

**MONROE COUNTY
HUMAN SERVICES ADVISORY BOARD
Application for Funding
Application Due at Noon, Thursday, May 4, 2023*
Fiscal Year
October 1, – September 30,**

| | |
|---|--|
| Agency Name | |
| Physical Address | |
| Mailing Address | |
| City, State, Zip | |
| Phone | |
| Email | |
| Whom should we contact with questions about this application? | |

Amount requested for the upcoming fiscal year and select the category that best matches the proposed services. If the proposed program involves more than one (1) category enter the budget request for each category.

Amount of Request

Note: Funding requested should equal the Budget Q.36 (pg. 15) Total FY24 Request

| |
|--|
| For Fiscal Year _____, specifically how will the amount requested be utilized? |
| |

COVER LETTER (REQUIRED)

PART I: Provide a brief overview of your organization.

PART II: Indicate any change in organizational structure specific to services or method of providing services. The intent is to inform the HSAB of any consolidating, combining, or merging with other agencies to avoid duplication of services.

1. Who prepared your application?

Application was prepared by an internal source(s)

Application was prepared by an external source(s)

Preparation of the application was a collaborative effort with an external source.

Other (explain): _____

2. Please list below any overlap, common associations, common services, working relationships or sub-contractor relationships with any other organizations i.e., board members, personnel or shared services.

3. Describe any networking arrangements that are in place with other agencies.

4. What unique role in the community does the proposed program fulfill that no one else does?

5. Insert your agency's board-approved mission statement only.

6. List the services your agency provides.

7. What specific services will be funded by this request?

8. Have you previously been funded by HSAB? Yes No

9. Will County HSAB funds be used as match for a grant? Yes No

10. If your organization was awarded HSAB funds in FY 2023, please briefly and specifically explain:

a. How have the FY 2023 HSAB funds been spent?

b. Were all HSAB funds awarded in FY 2022 spent? Will all HSAB funds awarded in FY 2023 be spent?

c. Were HSAB funds used to leverage additional funding in FY 2023 and if so how?

d. How much additional funding was received?

e. How was the additional funding spent?

11. Have you experienced any changes specific to:

a. Mission Statement. Yes No

b. Goals. Yes No

c. Expansion or contraction of services, staff or location. Yes No

d. How prior year funds were spent. Yes No

12. Did your agency lose any funding, or partial funding in 2023? Yes No

13. Do you plan to allocate any part of this HSAB grant, if awarded, as a sub-grant to another organization?
Yes No

Please include these on the County HSAB Funding Budget form under “Grants to Other Organizations.”

14. Does your organization allocate sub-grants to other organizations using other (non-County) sources of funding? Yes No

Please include these on the Agency Expenses form, under “Grants to Other Organizations.”

15. Will you or have you applied for other sources of County funding? Yes No

Please include these on the Agency Revenue form.

16. What needs or problems in this community does your agency address?

17.

18.

19. Describe your target population as specifically as possible.

20. How are clients referred to your agency?

21. What steps are taken to ensure prospective clients are eligible and the neediest clients are given priority?

22. List all sites and hours of operation. Please note if these sites will be using HSAB funding and whether or not each site is currently utilized by your organization.

23.

24. What organizational challenges do you expect in the next two years, and how do you plan to respond to them?
25. How are clients represented in the operation of your agency?
- 26.
27. _____ hours of program service were contributed by _____ volunteers in the last year (FY2022 - October 1, 2021 through September 30, 2022).
28. Will any services funded by the County HSAB award be performed by an independent contractor and/or under a subcontract? If yes, what services, and who will perform them? (Report in Budget Q36 and Q37)
29. What measurable outcomes do you plan to accomplish in the next funding year?

30.

32. Address any topics not covered above (*optional*).

AGENCY REVENUE

Complete this worksheet for the entire agency. In-Kind will not be included in percentages

Note: Dates correspond with your fiscal year.

