coordinated entry, YNHS works with all agencies who are participating in coordinated entry to identify the most vulnerable in the community in order to prioritize them for housing.

Additionally, YNHS has been an early adopter of HMIS data and processes and continues to promote the shared enterprise of a county-wide HMIS database. Yakima County HMIS providers share one database so they can share and see what services homeless residents in Yakima County are receiving, and are able to coordinate services among the providers.

Letters of support from the Homeless Network of Yakima County, Rod's House, and Union Gospel Mission are attached.

9. PROJECT OUTPUTS: The overall goal of this RFP is to prioritize unsheltered, rapidly move households into

permanent housing, and reduce the time spent homeless and on the streets or in shelters. The next FOUR (4) questions address projected output.

Will your project have measurable outputs?

- Yes
- No
- Other:

10. A) PERSONS SERVED: Indicate number of projected unduplicated persons and households to be assisted for a 12 month program period. Unduplicated means that each person/household served by the project is counted only once during the program period.

Disregard Total at the bottom.

Unduplicated Persons (7/1/18 - 6/30/19)

Unduplicated Households (7/1/18 - 6/30/19)

TOTAL

11. B) SERVICE UNITS: Identify and describe THREE (3) service units to be provided. (Examples: number of outreach contacts, emergency shelter bed nights, housing stability service hours, vouchers, etc.)

For each service unit, indicate total number of service units to be provided in a 12-month program period. Identify how you track and monitor clients and services provided; be specific.

- Service Unit 1 – 1,100 intakes each year

There are no other service units other than those which occur after the intake as a result of other programs. The above estimate is based on previous year's activity and will be dependent on the rate of homelessness in the upcoming years.

12. C) EMERGENCY SHELTER & TRANSITIONAL HOUSING PROJECTS ONLY: How many units (or beds) are in your program and what percent of utilization do you anticipate:

Disregard Total at the bottom.

of Units

of Beds

% Utilization Rate

TOTAL

13. D) POTENTIAL BARRIERS: Describe any potential barriers to achieving the identified output(s) and the strategy for overcoming these barriers in order to meet the proposed performance targets.

The greatest challenge of the project is the explosion of homelessness in the Country, State, and County. In 2017, there was an increase of 28% of individuals experiencing homelessness in Yakima County according to the 2017 Annual Point in Time Count. The largest increase is for individuals who are literarily homeless, though temporarily sheltered, with individuals in Emergency Shelters and Transitional Housing showing a 54.3% increase. A majority of that increase is in the number of individuals staying in emergency shelters which includes Extreme Winter Weather Shelters and vouchers. This category alone showed an 82% increase from the previous year. Individuals who were unsheltered (sleeping in an abandoned building, vehicle, or outside) also increased by 23% from the previous year.

There are no identified barriers to continue being the access point for CE.

14. Please select your proposed project type for this application. Separate applications must be done for each project your agency will apply for.

Answer ONLY the questions below that pertain to your project type; type N/A in questions that do not pertain.

- Coordinated Entry Services
- Emergency Shelter (DV, Youth, 24-hour, overnight only)
- Winter Weather Hotel/Motel Vouchers
- Outreach Services
- Rapid Rehousing (RRH) / Rental Assistance (RA)
- HEN Rental Assistance
- TANF Rental Assistance
- Capital Improvement

15. COORDINATED ENTRY SERVICES: Describe your agency's process for completing the CE Intake Assessment and

ensuring the client gets prioritized appropriately. Indicate number of estimated assessments your agency is likely to complete per month.

Describe any potential barriers this project may encounter and the strategy for overcoming these barriers.

A coordinated entry assessment and system generated referral from the Active Client List are required for ALL program entries at participating agencies, except for domestic violence and other victim service providers and some shelter programs that admit on a per-night basis with limited or no entry criteria. Nightly shelters will be encouraged to adopt vulnerability over first come first served access but will not be required to comply.

Clients must provide consent before beginning the intake and assessment process using the Client Informed Consent form. If client consent is collected orally via call in, the consent must be collected when the first contact is made with a physical provider. Client informed consent documentation is secured in a HIPPA approved system for all adults in a household.

