# A logo for a company Description automatically generated with medium confidence

# FY2024 CoC Builds NOFO

# New Project Local Application Form

# *New Project Local Applications due to* [*submit@mtcoc.org*](mailto:submit@mtcoc.org) *by 5pm(MDT) on August 30, 2024*

# Applicant Information

|  |  |
| --- | --- |
| **Applicant**  **(Organization Name)** |  |
| **Applicant Organization Type** | Local/County Government  Non-profit 501(c)(3)  State Government  PHA  Tribe or TDHE  INSTRUMENTALITY |
| **Subrecipient (if applicable)**  **(Organization Name)** |  |
| **Subrecipient (if applicable)**  **Organization Type** | Local/County Government  Non-profit 501(c)(3)  State Government  PHA  Tribe or TDHE  INSTRUMENTALITY |
| **Proposed Project Name** |  |
| **Location(s) of Proposed Project** |  |
| **Does the applicant or subrecipient have site control for all locations** | Yes  No  If No, provide the date by which site control will be obtained: |
| **Applicant UEI**  **(Unique Entity Identifier)** |  |
| **Total number of new units**  **Proposed:** |  |
| **Primary Contact Name** |  |
| **Primary Contact Email** |  |
| **Primary Contact Phone** |  |
| **Secondary Contact Name** |  |
| **Secondary Contact email** |  |
| **Secondary Contact Phone** |  |

# Signature

***By signing this form, you are agreeing that you are an authorized representative of applicant organization and that you have verified and attest to the content of this proposal as submitted.***

|  |  |
| --- | --- |
| **Authorized Representative Name** |  |
| **Title** |  |
| **Date** |  |
| **Signature** |  |

**Project Description**

1. **Provide a description that addresses the entire scope of the proposed project. The description must be consistent with other parts of this application. Must include, if applicable (500-word limit):**

* A description of the proposed site(s)
* A description of units at the proposed site(s) not assisted with CoC funds including the # of units and target populations
* The target population(s) to be served using CoC funds– including disabilities/special needs addressed
* Plan for assessing and addressing the identified housing and supportive service needs of participants.
* Roles of any sub-recipients.
* Coordination with other partners (federal, state, local, nonprofit).
* How the CoC funding will be used.

**Target Population**

1. **COMPLETE THE CHART BELOW INDICATING POPULATION TO BE SERVED & UNITS TO BE PROVIDED IN THE PROJECT:**

Only include households to be served/units that will be funded through the new CoC funds you are seeking in this application. Indicate the # of households/units at a point-in-time when project is operating at full capacity.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HOUSEHOLDS** | **HOUSEHOLDS WITH AT LEAST ONE ADULT AND ONE CHILD** | **ADULT HOUSEHOLDS WITHOUT CHILDREN** | **HOUSEHOLDS WITH ONLY CHILDREN** | **TOTAL** |
| **TOTAL NUMBER OF HOUSEHOLDS** |  |  |  |  |
| **TOTAL NUMBER OF UNITS** |  |  |  |  |

1. **INDICATE BELOW WHICH SUBPOPULATIONS THIS PROJECT PROPOSES TO TARGET:**

Include only populations to be assisted in CoC funded units. Check all that apply. Note that all heads of household must be disabled, and all households must meet the HUD definition of literal homelessness.

chronically homeless

dedicated plus

literally homeless

young adults 18-24

veterans

serious mental illness

chronic substance use

domestic violence

HIV/aids

other– specify: Click or tap here to enter text.

