

# City of San Leandro Community Assistance Funding

**GRANT COVER PAGE**

ORGANIZATION:	IF APPLICABLE, FISCAL SPONSOR:
FEDERAL TAX ID#:	FEDERAL TAX ID#:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:
PHONE:	PHONE:
FAX:	FAX:
E-MAIL:	E-MAIL:
CONTACT NAME & TITLE:	CONTACT NAME & TITLE:

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## Program Description (Program for which you are requesting funding)

PROGRAM TITLE:

PROGRAM DESCRIPTION (Describe proposed program in 25 words or less):

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## Amount Requested

AMOUNT REQUESTED PER FISCAL YEAR: \$ \_\_\_\_\_  
(Amount must be the same for each year)

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**Checklists & Signatures - Verify, by checking each box that the following have been completed and are attached. See Basic requirements in Instructions for number of copies needed.**

### Required Attachments:

- ARTICLES OF INCORPORATION AND BYLAWS
- DOCUMENTATION OF GOOD STANDING FROM THE STATE OF CALIFORNIA
- STATE AND FEDERAL TAX EXEMPTION DETERMINATION LETTERS [IRS 501(C) 3]
- COPY OF NONDISCRIMINATION POLICIES
- LIST OF BOARD OF DIRECTORS
- BOARD OF DIRECTORS' AUTHORIZATION TO SUBMIT PROPOSALS AND DESIGNATION OF AUTHORIZED OFFICIAL
- ORGANIZATION CHART
- RESUME OF PROGRAM ADMINISTRATOR
- RESUME OF CHIEF FISCAL OFFICER
- FINANCIAL STATEMENT AND AUDIT
- EVIDENCE OF COMMITTED FUNDING
- REFERENCE ARTICLE SUPPORTING NEED FOR PROGRAM IN SAN LEANDRO
- LIST OF ALL CITY FUNDING RECEIVED BY THE AGENCY SINCE 2010

(Note: Certificates of General Liability and Workers Compensation will be required for funded agencies.)

APPROVED BY:

APPROVED BY

\_\_\_\_\_  
SIGNATURE/EXECUTIVE DIRECTOR                      DATE

\_\_\_\_\_  
SIGNATURE/BOARD PRESIDENT                      DATE

\_\_\_\_\_  
PRINT NAME/EXECUTIVE DIRECTOR

\_\_\_\_\_  
PRINT NAME/BOARD PRESIDENT

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**1. Organization Overview (briefly describe):**

**a. Background** (Provide a brief history of your organization. The number of years in existence. How long it has served San Leandro residents.)

**b. Mission** (Briefly describe the purpose, goals and objectives of your organization.)

**d. Current programs** (List your current programs and services.)

## 2. Compliance with HUD's National Objectives

### DOCUMENTATION OF BENEFIT TO LOW- AND MODERATE-INCOME PERSONS

a. Does the activity proposed by your agency on the grant application benefit a clientele at least 51% of whom are low- and moderate-income persons?\*

YES  NO

If YES, provide verification/documentation that at least 51% of the clientele are low- and moderate-income persons. Such documentation includes:

1) Information on household size and income so that it is evident that at least 51% of the clientele are persons whose household income does not exceed the low- and moderate-income limit.\*\*

Or

2) Income eligibility requirements which limit the activity exclusively to low- and moderate-income persons.

If NO, does the activity proposed by your agency on the grant application *primarily* benefit the following eligible clientele? This clientele are presumed by HUD to be principally low- and moderate-income persons?

YES  NO

Check all that applies.

Abused children

Elderly persons

Battered spouses

Severely disabled adults

Homeless persons

Migrant farm workers

Illiterate persons

Persons living with AIDS

\* "Low Income" and "Moderate-Income" are defined in the federal Housing and Community Development Act of 1974, as amended. A Low-income person is a member of a family with a gross income of no more than 50 percent of the area median income. A Moderate-Income person is a member of a family with a gross income of no more than 80 percent of the area median income.

