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 <u>measurable</u> outcomes do you plan to accomplish in the next funding year?

30.

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

BOARD INFORMATION
You must have at least five directors

33.

Name/Board Position	Affiliation/Title	City/State	Telephone No.	Years Served	Current Term Expiration Date

AGENCY COMPENSATION DETAIL

Include each position in the entire agency

Put an " ✓ " next to each position directly related to program for which funding is requested.
A 40-hour/week employee would be 1.00 FTE; a 20-hour/week employee would be .5 FTE, etc. Indicate
whether the position is programmatic or administrative, with a "P" or "A" next to that position.
Note: Dates correspond with your fiscal year

34.

Position Title	"✓"	# FTE'S	Proposed - Upcoming Fiscal Year Ending: ___/___/_____ Total Compensation		Projected - Current Fiscal Year Ending: ___/___/_____ Total Compensation			"P" or "A"
			Salaries	Benefits Package*	# FTE'S	Salaries	Benefits Package*	

Please list benefits included:

PROFILE OF CLIENTS, CLIENT NUMBERS AND SERVICES
(Performance Report)

35.

List Services Here	Target Population	# of Persons in Target Population	Area	Days/Hours	Total Number of Clients Served during most recent completed fiscal year	Current # of Clients ("snapshot") as of ____/____/____
SAMPLE SERVICE 1	homeless adults with no support from family or friends	800	county-wide	7 days/24 hours	200	75
SAMPLE SERVICE 2	mentally ill minors and adults	2,000	Marathon	8 AM - 5 PM	100	65

Total number of unduplicated clients for the entire agency served during most recent completed fiscal year	
Current number of unduplicated clients for the entire agency ("snapshot") as of _____/_____/_____	
How many clients served are Monroe County residents:	

Please list or describe achieved measurable outcomes for your target populations:

14

Show the proposed budget detail for the County HSAB funds requested.

Total Expenses must equal Amount Requested on page 1.

36.

Proposed Grant Budget	Proposed County Funded Expense Budget for Upcoming Fiscal Year Ending: _____ ____, ___4_	
Expenditures	**Total**	**%**
Salaries - Program		
Payroll Taxes - Program		
Employee Benefits - Program		
Salaries - Administrative		
Payroll Taxes - Administrative		
Employee Benefits - Administrative		
Subtotal Personnel/Staff		
Office Supplies		
Telephone		
Professional Fees		
Independent Contractor:_____		
Independent Contractor:_____		
Condo Association Fees		
Utilities		
Repairs & Maintenance		
Travel		
Grants to Other Organizations		
Loan(s)		
Bank Charges		
Rent Expense - Currently Utilized Property		
Rent Expense - Not Currently Utilized Property		
Other Expenses (Describe Below)		
Total Expenses		

AGENCY EXPENSES
Complete this worksheet for the entire agency
Note: Dates correspond with your fiscal year

37.

Proposed Budget vs. Current Budget:	Proposed Expenses Budget for the Upcoming Fiscal Year:		Projected Expenses for the Current Fiscal Year:	
Budget Period:	Beginning: ____/____/_____ & Ending: _____/_____/_____		Beginning: ____/____/_____ & Ending: _____/_____/_____	
Expeditures	**Total**	**%**	**Total**	**%**
Salaries - Program				
Payroll Taxes - Program				
Employee Benefits - Program				
Salaries - Administrative				
Payroll Taxes - Administrative				
Employee Benefits - Administrative				
Subtotal Personnel/Staff				
Other Expenses (Describe Below)				
Total Expenses				
Revenue Over/(Under) Expenses				

AGENCY REVENUE

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

<u>Note</u>: 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:		
	____/____/____			____/____/____		
Revenue Sources	Cash	In-Kind	%	Cash	In-Kind	%
LOCAL GOVERNMENT:						
STATE:						
FEDERAL:						
FOUNDATION:						
ALL OTHER SOURCES:						
Total Revenue						

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 organizaton 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:
LOCAL GOVERNMENT:						
STATE:						
FEDERAL:						
FOUNDATION:						
ALL OTHER SOURCES:						
Total Covid-19 Assistance						

41.

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 recenlty completed fiscal year and an IRS Forrm 990 also from the organization's most recently completed fiscal year. (If the audit is qualified, the organization must include a statement of deficiences with corrective actions recommeded/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.