# ATTACHMENT A: BUDGET

**Capital:** Complete table below for Units for which you are requesting CoC Capital Funding:

|  |  |
| --- | --- |
| **Funding Type** | **Request Amount ($)** |
| Construction |  |
| Acquisition |  |
| Rehabilitation |  |
| **Total Capital Request:** |  |

**Rental Assistance:** Complete table below for Units for which you are requesting CoC Project-Based Rental Assistance:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Unit Size** | **No. of Units** | **Monthly FMR**  ***(Insert local FMR)*** | **Term**  **(12 months)** | **Total Costs ($)** |
| Efficiency |  | $ | X 12 months |  |
| 1 Bedroom |  | $ | X 12 months |  |
| 2 Bedroom |  | $ | X 12 months |  |
| 3 Bedroom |  | $ | X 12 months |  |
| 4 Bedroom |  | $ | X 12 months |  |
| **Total** |  |  |  |  |

**Operating Costs:** Enter a brief description and annual budget request for each CoC operating cost you are requesting. When including staff costs, please include title, salary, FTE, and fringe. ***Please note that you may not apply for both rental assistance and operating costs.***

|  |  |  |
| --- | --- | --- |
| **Operating Costs** | **Brief Description**  **(max 400 characters)** | **Annual Budget Request** |
| Maintenance and repair |  |  |
| Electricity, Gas and Water |  |  |
| Property Tax and Insurance |  |  |
| Furniture |  |  |
| Replacement Reserve |  |  |
| Equipment |  |  |
| Building Security |  |  |
| **Total Operating Request** | |  |

# Supportive Services: Enter a brief description and annual budget request for each CoC supportive services cost you are requesting. When including staff costs, please include title, salary, FTE and fringe. *Note on Supportive Services Operating Costs - If the supportive services are provided in a facility not contained in a housing structure, the costs of day-to-day operation of the service facility are eligible on this line, including maintenance & repair, building security, furniture, utilities, equipment*

|  |  |  |
| --- | --- | --- |
| **Eligible Costs** | **Brief Description**  **(max 400 characters)** | **Annual Budget Request** |
| Assessment of Service Needs |  |  |
| Assistance with Moving Costs |  |  |
| Case Management |  |  |
| Child Care |  |  |
| Education Services |  |  |
| Employment Assistance |  |  |
| Food |  |  |
| Housing Search/Counseling |  |  |
| Legal Services |  |  |
| Life Skills |  |  |
| Mental Health Services |  |  |
| Outpatient Health Services |  |  |
| Outreach Services |  |  |
| Substance Abuse Treatment |  |  |
| Transportation |  |  |
| Utility Deposits |  |  |
| Operating Costs *(see note above)* |  |  |
| **Total Annual Assistance Requested for Supportive Services** | |  |

**Sources of Match – Please complete the match table below.**

Match is actual cash or in-kind resources contributed to the grant. All costs paid for with matching funds must be for activities that are eligible under the CoC Program. All grant funds must be matched with an amount no less than 25% of the awarded grant amount (with cash and/or in-kind resources). Match resources may be from public or private resources. Because documentation requirements for in-kind match are significantly more onerous, the MT CoC strongly encourages use of cash match whenever feasible. Click here for more information about matching requirements

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Identify Type of**  **Contribution:**  **Cash or In kind** | **Name the Source of Contribution** | **Identify Source as:** | **Date of Written Commitment** | **Value of Written Commitment** |
| **(G) Government**  **or (P) Private** |
| ***Example: Cash*** | ***DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES*** | ***G*** | ***5/15/23*** | ***$10,000*** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  | | | **TOTAL:** |  |

**Total Proposed CoC Project Budget**

|  |  |
| --- | --- |
| **Activities** | **Total Assistance Requested** |
| 1. Capital |  |
|  |  |
| 1. Rental Assistance |  |
| 1. Supportive Services |  |
| 1. Operations |  |
| 1. Project Admin Costs (may request up to 10% of total amount in lines 1-4) |  |
| 1. **Sub-total Renewable Costs Request (Add lines 2-5) –** may not exceed 20% of Capital Costs (line #1) |  |
|  | **Total Amount Committed** |
| 1. Cash Match |  |
| 1. In-kind Match |  |
| 1. Total Match (Add lines 7 & 8) – must equal at least 25% of total request line (1 plus line 6) |  |
|  | **Total Annual Budget** |
| 1. Total Project Budget (Add lines 1, 6, & 9) |  |
| 1. Total Subaward Amount (if applicable) |  |

# 