\*\* 2014 HUD Income Limits for Low- and Moderate-Income:

Persons in Household	Annual Income Extremely Low (30%)	Annual Income Very Low (50%)	Annual Income Low (60%)	Annual Income Low (80%)	Annual Income Median (100%)	Annual Income Moderate (120%)
1	\$19,350	\$32,200	\$38,640	\$47,350	\$61,950	\$77,280
2	\$22,100	\$36,800	\$44,160	\$54,100	\$70,800	\$88,320
3	\$24,850	\$41,400	\$49,680	\$60,850	\$79,650	\$99,360
4	\$27,600	\$46,000	\$55,200	\$67,800	\$88,500	\$110,400
5	\$29,850	\$49,700	\$59,640	\$73,050	\$95,600	\$119,280
6	\$32,050	\$53,400	\$64,080	\$78,450	\$102,700	\$128,160
7	\$36,030	\$57,050	\$68,460	\$83,850	\$109,750	\$136,920
8	\$40,090	\$60,750	\$72,900	\$89,250	\$116,850	\$145,800

*Subject to change by HUD.*

b. Will this program's activities specifically address any of the following needs? (Select more than one, if applicable.)

Homeless prevention

Persons with disabilities

Homeless persons

Persons with HIV/AIDS

N/A

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### 3. Scope of Work

a. **Project Goals and Objectives** (Describe the project or program and how participants will benefit.):

b. **Major Activities** (Describe the activities and services provided through this project or program.)

c. **Performance Measures** (Describe the direct quantifiable outputs of the program activities. For example: the number of meals provided or participants served. Program outputs should be measurable and realistic.)

d. **Timelines** (Provide a quarterly timeline for the performance measures. For example: 1<sup>st</sup> Quarter (Jul – Sept) – Provide 100 hot meals to eligible seniors.)

e. **What are your sources of data and how will you collect the information?**

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#### 4. Program Model

a. Is this an ongoing program of your agency?  yes  no If yes, how long has it been in operation?

b. On what do you base the likelihood this program will achieve the proposed outcomes described in Attachment A?  
**(choose one and explain):**

We have experience operating this program and have achieved similar outcomes under similar circumstances with similar populations.

We will be replicating a program model that has achieved similar outcomes under similar circumstances with similar populations.

We have developed a new program model and believe we can achieve the proposed outcomes.

Other (describe):

**Please explain your response:**

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## 5. Target Population(s)/Client Demographics

- a. Are you able to track the numbers of persons/households and services related to the above populations?  
[ ] Yes [ ] No [ ] N/A
- b. If funded, you will also be required to maintain records on ethnicity, gender, family size, female/male heads of households, geographic location, income and unduplicated clients served by the program. Are you able to track this information?  
[ ] Yes [ ] No
- c. Briefly describe your program's target population(s). What are the common needs or characteristics, risk factors, barriers, health or economic status, etc.? Cite any relevant data you may have regarding the characteristics. Why do you believe this program will be effective with the population(s)?
- d. How will target population(s) be referred to or find this program? What is your experience in outreach to the population(s)? What are your experience and expertise in working with the population(s)?
- e. Briefly describe the needs of the neighborhoods and geographic areas to be served. What unmet need(s) will the program address or mitigate? How will this program use or work with other community resources to address the identified needs? Why do you believe this program will be effective in the geographic areas identified?

## 6. Program Target Population/Client Profile

Please estimate the number and/or percentage of clients to be served per year by this program.

Number of UNDUPLICATED clients served by this program:	
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GEOGRAPHIC LOCATION OF PEOPLE SERVED BY THE PROGRAM	NUMBER	% OF TOTAL
San Leandro		
Oakland		
Hayward		
Unincorporated		
Other		
TOTAL		

GENDER	NUMBER	% OF TOTAL
Female		
Male		
TOTAL		

INCOME LEVEL	NUMBER OF PERSONS	NUMBER OF HOUSEHOLDS
1. Extremely Low Income (0-30% AMI)		
2. Very Low Income (31 – 50% AMI)		
3. Low Income (51 – 80% AMI)		
4. Moderate Income (>80% AMI)		
TOTAL		

RACIAL/ETHNICITY DATA	PERSONS	HOUSEHOLDS
White		
Black/African American		
Asian		
American Indian or Alaskan Native		
Native Hawaiian or Pacific Islander		
American Indian or Alaskan Native <i>and</i> White		
Asian <i>and</i> White		
Black/African American <i>and</i> White		
American Indian/Alaskan Native <i>and</i> Black/African American		
Other Multi-Racial Combinations		
TOTAL		

Hispanic Ethnicity	PERSONS	HOUSEHOLDS

*Note:* Above categories may vary depending on federal government regulation changes. Under OMB 1997, Hispanic is not a race category, but an ethnic category that cuts across all races. Hispanic: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, **regardless of race**. Participants must choose a race/ethnicity category and may also choose to identify as Hispanic.