All clients will complete standardized intake information. This may include some of all: a pre-screening form to divert at risk households, an up-to-date HMIS data standards compliant intake form (preferably the coordinated entry HMIS form), and the VI-SPDAT-Single or Family or TAY adaptation adopted for coordinated entry use. All VI-SPDAT assessments will use the same script during the assessment.

ALL intake and assessment data is entered into HMIS system within 24 hours. If the system is not currently available for some reason, it may be held on paper until the system access is restored.

An estimated 100 assessments will be completed each month. based on previous year's activity and will be dependent on the rate of homelessness in the upcoming years.

16. EMERGENCY SHELTER: Emergency Shelter Projects have the following performance targets: at least 60% of clients exit to permanent housing and an average length of stay of 20 days. Describe your action plan to achieve these targets.

Describe any potential barriers to achieving the identified outcomes and the strategy for overcoming these barriers.

This is not an Emergency Shelter project

17. RAPID REHOUSING (RRH)/RENTAL ASSISTANCE (RA) - Describe your agency's process for assisting clients in obtaining necessary identification, disability, and homeless verification documentation to obtain housing assistance.

Describe any potential barriers this project may encounter and the strategy for overcoming these barriers.

This is not a Rapid Rehousing/Rental Assistance project

18. RRH: RRH projects have the performance targets of: at least 90% of clients exit to permanent housing, an average length of time from enrollment to move-in of 14 days or less, and less than 5% of clients returning to homelessness within 1 year.

Describe your action plan for meeting the identified outcomes and your strategy for overcoming any barriers to meeting the proposed performance targets.

This is not a Rapid Rehousing/Rental Assistance project

19. RA: TH or PSH: TH projects will only be considered for youth or DV clients. Performance targets for: TH - at least 80% exit to PH and average LOS less than 180 days. PSH - at least 90% retain or exit to PH.

Describe your action plan for meeting the identified outcomes and your strategy for overcoming any barriers to meeting the proposed performance targets. Describe your action plan for increasing or maintaining the total income of clients served.

This is not a Rapid Rehousing/Rental Assistance project

20. CAPITAL IMPROVEMENT: Please attach a copy of the signed Purchase Agreement, Lease Agreement, Zoning Approval and any other supporting documentation under the Documents tab.

Please give a "yes", "no", or "unknown" response for each question below.

Does your agency own the property or have a contract to purchase or lease the property?

Does the proposed use of project comply with city zoning codes and state regulations?

Will this project require relocating individuals and if so, does your agency intend to comply with the Uniform Relocation Act (URA)? (See Library Tab)

Does the proposed use of this project directly benefit homeless individuals?

Does this proposed project align with the goals outlined in the Yakima County 5-Year Plan? (see Library Tab)

TOTAL

21. CAPITAL IMPROVEMENT: Describe your proposed project in detail including timeline for completion, proposed deliverable, and how it aligns with the 5-year plan.

This is not a Capital Improvement project

22. OUTREACH SERVICES: Describe the anticipated outcomes of your project and what will be the proposed deliverables?

Describe your action plan for connecting your target population to a Coordinated Entry Access Point and prioritized for housing or other services.

This is not an Outreach Services project

AGENCY CAPACITY AND EXPERIENCE

23. AGENCY CAPACITY AND EXPERIENCE: Please provide a brief response to each question below.

Please give a "yes", "no", or "unknown" response for each question below

- Yes Does your agency have experience providing homeless housing and/or services?
- Yes Does your agency have experience managing and accounting for public funding?
- Yes Have you had an audit in the last 24 months?
- No Has your agency received any audit or monitoring findings in the last 3 years? If yes, upload audit in Documents Tab.
- No Has your agency undergone organizational restructuring in the last 24 months?
- No Has your agency experienced turnover in key management positions in the last 24 months pertinent to this project?
- Yes Does your agency maintain policies for minimum qualifications for the staff members who will provide client services. If yes, please attach in Document Tab.
- Yes Does your agency utilize policies, procedures, and best practices to promote fairness and opportunity for all people, particularly people of color and communities that are disproportionately represented among the homeless population?
- Yes Does your agency assure access to underserved communities impacted by homelessness?
- Yes Will your agency provide services to racial and ethnic minorities, immigrants and refugees, individuals with disabilities, LGBTQ, and people with limited English proficiency?
- Yes Does your agency identify specific cultural based needs of populations and use that information to modify engagement and services?
- Yes Does your agency conduct self-assessment of its fair and just practices and cultural competency including both internal and external input?
- Yes Does your agency participate in HMIS currently?
- Yes Does your agency currently participate in the Coordinated Entry System for Yakima?
- TOTAL**

