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.

The YNHS Housing and Essential Needs (HEN) project provides access to essential needs items and potential housing assistance for low-income adults who are unable to work for at least 90 days due to a physical or mental incapacity and are ineligible for Aged, Blind, or Disabled (ABD) cash assistance. This project is in partnership with the Washington State Department of Social and Health Services.

- Limited Rent and Utility Assistance
- Personal health and hygiene items
- Transportation assistance

The Yakima Neighborhood Health Services (YNHS) HEN program utilizes the Housing First model. 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. Housing First and Rapid Rehousing (RRH) has demonstrated success by helping households exit homelessness and not return to shelter. HUD released the evaluation of the first and second years of the HPRP program, finding nearly 85% of RRH program participants exited to permanent housing. Further evidence was provided by the Short-Term Impact Report conducted in 2015 with the following findings in regards to Housing First:

- Families that enrolled in a RRH program exited shelter in an average of 2 to 3.2 months faster than those that were referred to RRH but did not enroll.
- 77% of families that enrolled in RRH did not return to shelter.
- Families referred to RRH had incomes 10% higher than those referred to usual care. RRH also led to improvements in food security relative to usual care.
- 5 families can be rapidly re-housed ($6,578 per family) for what it costs to house one family in transitional housing ($32,557...
We anticipate most of these residents will need multiple contacts each week as they transition from the streets to individual units. Case Management also provides case management services which support housing stability and self-sufficiency. We anticipate most of these residents will need multiple contacts each week as they transition from the streets to individual units. Case Management also includes a complete assessment of functional status, and identification of support needs, both urgent and long term, prioritizing safety and basic needs first. Addition support includes health interventions (primary care, including mental health and chemical dependency), referrals, and Tenancy supports, providing guidance to residents on apartment maintenance, budgeting, community living, landlord relations, etc. Case managers will also conduct Weekly inspections of each resident’s unit to identify physical repairs / updates needed. Additional funds are for a Landlord Stabilization fund for repairs and maintenance of unusual wear and tear to the leased units.

This project addresses the following barriers identified in the Yakima County’s 5-Year Homeless Plan (5-Year Plan): Housing First/Harm Reduction housing (for chronically unsheltered and other high-needs populations) and Additional units of Permanent Supportive Housing. Additionally, these projects also address Goal 1 of the Plan: Make homelessness brief and rare (by providing RRH and accompanying case management services for all non-chronically homeless households).

Alignment with the Action Plan includes:
• Goal 4: Create additional RRH options to provide a transition from homeless shelter to more permanent housing
  o 4.1 Work with landlords to gain acceptance to participate in this program with existing housing
  o 4.3 Work with the owners of existing motels, single room occupancy and other existing structures
  o 4.4 Provide funding for case management related to the human service needs of those in the RRH programs
• Goal 5: Expand Permanent Supportive Housing options and prioritize services and housing for chronic homeless families and individuals using Coordinated Entry
  o 5.1 Promote Housing First as a model of care. We encourage providers to obtain Housing First Certification through CSH.

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.

An estimated 317 individuals a year will be served by the HEN Program which is focused on assisting individuals literally homeless or at-risk of being homeless with housing assistance. This project serves chronically homeless individuals and households as well as those with disabilities and special needs population. Needs met include housing, case management, utility deposits, security deposits, application fees to landlords, hotel/motel vouchers while waiting for vouchers, and supportive services. Last year, this program served 327 households and 331 individuals.

This project addresses the following target populations identified in the Yakima County’s 5-Year Homeless Plan (5-Year Plan): Housing First/Harm Reduction housing (for chronically unsheltered and other high-needs populations) and Additional units of Permanent Supportive Housing. Additionally, these projects also address Goal 1 of the Plan: Make homelessness brief and rare (by providing RRH and accompanying case management services for all non-chronically homeless households).

Yakima Neighborhood Health Services (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/ACTIVIES: 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.

HEN support services include 1) a complete assessment of functional status, and identification of support needs, both urgent and long term, prioritizing safety and basic needs first; 2) Support for health interventions (primary care, including mental health and chemical dependency) and referrals; 3) Tenancy supports, providing guidance to residents on apartment maintenance, budgeting, community living, landlord relations, etc.; 4) Weekly inspections of each resident’s apartment to identify physical repairs / updates needed; and 5) Case management services to support housing stability and self-sufficiency.

We anticipate most of these residents will need multiple contacts each week as they transition from the streets to individual...
In addition to services provided by HEN, YNHS has adopted the Screening, Brief Intervention, and Referral for Treatment (SBIRT) approach and screening to identify those with SUDs or CODs. If the SBIRT screening indicates drug use within the past year additional screening using the Drug Abuse Screening Test (DAST) will be administered. Those whose screening indicates little or no risky behavior will not be included in this program but will continue to receive all other services available to the homeless. With further engagement over time, if it appears that risky behavior is present, the client will be re-screened and may become eligible for the program at that time. Those whose scores indicate moderate risky behaviors will be referred to the behavioral health staff at YNHS to develop an appropriate treatment plan for brief intervention and treatment. Our staff includes masters trained behavioral health specialists, a psychiatric Nurse Practitioner, and a psychologist. Those persons with high scores will be referred to one of our partner organizations for further diagnostic assessment, development of a treatment plan, and more intensive, long term specialty treatment. Comprehensive Health Services will provide Detoxification services and Triumph Treatment Services will provide residential treatment of 90-days or less. Both will also provide more intensive integrated specialty mental health and substance use disorder outpatient services. Third party payors, including Medicaid, will be billed for these services by each agency. YNHS will reimburse at Medicaid rates for services provided to uninsured clients.