HOUSEHOLD TYPE	NUMBER OF PERSONS	NUMBER OF HOUSEHOLDS
Homeless		
Female-Headed Household		
Disabled/Special Needs		

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## 7. Organization Experience & Capacity

**a. Enclose a list of the organization's Board of Directors, including titles and affiliations.**

**b. Oversight of the Organization--** Please describe the key staff person responsible for organizational oversight. Include their: a) Name and Title; b) Brief statement of qualifications/experience; c) Length of time in position; d) Length of time of predecessor in position; and, e) Brief statement of individual's roles & responsibilities.

**c. Oversight of the Organization's Finances --** Please describe the key staff person responsible for financial oversight. Include their: a) Name and Title; b) Brief statement of qualifications/experience; c) Length of time in position; d) Length of time of predecessor in position; and, e) Brief Statement of individual's roles & responsibilities.

**d. Oversight of the Proposed Program --** Please describe the key staff person(s) responsible for oversight and implementation of the proposed program. Include their: a) Name(s) and Title(s); b) Brief statement of qualifications/experience; c) Length of time in position(s); d) Length of time of predecessor(s) in position(s); and, e) Brief statement of individuals' roles & responsibilities.

## 8. First Year Budget

1. Program Budget (Complete this budget only for the program for which you are requesting Community Assistance funding. BUDGET PERIOD: JULY 1, 2015 to JUNE 30, 2016)

EXPENSES	Allocation of San Leandro Grant Request	Total Program	REVENUE	Committed	Pending
Personnel ( <i>salaries &amp; fringe benefits</i> )			Fund Raising		
Operating			Foundations/ Corp		
(Operating includes all non-personnel program-related expenses. Note: SLCA does not make grants for the purchase of capital items, organizational deficits, interest on indebtedness or depreciation expenses.)			Individual Donations		
			Counties		
<b>Total Program Expenses</b>			State Grants		
			Federal Grants		
			Cities:		
<b>Cost Per Client or Service Unit</b>			<b>Total Program Revenue</b>		

2. Program Staffing (Identify each paid staff position in this program by title and the full time equivalent percentage.)

Paid Program Staff Title

FTE%

3. List all City of San Leandro Funding Received by the Agency

\_\_\_\_\_ None

\_\_\_\_\_ Attach list of all funding provided by the City of San Leandro during the last two grant cycles (since 2010). For example: CAP Grant, CDBG Capital Grant, Redevelopment, Housing, in-kind rent or other support.

4. **Committed Funding.** (Enclose evidence of any committed funds for this program. Evidence may include copies of award letters and grant contracts, including the source, amounts, and description of how these funds will be used. If the Board of Directors has allocated any organizational or special funds for this program, enclose a letter signed by the Board President or Chair indicating that such action has been taken.)

5. Total Organizational FY 2015-2016 Budget

Total Organization Expenses  
(including this program)

\$ \_\_\_\_\_

Total Organization Revenue  
(including this program)

\$ \_\_\_\_\_

## 9. Second Year Budget

1. Program Budget (Complete this budget only for the program for which you are requesting Community Assistance funding. BUDGET PERIOD: JULY 1, 2016 to JUNE 30, 2017)

EXPENSES	Allocation of San Leandro Grant Request	Total Program	REVENUE	Committed	Pending
Personnel ( <i>salaries &amp; fringe benefits</i> )			Fund Raising		
Operating			Foundations/Corp		
(Operating includes all non-personnel program-related expenses. Note: SLCA does not make grants for the purchase of capital items, organizational deficits, interest on indebtedness or depreciation expenses.)			Individual Donations		
			Counties		
<b>Total Program Expenses</b>			State Grants		
			Federal Grants		
			Cities:		
<b>Cost Per Client or Service Unit</b>			<b>Total Program Revenue</b>		

2. Program Staffing (Identify each paid staff position in this program by title and the full time equivalent percentage.)

Paid Program Staff Title

FTE%

3. **Committed Funding.** (Enclose evidence of any committed funds for this program. Evidence may include copies of award letters and grant contracts, including the source, amounts, and description of how these funds will be used. If the Board of Directors has allocated any organizational or special funds for this program, enclose a letter signed by the Board President or Chair indicating that such action has been taken.)

4. Total Organizational FY 2016-2017 Budget

**Total Organization Expenses  
(including this program)**

\$ \_\_\_\_\_

**Total Organization Revenue  
(including this program)**

\$ \_\_\_\_\_

