# ILLINOIS DEPARTMENT OF HUMAN SERVICES

**SUPPORTIVE HOUSING PROGRAM**

**FISCAL YEAR 2019**

**FUNDING PLAN**

The Illinois Department of Human Services (IDHS) is requesting a Funding Plan from Supportive Housing providers in Fiscal Year 2019. The goal of the Supportive Housing Program is to strengthen, through supportive services, the ability of low-income individuals and families to retain permanent housing. To that end, supportive services should address the special needs that have prevented participants from achieving permanent housing within the community.

Funding for transitional programs must be used to increase or maintain available services to assist people into permanent housing. Supportive services may include, but are not limited to those relating to alcohol and substance abuse, mental health, transportation, education and training. **Case management, advocacy, and counseling are required program services**.

Fiscal Year 2019 Funding Plans for the Supportive Housing Program are subject to an appropriation by the General Assembly and are subject to change.

Fiscal Year 2019 Funding Plans for the Supportive Housing Program must be submitted and required attachments received on or before close of business Thursday, March 15, 2018:

Illinois Department of Human Services

Bureau of Homeless Services and Supportive Housing

823 East Monroe

Springfield, IL 62701

ATTN: Angela Campo

217/ 524-5975

[Angela.Campo@illinois.gov](mailto:Angela.Campo@illinois.gov)

If you have any questions regarding the Funding Plan, you may call Angie at 217/524-5975 or send an e-mail to: [Angela.Campo@illinois.gov](mailto:Angela.Campo@illinois.gov)

# ILLINOIS DEPARTMENT OF HUMAN SERVICES

**SUPPORTIVE HOUSING PROGRAM**

**FISCAL YEAR 2019**

**FUNDING PLAN**

**(A separate Funding Plan must be submitted for each SHP funded project.)**

ALL INFORMATION BELOW IS REQUIRED:

Legal Name of Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Executive Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type(s) of Program: \_\_\_ Transitional Housing \_\_\_ Permanent Housing \_\_\_ Scattered Site

\_\_\_\_\_ Total # of Units \_\_\_\_\_ Number of SHP Units \_\_\_\_\_ Number of Persons

in the Project within the project Served in SHP Units

FY’18 SHP Amount $ FEIN Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County to be served: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization

I hereby affirm that I am duly authorized to submit a Supportive Housing Program (SHP) Funding Plan on behalf of this organization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Title Date

List the name and phone number of each current member of your agency’s Board of Directors.

Name Phone Number

**SUB CONTRACTOR INFORMATION (to be completed if applicable)**

Provide information regarding sub-contractors:

Agency Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of supportive services provided by sub contractor:

Amount of contractual agreement: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Phone Numbers**:

If in an emergency ie., nights or weekends, DHS staff need to contact the Executive Director, Program Director or other administrative staff:

Phone # Staff Person Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # Staff Person Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # Staff Person Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If DHS staff need to contact a program/shelter after 5:00 p.m. or on weekends to access shelter for a homeless person/family:

Phone #

Phone number given to the general public for program/shelter inquiries/emergencies:

Phone #

List the counties that will be served by the program?

The Supportive Housing Program requires a 25% match. What funds within your agency’s budget are used to match this contract?

If your agency applies in-kind contributions toward match requirements, briefly describe the system used for recording and verifying volunteer hours or verifying in-kind contributions. Half of the match must be cash.

If Applicable:

Projected number of volunteer hours \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a member of your local Continuum of Care?

Yes No

Continuum Name

If no, why not?

SUMMARY

Briefly describe the following:

1. Need for the project, (permanent or transitional housing, scattered site apts., etc.).

2. Number of participants to be served.

3. Services to be offered.

4. Name of Agency(s) providing SHP funded supportive services.

1. Services delivery system (on-site or off-site)

6. Description of staff providing supportive services.

SUMMARY (continued)

7. Case management system to be used.

8. How progress to participant and project objectives will be measured.

PROJECT PLAN

Briefly describe the following:

1. Estimated Annual Vacancy Rate for the project: \_\_\_\_\_\_\_\_\_\_\_%

2. Participant access to case management outside of normal business hours.

1. The process utilized to develop individual participants service plans.
2. How the services will move participants to self-sufficiency.
3. The plan for participants to gain access to all public benefit programs (TANF, food stamps, child care, etc.).

PROJECT PLAN (continued)

1. Linkage agreements other community service agencies that provide supportive services. List Agency and service provided through linkage agreement.
2. Description of permanent or transitional housing provided (number of units, participants to be served, scattered sites, etc).
3. Provide property ownership information including names of other partners in the project.
4. Provide information pertaining to participant units by size and leaseholder.

