**City of Cincinnati**

**Application to Request Funding**

**2025 HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)**

# New Program Application

**Due via email to** **NOFAS@end-homelessness.org** **by January 21, 2025, at 4:00 P.M.**

**Projected Funding**

**Available:** $1,859,246

**Funding Period:** January 1, 2025, through June 30, 2026

**Eligible Applicants:** Private, non-profit organizations incorporated in Ohio,

Kentucky or Indiana serving clients living within the Cincinnati EMSA with valid 501(c)3 status from the IRS; and units of local government.

**Eligible Recipients:** Low-income persons (80% or below median area income)

diagnosed with HIV/AIDS and their family members

**Eligible Activities:** 1. Tenant-based rental assistance

2. Operating Subsidies/Leased Units

* 1. Operating/Leasing Permanent Housing
	2. Operating/Leasing Transitional Housing
1. Capital development (new construction, acquisition, rehabilitation, operating)\*
2. Permanent Housing Capital Development Projects
3. Transitional Housing Capital Development Projects
4. Short-term rent, mortgage, and utility payments
5. Permanent housing placement
6. Supportive services
7. Administrative expenses **(limited to 7% of total request)**

*\*Projects intending to request funding for acquisition, rehabilitation or new construction must contact* *NOFAS@end-homelessness.org* *prior to the submission of this grant application. All regulations within the Code of Federal Regulations relating to the HOPWA program (24 CFR part 574) will require certification prior to contract notification and within two months of award notice*.

**Program Requirements:** All applicants must adhere to program regulations as published

within *The Code of Federal Regulations* for the Department of Housing and Urban Development pertaining to the HOPWA program [24 CFR Chapter V Part 574].

**Submission and Review:** Email one application to: NOFAS@end-homelessness.org by **4:00 P.M. on January 21, 2025**

Strategies to End Homelessness, Inc. staff and the HOPWA Advisory Committee will review the applications. Preference will be given to continuation (renewal) of previously funded HOPWA programs in Ohio, Kentucky or Indiana and serving persons with AIDS in the Greater Cincinnati EMSA who have demonstrated success with previously funded awards.

**The HOPWA Advisory Committee Allocation Meeting** will be held on:

**Wednesday, January 29, 2025**

**3:00PM-4:00PM**

via Microsoft Teams.

Funding recommendations will be determined during this meeting. Agencies must have a representative participate in this meeting in order to be considered for funding.

The project application responses will be circulated to the local HOPWA Advisory Committee in advance of the 2025 Allocation Meeting. Then, at the Advisory Committee Allocation Meeting, the Advisory Committee will collectively consider, weigh, and make recommendations as to which projects best address community need based on the factors outlined in the projects’ application answers as well as Advisory Committee members’ own expertise in the field in our EMSA.

**APPLICATION INSTRUCTIONS:**

* All projects will be required to answer all applicable questions in this application form.
* To complete this form, click on the boxes highlighted in gray and enter your response.
* Please do not change the form, rearrange the questions, or delete any sections.
* Please ensure you submit all required attachments in Section G.
* If you have questions regarding this application, please contact Strategies to End Homelessness, via email at NOFAS@end-homelessness.org.
* Please include a Program Budget, which can be found at <https://www.strategiestoendhomelessness.org/partner-agencies/apply-for-funds/>

**Applicant:**

*(Full legal name as it appears on your agency’s Articles of Incorporation)*

**Address**:

**City**:       **County**:       **State**:       **Zip**:

**Executive Director’s Name**:

**Grant Contact Person’s Name**:

**Telephone**:       **Fax**:

**Email**:

**Applicant Federal Tax ID Number**:       **UEI Number**:

**Is your agency registered in the System for Award Management (SAM)?**

The City of Cincinnati HOPWA funding is limited to service for those persons with HIV/AIDS who reside in one of the following counties. Please identify which county or counties your project proposes to serve ***(double click on the box and choose “checked”)***:

