**EXHIBIT A**

**CITY OF GARDEN GROVE**

**HEART PROGRAM**

**APPLICATION OUTLINE**

|  |  |
| --- | --- |
| Name of Organization |  |
| Tax ID Number |  |
| DUNS Number |  |
| Organization Contact Name and Title |  |
| Mailing Address |  |
| Telephone |  |
| Email Address |  |
| Fax |  |

*The undersigned certifies the information contained herein is true, correct and complete to the best of his/her knowledge and belief. The applicant further understands that the application is a request and there is no guarantee, expressed or implied, that funds will be provided to applicant. All organizations awarded federal funds will be subject to federal, state and local regulatory compliance.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Title of Authorized Person

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Person

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Section 1. Experience of the Program Operator**

1. Describe the homeless population your agency serves and the specific types of services provided. How long has your agency been providing homeless services?
2. Describe your experience working with the homeless and specifically the chronically homeless population.
3. Describe your experience in assisting the chronically homeless secure permanent housing and providing case management services.
4. Describe your knowledge of available County housing resources and experience making client referrals to the programs.
5. Describe your experience, if any, working with mental, behavioral and medical health professionals in support of homeless individuals.
6. Identify agency personnel who will be directly involved in implementing the City program; describe all relevant experience of each individual.
7. Does your agency currently utilize HMIS/CMIS? Does your agency have staff trained to conduct VI-SPDAT assessments? Identify trained and authorized personnel.

**Section 2. Service Approach**

1. Describe the methodology your agency uses to assess services needed by families, including an evaluation of barriers to self-sufficiency and/or housing stability. Include information on how critical issues such as mental health, physical health, drug abuse or other related conditions are addressed.
2. Provide evidence of demonstrated success in providing case management services that include coordinating and securing resources (including those targeted to credit repair) and developing individualized housing service plans. Include a discussion of successful outcomes achieved by clients (such as housing stability, drug treatment and health care services, etc.)
3. Describe the networks and/or collaborative efforts your agency currently participates in, the types of assistance available through those networks, and how those resources are used in your case management delivery system. Include information on how your agency proposes to leverage outside resources for the benefit of program participants.
4. Describe how your agency measures the progress of individual clients.
5. Describe your proposed assessment techniques and methodology.
6. Describe how your agency measures the effectiveness of your case management delivery system. Include information on improvement and/or adjustments your agency has made to its case management delivery system in the past five years. Why did you make these changes and how have the changes impacted outcomes?
7. Describe your bridge and permanent housing resources that will be available to program participants. Does your agency have access to units and if so how many. Does your agency have any agreements with landlords, which includes master leases? Describe your agency’s methodology to secure permanent housing units for the program.

**Section 3. Program Budget/Financial Management**

1. Provide an itemized operating budget of the proposed program for a 12-month period, which includes up to $250,000 in HOME and $50,000 in LMIHTF funding. The budget should include proposed matching resources. Please include the matching information in the following table.

|  |
| --- |
| **Category LMIHTF Funds HOME Funds Other Funds Total**  |
| Personnel Services |
| Salaries |  $  | $ |  $  |  $  |
|   |  $  | $ |  $  |  $  |
|  |  $  | $ |  $  |  $  |
| Operating Costs |
|  |  $  | $ |  $  |  $  |
|  |  $  | $ |  $  |  $  |
|  |  $  | $ |  $  |  $  |
|  |  $  | $ |  $  |  $  |
|   |  $  | $ |  $  |  $  |
| Other Costs |
|   |  $  | $ |  $  |  $  |
|  |  $  | $ |  $  |  $  |
|   |  $  | $ |  $  |  $  |
| **Totals:** |  **$**  | **$** |  **$**  |  **$**  |

B. If applicable, explain the funding source and status of any funds listed as 'Other Funds' above. Be specific.

C. If applicable, describe the types of in-kind services to be dedicated to the City program and the approximate value of such services.

D. Describe your agency’s experience in managing grant funds and grant-funded programs, including policies, procedures, and internal reviews for compliance with federal, state and local regulations and requirements.