APPLICATION FOR SHASTA COUNTY

EMERGENCY FOOD AND SHELTER PROGRAM

PHASE 41

Application Instructions: Respond to all items fully and completely. Attach additional sheets if more space is needed. Return to Shasta County Department of Housing and Community Action Programs, 2600 Park Marina Drive, Redding, CA 96001 **or** via email **hcap@co.shasta.ca.us** by **March 29, 2024 at 4:00 p.m.**

1. Legal name of agency: _____

2. Agency Phone Number:_____ Agency Fax Number: _____

3. Agency mailing address:

   _____

   _____

4. Agency service address:

   _____

   _____

5. Name of representative submitting application:_____

6. Agency UEI Number: _____ Agency Tax Payer ID: _____

7. Email of agency contact person: _____

8. FUNDS REQUEST SUMMARY

Type of Assistance	Amount Requested	For office use only
Food Bank/Closet	$	$
Mass Shelter (overnight) Per Diem $____	$	$
Rent Vouchers	$	$
Motel Vouchers	$	$
Utility Assistance	$	$
Total Request	$	$

9. Program Summary (Describe the program – who are your clients, kinds of activities in the program and the problem(s) to be resolved, how many people served, etc.):

   _____

   _____

   _____

10. Project Outcome (Describe the impact on life of your clients. Will your service enable them to obtain a job, secure housing, become self-sufficient, etc.):

_____

_____

_____

_____

11. Does any other organization provide a similar program to the same target population that you intend to serve? If yes, please explain how you will collaborate and partner with them to maximize effectiveness and avoid unnecessary duplication of services:

_____

_____

_____

_____

12. Describe any partnerships or collaborations with other agencies not shown in question 11 above:

_____

_____

_____

_____

13. Demographic Information:

Total Unduplicated Clients to be served: _____

Average number of times each Client is served: _____

What geographical area will you cover? _____

14. How does the agency determine client eligibility for this service?

_____

_____

15. Does the agency serve clients directly or pass funds to another organization?

_____

16. What financial resources, other than EFSP, are available for this program?

_____

_____

_____

_____

17. Provide contact information would be responsible for submitting the required EFSP reports and documentation on behalf of the agency.

Name: _____

Title: _____

Contact Information: _____

18. Check the type of audit the agency receives:

No Annual Audit	Independent Annual Audit	Independent Annual Audit in accordance with Government Auditing Standards

19. If the applicant agency was previously funded by EFSP, was the entire allocation expended? If yes, how were the funds expended? If not, how much was returned unexpended and why?

_____

_____

_____

_____

20. What impact will an award, that is less than the amount requested, have on the applicant agency's program(s) and the number of clients served?

_____

_____

_____

_____

_____

21. Is the Agency a: ____ Non-Profit ____ Unit of Government?

22. How many volunteer hours were donated to the agency to assist with the EFSP Program?

_____

Representative Signatures: _____

_____

Incomplete applications will not be accepted.