**Indiana**: [ ] Dearborn [ ] Ohio [ ]  Union [ ]  Franklin

**Kentucky**: [ ] Boone [ ] Campbell [ ] Gallatin [ ] Grant  [ ] Kenton [ ] Pendleton [ ]  Bracken

**Ohio**: [ ] Brown [ ] Clermont [ ] Hamilton [ ] Warren [ ]  Butler

**Project Identification**:

 (*name of program*)

**Total amount of funds requested under this application**: $

To the best of my knowledge and belief, all data in this application are true and correct. The application has been duly authorized by the governing body of the applicant, and the applicant will comply with all federal HOPWA program regulations (i.e. 24 CFR part 574) and local government reporting requirements if granted.

|  |  |
| --- | --- |
| **Name of Authorized Representative & Title** | **Telephone Number** |
|       |       |
| **Signature of Authorized Representative\***  | **Date Signed** |
|       |       |

\* You may print/sign/scan, enter initials or paste an electronic signature.

**1. TENANT-BASED RENTAL ASSISTANCE (TBRA)**

**[ ]  This is a request for TBRA**

Amount being requested for TBRA activities: $

Anticipated Program Income: $

Total TBRA budget: $

Briefly describe in a narrative how you propose to use the TBRA funds requested. Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

|  |  |
| --- | --- |
| **Project Outputs and Goals** | **Projections for 1/1/2025-6/30/2026** |
| 1.Number of persons with HIV/AIDS to receive HOPWA TBRA (primary client only) |       |
| 2.Number of other persons in household to receive HOPWA TBRA |       |
| 3.Total number of persons to receive HOPWA TBRA (line 1+2) |       |

**2. OPERATING SUBSIDIES/LEASED UNITS**

**[ ]  This is a request for OPERATING SUBSIDIES/LEASED UNITS**

 **Please choose one: [ ]  Permanent Housing [ ]**  **Transitional/Short-term Housing**

Amount being requested for Operating Subsidies/Leased Units activities: $

Anticipated Program Income: $

Total Operating/Leased Units budget: $

Briefly describe in a narrative how you propose to use the Operating/Leasing funds requested. Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

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| --- | --- |
| **Project Outputs and Goals** | **Projections for 1/1/2025-6/30/2026** |
| 1.Number of persons with HIV/AIDS to receive HOPWA operating subsidies/leased units (primary client only) |       |
| 2.Number of other persons in household to receive HOPWA operating subsidies/leased units |       |
| 3.Total number of persons to receive HOPWA housing services (line 1+2) |       |

**3. CAPITAL DEVELOPMENT**

**Please choose one: [ ]  Permanent Housing [ ]**  **Transitional/Short-term Housing**

**Will this development be open during this operating year? [ ]  Yes [ ]  No**

Amount being requested for Capital Development activities: $

Anticipated Program Income: $

Total Capital Development budget: $

Briefly describe in a narrative how you propose to use the Capital funds requested. Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

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| --- | --- |
| **Project Outputs and Goals** | **Projections for 1/1/2025-6/30/2026** |
| 1.Number of persons with HIV/AIDS served by HOPWA Capital Development funds (primary client only) |       |
| 2.Number of other persons in household served by HOPWA Capital Development funds |       |
| 3.Total number of persons served by HOPWA Capital Development funds (line 1+2) |       |

1. **SHORT-TERM RENT, MORTGAGE, AND UTILITY (STRMU) ASSISTANCE**

**[ ]  This is a request for STRMU ASSISTANCE**

Amount being requested for STRMU activities: $

Anticipated Program Income: $

Total STRMU Units budget: $

Briefly describe in a narrative how you propose to use the STRMU funds requested Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

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| **Project Outputs and Goals** | **Projections for 1/1/2025-6/30/2026** |
| 1.Number of persons with HIV/AIDS to receive HOPWA STRMU housing services (primary client only) |       |
| 2.Number of other persons in household to receive HOPWA STRMU housing services |       |
| 3.Total number of persons to receive HOPWA STRMU housing services (line 1+2) |       |