PARTICIPANT POPULATION

Briefly describe the following:

1. Population served by this program

\_\_\_ Single Male \_\_\_ Couples/ No Children \_\_\_ Males With Children

\_\_\_ Single Female \_\_\_ Couples/ With Children \_\_\_ Females With Children

2. The characteristics and needs, including the need for supportive services of the participants to be served.

1. The literacy and skills level of the participants.
2. How participants will be referred to the program.

5. Participant disabilities or special need for supportive services.

6. List Eligibility Requirements of this program.

ORGANIZATIONAL CAPACITY

Briefly describe the following:

1. Entity that governs the provider (Board of Directors, county, etc.).

2. Organization’s experience in case management, permanent housing, and supportive service delivery.

1. Organization’s history of tracking the progress of participants towards individual service plan goals.
2. Organization’s effectiveness of evaluating the impact of the SHP on the participants.
3. Qualifications and experience of supervisory and supportive service staff (do not include resumes).

6. Organization’s ability to provide outcome data for the SHP (e.g., number of residents place in employment, number of persons that earned GED certificates, etc.).

SERVICE PLAN

Briefly describe the following:

1. On the average, the Case Manager/Case Worker meets with the participants how often?

\_\_\_ Daily \_\_\_ Twice per week \_\_\_ Once per week \_\_\_ Bi-weekly

\_\_\_ Monthly \_\_\_ Quarterly

2. What is the service cost per participant?

3. How participant needs will be assessed and used to determine the scope, frequency and scheduling of supportive services to meet the identified needs.

4. Required case management, advocacy, and counseling services and how these services will assist participants to meet program goals.

5. The supportive service costs, and funding other than SHP that will fund the services.

SERVICE PLAN (continued)

1. How the supportive services delivered to participants in transitional housing will assist them to move to permanent housing.
2. How the case managers will coordinate supportive services, the frequency of contact with participants, update individual service plans, and assist with access to all public benefits.

8. Provide justification for the ratio of case managers to participants in the program.

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**SUPPORTIVE HOUSING PROGRAM**

## FISCAL YEAR 2019

# FUNDING PLAN

**Required Attachments**

**Check-Off List to be completed and sent or e-mailed to:**

Illinois Department of Human Services

Bureau of Homeless Services and Supportive Housing

823 East Monroe

Springfield, IL 62701

ATTN: Angela Campo

217/ 524-5975

[Angela.Campo@illinois.gov](mailto:Angela.Campo@illinois.gov)

The absence of any of the required forms will result in significant processing delays.

POP UP OVER NEXT SECTION REGARDING FIRE/SAFETY INSPECTION: “If your agency provides housing or leases housing on behalf of participants, you must submit a Fire/Safety inspection completed by the local fire department or other locally authorized entity within the last six months. This inspection must be received by IDHS before any funds are paid to the Provider.”

\_\_\_\_\_ If required, a copy of a Fire/Safety inspection completed within the last six (6) months.

\_\_\_\_\_ Not Applicable

“If you are feeding residents at the program site, i.e. food is prepared for the residents (not by the residents), you must submit a Public Health inspection done within the last six months. This inspection must be received by IDHS before any funds are paid to the provider.”

\_\_\_\_\_ If required, a copy of a Public Health inspection completed within the last six (6) months.

\_\_\_\_\_ Not Applicable

\_\_\_\_\_ Copy of Blank agency forms (intake/assessment, program plan forms and any other forms that are used to assist participants).

\_\_\_\_\_ Copy of Sub-Contractor Agreements.

\_\_\_\_\_ Not Applicable

\_\_\_\_\_ Organizational Chart (for the Supportive Housing Program Project).

\_\_\_\_\_ Copy of your agency’s program participation requirements including program or housing rules and regulations, fees assessed to participants, and service plan requirements.

##### BUDGET

##### **Other Sources (Match Requirements)**

All grants must be matched by at least 25 percent from other sources. The 25 percent match must be cash from local sources or unrestricted federal or state funds. Federal or state funds used as match for the proposed project may not be used as match for other projects.

**Direct Personnel**

At least 85 percent of the grant must be used for direct participant services. Direct service costs are those directly related to case management and provision of supportive services to participants, such as staff salaries for assessment, training, counseling, etc. Indirect costs (operating costs) are ineligible.

**Admin Personnel**

No more than 15 percent of the grant may be used for administrative costs. Administrative costs may include but are not limited to portions of the Executive Director’s time, administrative personnel costs, supplies, etc.

**A GATA budget has to be submitted.**