



Social Action Funding Application FY 2009-2010

THIS APPLICATION RESPONDS TO ADULT FUNDING PRIORITIES

SOCIAL ACTION FUNDING: HEALTH ____ FOOD/NUTRITIONAL SVC ____
 SELF SUFFICIENCY ____ DAY/DROP-IN SVC. ____

HOMELESS INITIATIVE: EMERGENCY SHELTER ____

1 X (Time) ONLY HOMELESS FUNDING: PROGRAM SVC. ____

Agency Information:

Legal Name of Organization: _____

Complete Mailing Address: _____

Program Name: _____

Executive Director/CEO: _____

Email: _____ Phone: _____

Contact Person for this Application: _____

Title: _____ Phone: _____

Email: _____ Fax: _____

Federal Tax Identification Number: _____

Total agency budget applied to Pinellas County \$ _____

AGENCY MISSION:

<u>Funding Requests and Priorities</u>		Pinellas County			Rank #	Required for Match? *
Program Names for which funding is being requested	Social Action Funding	Homeless Initiative	1 Time Homeless Funding			
Total Funds Received in FY 2009→		\$ _____				
	\$	\$	\$	1	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$	\$	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$	\$	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$	\$	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	

*See the Glossary for a definition of **Match** and see page 9 to determine **Match** requirement

Received in funder's office by: _____ Date: _____

Agency Name: _____

To be used by Review Panel/County staff

AGENCY _____

Y/N	COMMENTS	
	ATTACHMENTS	
	501(c)(3)	
	Agency Organizational Chart	
	Program Organizational Chart	
	Required Job Descriptions	
	Agency Budget	
	Program Budget	
	Match Ratio _____:_____	
	State Registration is filed/current	
	Current Certificate of Insurance	
Contract Compliance - Currently funded agencies, only		
	Documentation of Match	
	Fiscal Reports	
	Outcome Reports	

COMMENTS - FOR STAFF USE	

Agency Name: _____

Efforts to Secure Additional Funding

☞ Refer to application guidelines on page 4 and rating form (Appendix A).

List all efforts to obtain funding from other sources during FY 2008/09, to support your program AND agency.

☞ Attach additional sheets, as needed.

Date:	Amount:	Source:	Result:
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Agency Name: _____

AGENCY BUDGET

☞ Refer to application guidelines on page 5 and rating form (Appendix A).

	LAST FY	CURRENT FY	PROJECTED FY
List mo/yr - mo/yr for each FY →	_____ - _____	_____ - _____	_____ - _____
Revenue:			
Federal	_____	_____	_____
State	_____	_____	_____
Local Government	_____	_____	_____
* City	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
* County	_____	_____	_____
School Board	_____	_____	_____
JWB	_____	_____	_____
United Way	_____	_____	_____
Contributions	_____	_____	_____
Fundraising	_____	_____	_____
** In-Kind (<i>specify</i>)	_____	_____	_____
Interest (<i>specify</i>)	_____	_____	_____
Foundation/Endowment	_____	_____	_____
Program Fees (<i>explain</i>)	_____	_____	_____
_____	_____	_____	_____
Misc. (Dues, Sales)	_____	_____	_____
TOTAL REVENUE:	_____	_____	_____
Expenditures:			
Salaries	_____	_____	_____
Fringe Benefits	_____	_____	_____
Operating Expenses	_____	_____	_____
** In-Kind Costs (<i>specify</i>)	_____	_____	_____
Capital Expenses	_____	_____	_____
TOTAL EXPENDITURES:	_____	_____	_____
***SURPLUS (+) OR DEFICIT (-)	_____	_____	_____

* Include this funding request in your proposed Revenue for FY10.

** Note: In-kind income and expense should balance out.

*** Please explain reason for any significant surplus or deficit.



ATTACH an organizational chart for agency.

Agency Name: _____

Funding Program: SAF: <input type="checkbox"/> HI: <input type="checkbox"/> 1X Only <input type="checkbox"/> Program Name: _____
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Purpose of Funding Request: (seven words or less, please) _____	*Sole Source? <input type="checkbox"/> Yes <input type="checkbox"/> No (to be approved by staff)	
Amount of Request: \$ _____	Match Ratio: _____ : _____	Unduplicated # to be served: _____

PROGRAM NARRATIVE  Refer to the guidelines on page 5 and the rating form (Appendix A).

 **ATTACH** an organizational chart for this program. ▪ **DO NOT EXCEED THIS PAGE.**

Please provide a BRIEF explanation describing the need for this request.
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Agency Name: _____

PROGRAM OUTCOME OBJECTIVES MATRIX

This form will become your Programmatic Report

☞ Refer to application guidelines on page 6 and 8 and rating form (Appendix A).

Program Goal: _____

Objectives - UNDUPLICATED #'S Include <u>both</u> process and outcome objectives as appropriate to your program (qualitative and/or quantitative, please show #'s & %)	Outcome Indicators How will we know when the objectives are achieved?	Comments/Status
<p>1. An unduplicated number of persons _____, will be served.</p> <p>2. Collaborative partnerships will be maintained or grown by responding to community need. _____#</p> <p>3. 80% of target population will be linked to health & social service programs.</p>		

SHELTER PROGRAM OUTCOME OBJECTIVES MATRIX

PROGRAM GOAL: To improve the living situation of homeless persons by providing emergency shelter and supportive services and assisting them in obtaining and sustaining permanent housing.