Dates of FY end will auto-fill (below) to correspond with dates entered from Q.37

38.

| | Proposed Revenue Budget for Upcoming Fiscal Year Ending: | | | Projected Revenue for Current Fiscal Year Ending: | | |
|---------------------------|---|---------|---|--|---------|---|
| | Cash | In-Kind | % | Cash | In-Kind | % |
| Revenue Sources | | | | | | |
| LOCAL GOVERNMENT: | | | | | | |
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| ALL OTHER SOURCES: | | | | | | |
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| Total Revenue | | | | | | |

EMPLOYEE INFORMATION

39. What is the current number of employees, full-time and part-time, on the payroll for the entire organization?

There are _____ employees ("snapshot") as of today's date

40. Please list the positions, if any, within your organization that are currently vacant and explain why each position is vacant.

ADDENDUM TO THE FY2023 HSAB APPLICATION COVID-19 ASSISTANCE

A.1. Did your organization receive any local, state, federal assistance (i.e. Paycheck Protection Program, EIDL, CARES Act) or insurance for your COVID-19 related impacts? Yes _____ (Describe Below) No _____

| Revenue Sources/ Award Title | Jan 2022 - Dec 2022 Cash | Jan 2022 - Dec 2022 In-kind | Jan 2023 -Dec 2023 Cash | Jan 2023 -Dec 2023 In-kind | Is Payback Forgiven? Yes/ No/Pending | Purpose: |
|---------------------------------|--------------------------------|-----------------------------------|-------------------------------|----------------------------------|--|----------|
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| Total Covid-19 Assistance | | | | | | |

ATTACHMENT CHECKLIST

| Item | Help | ATTACHMENT TITLE | ATTACHED | | ATTACHMENT | COMMENTS |
|------|---|--|----------|----|---|---|
| | | | YES | NO | | |
| | | | | | | IF NOT ATTACHED,PLEASE EXPLAIN |
| EX | | SAMPLE ITEM WITH ATTACHMENT | | |  | |
| EX | | SAMPLE ITEM WITHOUT ATTACHMENT | | | | This does not apply to our org. |
| A |  | Evidence of Annual Election of Officers | | | |  |
| B |  | Unqualified Audited Financial Statement* or Statement of Functional Expenses | | | |  |
| C |  | Copy of submitted IRS Form 990 for most recent fiscal year (Enter Period Date in Comments) | | | |  |
| D |  | Copy of current fee schedule | | | | |
| E |  | Proof of Registration with Fl. Department of Agriculture & Consumer Services. | | | |  |
| E.1 |  | Proof of Exemption with Fl. Department of Agriculture & Consumer Services. | | | | |
| F |  | Copy of IRS Letter of Determination indicating 501 C 3 status | | | |  |
| F.1 |  | Copy of GUIDESTAR printout | | | |  |
| G |  | Copy of Personnel Manual for hiring policies, drug free workplace and EEO provisions. | | | |  |
| H |  | Copy of Florida Dept. of Children & Families (DCF) License or Certification. | | | | |
| I |  | Copy of any other Federal or State Licenses. | | | |   |
| J |  | Copy of Florida Department of Health Licencses/Permits. | | | |   |
| K |  | Copy of Current Occupational Licenses for Organization & Independent Contractors | | | |  |
| L |  | Audit Documentation, for recipients of \$100K+ from Monroe County.** (See Instructions) | | | |   |
| M |  | Copy of Organization's Corporate Bylaws. | | | |  |
| N |  | Copy of Summary Report of most current Evaluation/Monitoring.*** | | | |    |
| O |  | Data showing need for your program. (Q.17) | | | |  |
| P |  | Certification Page - Blank Page is available here.  | | | |  |
| Q |  | Other - If additional space is needed to address earlier questions please label and include here. | | | |  |

(B)*Resolution No. 277-2009 - For organizations with total annual expenditures of \$150,000, including the amount of the County grant, an annual audited financial statement from the organization's most recently completed fiscal year and an IRS Form 990 also from the organization's most recently completed fiscal year. (If the audit is qualified, the organization must include a statement

of deficiencies with corrective actions recommended/taken. (L)**Proof CPA who performs audit is a member of the AICPA, malpractice insurance & County considered "intended recipient" of said audit. (N)*** Must include summary of deficiencies and suggested corrective action; may include your responses and actions taken.