24. AGENCY COMMUNITY PARTICIPATION/COLLABORATION: Upload any MOUs between partnering agencies in the Documents Tab.

Please give a "yes", "no", or "unknown" response for each question below

- Yes Does your agency participate in local homeless planning committees?
- Yes Is your agency collaborating with partner agencies? Please attach all MOU's.
- TOTAL**

Budget

CAPITAL IMPROVEMENT PROJECT BUDGET

	This Request	Other Federal	Other State/Local	Private or Other	TOTAL
Design & Inspection					USD\$ 0.00
Project Manager/Consultants					USD\$ 0.00
Relocation Costs (if applicable)					USD\$ 0.00
Title Insurance					USD\$ 0.00

Environmental Review	USD\$	0.00
Permits & Fees	USD\$	0.00
Land Acquisition	USD\$	0.00
Site Development & Landscape	USD\$	0.00
Utilities	USD\$	0.00
Other:	USD\$	0.00
Total	USD\$ 0.00	USD\$ 0.00

ALL OTHER PROJECT TYPES BUDGET	TOTAL Project Cost	Request Amount	Other Revenue	In-Kind Contribution	Anticipated Donations
Personnel Costs (Direct - 100% to program)	USD\$ 61,200.00	USD\$ 61,200.00			
Admin (Indirect - expenses shared with organization)	USD\$ 10,800.00	USD\$ 10,800.00			
Facilities Costs (Rent/Mortgage)					
Operating Costs (Insurance, Utilities, Phone, Supplies, Mileage, etc.)					
Operating Equipment (max \$1,500)					
Program Expenses:					
Specific: Case Management					
Specific: Hotel/Motel Vouchers					
Specific: Coordinated Entry Access Point					
Specific: RRH/RA - (For-Profit Only)					
Specific: TANF RA - (For-Profit Only)					
Specific: HEN RA					
Specific: Outreach Services					
Specific: Emergency Shelter Services					
Total	USD\$ 72,000.00	USD\$ 72,000.00	USD\$ 0.00	USD\$ 0.00	USD\$ 0.00

Budget Narrative

All costs were determined using the previous budget of actual costs to provide current services.

- Personnel Salaries / Wages in the amount of \$30,600 a year for a Coordinated Entry/Eligibility Specialist (CE/ES) to conduct intakes as required by Access points as well as assist homeless clients with applications for benefits
- Admin – Administrative costs are calculated at 15% of the total request.

Documents

Documents Requested *

Required? Attached Documents *

Commitment letters for all leveraged funds/Letters of Support



[YNHS - CE Network](#)

[YNHS - CE Rods House](#)

[YNHS - CE UGM](#)

Verification and Signature (2018 RFP APPLICATION COVER SHEET)
[download template](#)



[YNHS CE - Verification](#)

Project Map/Program Service Area

[YNHS - CE Map of Service Area](#)

For Non-Profits: IRS Form 990



[YNHS - CE - 990](#)

For Non-Profits: Board Documentation (List of Board Members, Charter, ByLaws)	✓	YNHS - CE Board of Directors
For Non-Profits: 501(c)3 Tax Exempt Letter	✓	YNHS - CE IRS tax exempt status YNHS - CE - Tax ID Certification
General Liability Insurance Certificate	✓	YNHS - CE Liability
Agency's Audit Report for the most recent Fiscal Year	✓	YNHS - CE Audit
Other relevant documentation		YNHS - CE Rhonda Hauff Qualifications YNHS - CE Annette Rodriguez Qualifications
Board Documentation (List of Board Members, Organizational Chart)	✓	YNHS - CE Bylaws

* ZoomGrants™ is not responsible for the content of uploaded documents.

Application ID: 110600

Become a [fan of ZoomGrants™](#) on Facebook
 Problems? Contact us at Questions@ZoomGrants.com
 ©2002-2018 GrantAnalyst.com. All rights reserved.
 "ZoomGrants" and the ZoomGrants logo are trademarks of GrantAnalyst.com, LLC.
[Logout](#) | [Browser](#)