Objectives	Outcome Indicators	Status of Indicators
<p>1. 80% of shelter residents who remain in the shelter for 72 hours will have completed the Client Assessment.</p> <p>2. 60% of shelter residents remaining for 72 hours will have a completed Case Plan within 7 days.</p> <p>3. 45% of shelter residents will secure stable transitional or permanent housing (includes public housing, Section 8, private landlord, transitional housing, program placement, living with family or friends) upon program discharge or case closure.</p> <p>4. 25% of shelter residents will obtain/maintain employment or some source of income, which includes county vouchers, by program completion/discharge or case closure.</p> <p>5. 40% of successfully housed shelter residents, excluding those placed in programs, will remain housed for at least six (6) months after program completion or discharge</p> <p>6. 90% compliance with TBIN data entry.</p> <p>7. ____ persons will receive shelter in 2009/2010.</p>	<p>1. As determined by electronic tracking through TBIN, electronic client tracking logs, and responses on Client Assessment and Case Plan forms.</p> <p>2. As measured by responses on CC's electronic client tracking logs and Case Plan forms. Exit Assessment form.</p> <p>3. As measured by TBIN, electronic client tracking logs and Exit Assessment form.</p> <p>4. As measured by TBIN, electronic client tracking logs and Exit Assessment form.</p> <p>5. As measured by electronic tracking logs, case plans, exit assessment and follow-up tracking process.</p> <p>6. As measured by TBIN UDE/PSDE Reports on accuracy and completion rates.</p> <p>7. Daily census will be maintained in TBIN as well as the electronic client tracking logs.</p>	

INDIVIDUAL ADJUSTMENTS MAY BE MADE BASED ON MUTUAL AGREEMENT BETWEEN THE COUNTY AND THE PROVIDER FOR PROGRAMS ADDRESSING THE HOMELESS POPULATION WITH ADDITIONAL SPECIFIC NEEDS.

Subsequent percentage requirements may be adjusted while tracking/monitoring systems are developed and refined.

Agency Name: _____

Program Name:

PROGRAM BUDGET ☞ Refer to Glossary, application guidelines pg. 6 and rating form (Appendix A).

	[1] Last FY	[2] Current FY	[3] Projected FY	[5] County Request
Indicate mo/yr - mo/yr for each FY →	____ - ____	____ - ____	____ - ____	
PROGRAM REVENUE				
Federal/ State	_____	_____	_____	
Social Action Funding/HI/ 1X Only	_____	_____	_____	
Other Local Govt. (City, County, JWB, etc.)	_____	_____	_____	
Contributions/Fundraising	_____	_____	_____	
In-Kind	_____	_____	_____	
Program fees	_____	_____	_____	
Other (specify)	_____	_____	_____	
Misc. (dues, sales, etc.)	_____	_____	_____	
TOTAL PROGRAM REVENUE:	=====	=====	=====	
PROGRAM - PERSONNEL EXPENSES				
Regular Salaries and Wages	_____	_____	_____	
Benefits (FICA, health, unemployment, Worker's Comp, etc.)	_____	_____	_____	
Subtotal Personnel Expenses	=====	=====	=====	
OPERATING EXPENSES				
In-Kind	_____	_____	_____	
Travel (including conference/training)	_____	_____	_____	
Professional / Contractual Services	_____	_____	_____	
Accounting / Auditing	_____	_____	_____	
Insurance	_____	_____	_____	
Utility Services (electric, water, phone, etc.)	_____	_____	_____	
Rentals/Leases (buildings, land, vehicles)	_____	_____	_____	
Maintenance/Repair (buildings, equipment, vehicles)	_____	_____	_____	
Office Supplies	_____	_____	_____	
Printing/Binding/Copying	_____	_____	_____	
Postage/Shipping	_____	_____	_____	
Conference/Training	_____	_____	_____	
Specific Assistance to Individuals	_____	_____	_____	
Other (specify)	_____	_____	_____	
Other (specify)	=====	=====	=====	
Other (specify)	=====	=====	=====	
Subtotal Operating Expenses	=====	=====	=====	
TOTAL EXPENSES	=====	=====	=====	
			↓	Total Request
Total PROGRAM budget is what percentage of AGENCY budget?			_____ %	
County funding request is what percentage of the PROGRAM budget?		 %	
County funding request is what percentage of the AGENCY budget?		 %	

Agency Name: _____

Program Name:

☞ Refer to application guidelines on page 6 and rating form (Appendix A).

PROGRAM BUDGET NARRATIVE

NOTE: If salary/fringe is requested, please list/detail positions for which funding is requested. (job descriptions must be attached)

% of Time Spent on Program	Position/Last Name of Employees	Actual Salary & Fringe FY10	Projected Salary & Fringe FY10	Funding Request Salary & Fringe FY10
50%	John Smith, Case Manager	\$ 29,000	\$ 31,500	\$11,250

MATCH REQUIREMENT(S) (if applicable)

☞ Refer to Glossary (Appendix B) for a definition and to rating form (Appendix A).

Source of Funding ("A") Requiring Local Match	Total of Funding From Source "A"	Required Local Match ("B")	Match Ratio
EXAMPLE: HUD	\$ 80,000	\$ 20,000 (County SAF)	(4:1)
_____	\$ _____	\$ _____	_____ : _____
"A"	"A"	"B"	"A" : "B"
_____	\$ _____	\$ _____	_____ : _____
"A"	"A"	"B"	"A" : "B"