The frequency and duration of services are based on the individual’s identified need. Specific services, align with the following goals in the 5-year plan:

- **Goal 4:** Create additional RRH options to provide a transition from homeless shelter to more permanent housing
  - 4.1 Work with landlords to gain acceptance to participate in this program with existing housing
  - 4.3 Work with the owners of existing motels, single room occupancy and other existing structures
  - 4.4 Provide funding for case management related to the human service needs of those in the RRH programs

- **Goal 5:** Expand Permanent Supportive Housing options and prioritize services and housing for chronic homeless families and individuals using Coordinated Entry
  - 5.1 Promote Housing First as a model of care. We encourage providers to obtain Housing First Certification through CSH.

### 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.*

Project and services are located in Yakima and Sunnyside. The Yakima location is near a public transit line though YNHS provides coordination or provision of transportation as needed to medical appointments, occupational and/or physical therapy. Our Sunnyside offices are accessible via the Community Connector, as well as YNHS-provided transportation for individuals with other barriers.

### 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.*

Homelessness, or the threat of homelessness, is a reality for many living in Yakima County. The Fair Market Rent (FMR) for a two-bedroom apartment is $814. In order to afford this level of rent and utilities, without paying more than 30% of income on housing, a household must earn $2,713 monthly or $32,560 annually. Assuming a 40-hour work week, 52 weeks per year, this level of income translates into a Housing Wage of $15.65 an hour (National Low-Income Housing Coalition; Out of Reach 2017). In Yakima County, there are an estimated 30,003 Renter Households, who earn an average of $11.27 an hour. To afford a two-bedroom apartment at FMR, they would have to work 1.4 fulltime jobs. Currently, Yakima County has an extremely low vacancy rate which means that landlords can often raise their rates and still find tenants. In 2015, 52.3% of all renter households in Yakima County paid more than 30% of their income towards housing (US Census; American Community Survey 2011-2015). It is almost impossible to secure housing without considerable cash. Move in costs are estimated to be at least $3,000, including application fees, background and credit checks, security deposits, and first and last month’s rent.

The two models that have informed the design of the HEN program are Housing First and Trauma Informed Care in their design of services and activities. 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:**
  - A focus on helping individuals and families access and sustain permanent rental housing as quickly as possible;
  - A variety of services delivered to promote housing stability and individual well-being on an as-needed and entirely voluntary basis; and
  - A standard lease agreement to housing – as opposed to mandated therapy or services compliance.
- **While all Housing First programs share these elements, program models vary significantly depending upon the population**
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. **ACCESSIBILITY**: 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. YNHS is also increasing outreach to private landlords.

The intended audience for this outreach is homeless individuals and families as well as private landlords to aid in housing placement.

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.

Eligibility for a referral to the HEN program is determined by DSHS. After the initial referral, 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.
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.

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.
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) | 317 |
| Unduplicated Households (7/1/18 - 6/30/19) | 317 |
| TOTAL | 634.00 |

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 1 – HEN Certified Housing: 58 individuals a year will be housed and assisted with rent and move-in costs
• Service 2 – Housing Stability: 58 Individuals a year will be supported will supportive services
• Service 3 – Essential Needs and Transportation: 271 individuals served a year with identified needs to ensure housing stability and homeless prevention

All intake and assessment data is entered into HMIS system within 24 hours. HMIS is the primary tool for tracking and monitoring clients and services provided.

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:
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 barrier to meeting the suggested performance target that the average length of time between enrollment and move-in of 14 days or less is the lack of permanent housing options. 2017 Point in Time identified a 25% decrease in Permanent Supportive Housing (PSH) and current vacancy rate of fair market housing is less than 1%. Our strategy for address the last of permanent housing exit options is maintaining relationships with local landlords and working with the Homeless Network of Yakima County’s Affordable Housing Committee to address the lack of affordable housing.

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.*

This is not a Coordinated Entry project.

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 - process for HEN certified clients included:

- All HEN Clients are referred by the Washington State Department of Health. 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 – the case manager assists clients in obtaining the necessary documentation:
  - 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)
    - Signed and dated statements validating situation on letterhead from outreach workers and/or organizations that assisted the person in the recent past OR
    - 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
    - Verification from Homeless Network member known by YNHS staff with first-hand knowledge of client situation.
    - 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):
    - Verification signed and dated on shelter letterhead.
    - Shelter’s bed-night roster.
    - 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.