1. **PERMANENT HOUSING PLACEMENT**

**[ ]  This is a request for PERMANENT HOUSING PLACEMENT**

Amount being requested for Permanent Housing Placement activities: $

Anticipated Program Income: $

Total Permanent Housing Placement budget: $

Briefly describe in a narrative how you propose to use the Permanent Housing Placement funds requested. Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

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| --- | --- |
| **Project Outputs and Goals**. | **Projections for 1/1/2025-6/30/2026** |
| 1.Number of persons with HIV/AIDS to receive HOPWA Permanent Housing Placement (primary client only) |       |
| 2.Number of other persons in household to receive HOPWA Permanent Housing Placement  |       |
| 3.Total number of persons to receive HOPWA Permanent Housing Placement (line 1+2) |       |

1. **SUPPORTIVE SERVICES**

**[ ]  This is a request for SUPPORTIVE SERVICES**

Amount being requested for Supportive Service activities: $

Anticipated Program Income: $

Total Supportive Service budget: $

Briefly describe in a narrative how you propose to use the Supportive Services funds requested. Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

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| **Project Outputs and Goals** | **Projections for 1/1/2025-6/30/2026** |
| 1.Number of persons with HIV/AIDS to receive HOPWA supportive services (primary client only) |       |
| 2.Number of other persons in household to receive HOPWA supportive services |       |
| 3.Total number of persons to receive HOPWA supportive services (line 1+2) |       |

**PROGRAM AND AGENCY DESCRIPTION**

All agencies are requested to answer the following in narrative fashion.

1. Describe the organization’s history and mission.

1. Describe the proposed HOPWA project(s), including the housing and supportive services the project will provide.

1. Using data, describe the need for the proposed project within the geographic area to be served. Include information on how the proposed project impacts the community efforts to provide quality housing services to persons with HIV/AIDS

1. What was the process used to determine these services were appropriate and needed for the area? Who was involved and in what way were persons with HIV/AIDS included in the planning process?

1. Describe the coordination of the proposed project with other programs serving persons with HIV/AIDS within the geographic area. Include how you will ensure that there is no duplication of services.

1. Describe your project’s plan for connecting your participants with healthcare, and particularly to HIV/AIDS diagnosis-specific healthcare. Provide data on successful healthcare enrollment.

1. Explain the organization’s capacity to successfully implement the planned HOPWA activities.

1. Discuss the organization’s ability to manage the grant, including any previous HOPWA grant management experience and experience with other city or federal grants.

1. Describe your history of having handled HOPWA funding and whether your agency/project was the subject of any monitoring concerns by STEH or your prior HOPWA Administrative body.

1. State whether your agency/project timely submitted billing invoices to STEH or your prior HOPWA Administrative body

1. Describe the extent of inclusion of persons with HIV/AIDS in the project’s planning

**G. REQUIRED ATTACHMENTS:**  Please submit the documents listed below with your application.

[ ]  Corporate Resolution, signed by a representative of your Board of Directors, stating the name and title of the authorized representative of the agency to enter into a contract with Strategies to End Homelessnesss, should this application be approved. (Note: The signature on the letter and the authorized representative of the agency may not be the same person)

[ ]  List of the Board of Directors/Trustees

[ ]  Certification that no part of the net earnings of the organization are used to the benefit of any board member, founder, contributor, or individual who is not a consumer of the organization.

[ ]  Copy of the organization’s program termination and/or tenant/resident eviction policy for programs requesting Housing funds.

[ ]  Program Budget. Please use the Program Budget spreadsheet (included with this application and available at https://www.strategiestoendhomelessness.org/partner-agencies/apply-for-funds/ to provide budget detail for the funds being requested).

[ ]  Non-profit certification-IRS 501(c)3 ruling letter

[ ]  Most recent audit. If most recent audit is not complete prior to the application deadline, the audit must be submitted to the City within 30 days after the receipt of the auditor’s report, but not later than nine months after the end of your fiscal year.

[ ]  Proof that among the purposes of the organization (as stated in the by-laws or articles of incorporation) significant activities related to providing services or housing to persons with acquired immunodeficiency syndrome or related diseases are included.