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 action plan for HEN certified clients is included:

YNHS’s action plan for meeting the performance target of 90% of clients exiting from the program into permanent housing is to enroll them in the program as the project places them into permanent housing.
The strategy for keeping returns to homelessness less than 5% is by providing Housing Stability services through the provision of a case manager. The greatest barrier to meeting the suggested performance target that the average length of time between enrollment and move-in of 14 days or less is the lack of permanent housing options. 2017 Point in Time identified a 25% decrease in Permanent Supportive Housing (PSH) and current vacancy rate of fair market housing is less than 1%. Our strategy for address the last of permanent housing exit options is maintaining relationships with local landlords and working with the Homeless Network of Yakima County’s Affordable Housing Committee to address the lack of affordable housing.

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 placing clients into TH or PSH

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.

<table>
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<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>Does your agency own the property or have a contract to purchase or lease the property?</td>
<td>N/A</td>
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<tr>
<td>Does the proposed use of project comply with city zoning codes and state regulations?</td>
<td>N/A</td>
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<tr>
<td>Will this project require relocating individuals and if so, does your agency intend to comply with the Uniform Relocation Act (URA)? (See Library Tab)</td>
<td>N/A</td>
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<tr>
<td>Does the proposed use of this project directly benefit homeless individuals?</td>
<td>N/A</td>
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<tr>
<td>Does this proposed project align with the goals outlined in the Yakima County 5-Year Plan? (see Library Tab)</td>
<td>N/A</td>
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</table>

0.00 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
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 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?

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

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

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<th>Budget</th>
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<td>Personnel Costs (Direct - 100% to program)</td>
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<td>USD$ 83,328.00</td>
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<tr>
<td>Facilities Costs (Rent/Mortgage)</td>
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<tr>
<td>Operating Costs (Insurance, Utilities, Phone, Supplies, Mileage, etc.)</td>
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<tr>
<td>Operating Equipment (max $1,500)</td>
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<tr>
<td>Program Expenses: Specific: Case Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific: Hotel/Motel Vouchers</td>
<td></td>
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<tr>
<td>Specific: Coordinated Entry Access Point</td>
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<tr>
<td>Specific: RRH/RA - (For-Profit Only)</td>
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<tr>
<td>Specific: TANF RA - (For-Profit Only)</td>
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<tr>
<td>Specific: HEN RA</td>
<td>USD$ 960,400.00</td>
<td>USD$ 960,400.00</td>
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<tr>
<td>Specific: Outreach Services</td>
<td></td>
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<tr>
<td>Specific: Emergency Shelter Services</td>
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<tr>
<td>HEN - Essential Needs</td>
<td>USD$ 20,000.00</td>
<td>USD$ 20,000.00</td>
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<tr>
<td>Transportation</td>
<td>USD$ 24,000.00</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>USD$ 1,273,728.00</strong></td>
<td><strong>USD$ 1,273,728.00</strong></td>
</tr>
</tbody>
</table>

**Budget Narrative**

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

- The Personnel Costs include salary and benefits for 1.5 Case Managers to provide supportive services for home retention.
- The HEN RA line item includes estimated rental assistance for 24 months and is based on current actuals:
- Essential Needs line item is for Hygiene items associated with the HEN project for 24 months and is based on current actuals.
- Transportation costs line item is for bus passes that are distributed by the HEN project for 24 months and is based on current actuals.
- Administrative costs line item is a rate of 7%.

**Documents**

<table>
<thead>
<tr>
<th>Documents Requested *</th>
<th>Required?</th>
<th>Attached Documents *</th>
</tr>
</thead>
</table>
| Commitment letters for all leveraged funds/Letters of Support | ✔ ✔ ✔ ✔ | YNHS - HEN Network  
YNHS - hen Rods House  
YNHS - HEN UGM |
<p>| Verification and Signature (2018 RFP APPLICATION COVER SHEET) | ✔ ✔ ✔ ✔ | YNHS HEN Verification |
| Project Map/Program Service Area | | YNHS HEN Map of Service Area |
| For Non-Profits: IRS Form 990 | ✔ ✔ ✔ ✔ | YNHS - HEN 990 |
| For Non-Profits: Board Documentation (List of Board Members, Charter, ByLaws) | ✔ ✔ ✔ ✔ | YNHS - HEN Board of Directors |
| For Non-Profits: 501(c)3 Tax Exempt Letter | ✔ ✔ ✔ ✔ | YNHS - HEN IRS tax exempt status |</p>
<table>
<thead>
<tr>
<th>Document Type</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Liability Insurance Certificate</td>
<td>✔️</td>
<td>YNHS - HEN Liability</td>
</tr>
<tr>
<td>Agency's Audit Report for the most recent Fiscal Year</td>
<td>✔️</td>
<td>YNHS - HEN Audit</td>
</tr>
<tr>
<td>Other relevant documentation</td>
<td></td>
<td>YNHS - HEN Rhonda Hauff Qualifications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YNHS - HEN Annette Rodriguez Qualifications</td>
</tr>
<tr>
<td>Board Documentation (List of Board Members, Organizational Chart)</td>
<td>✔️</td>
<td>YNHS - HEN Bylaws</td>
</tr>
</tbody>
</table>

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