Maryland Department of Housing and Community Development (DHCD)

**State FY2023 Homelessness Solutions Program (HSP) Youth Homelessness Program Funding**

**Provider Profile**

Continuum of Care: MD-503

Provider Name:

Provider Funding Request:

Funding Request Type:

\_\_\_ Renewal Request

\_\_\_ Program Renewal Request with Budget Increase

\_\_\_ New Program Request

 

Larry Hogan Boyd K. Rutherford Kenneth C. Holt

GOVERNOR LT. GOVERNOR SECRETARY

**FY23 HSP YOUTH GRANT APPLICATION GUIDELINES & INSTRUCTIONS**

***Please review all guidelines and instructions before beginning the application.***

1. **Applications must be received at the ACDS office on Wednesday, April 20, 2022 by 3:00 pm.**
2. Applications and all required attachments may be submitted by hand, mail, or electronically to:

Arundel Community Development Services, Inc.  
ATTN: Hannah Breakstone  
2666 Riva Road, Suite 210  
Annapolis, MD 21401  
Email: [hbreakstone@acdsinc.org](mailto:hbreakstone@acdsinc.org)

1. Please include the following attachments with your application:
   1. Recent Financial Statement/Audit
   2. Insurance Certificate(s)
   3. 501(c)3 Letter
   4. Articles of Incorporation
   5. Bylaws
   6. Current Board List
   7. Match documentation

**YOUTH HOMELESSNESS PROGRAM FUNDS**

The Department is planning to award a minimum of $1 million dollars in FY2023 HSP funding to providers working with unaccompanied youth and young adults experiencing homelessness or at risk of homelessness, pending the approved final FY2023 budget.The Department intends to deploy these funds largely in alignment with the Ending Youth Homelessness Act of 2018. The text of the statute can be found here:

<http://mgaleg.maryland.gov/2018RS/Chapters_noln/CH_748_sb1218t.pdf>. Please refer to the definition of this special population found on page seven of the HSP Application Guidance when completing this portion of the application.

“**Unaccompanied homeless youth**”

An individual of 24 years of age or younger who is not in the physical custody of a parent or guardian and lacks a fixed, regular, and adequate nighttime residence who:

* Lives in a supervised publicly or privately operated shelter designated to provide temporary living arrangements.
* Lives in a motel, hotel, or campground due to lack of alternative adequate accommodations.
* Shares the housing of other individuals due to loss of housing, economic hardship, or similar reason.
* Lives in a transitional housing program or other time-limited housing.
* Has a primary nighttime residence which is a public or private place not designed or ordinarily used as a regular sleeping accommodations for individuals, such as a car, a park, an abandoned building, a bus or train station, or an airport.

“**Youth at risk of homelessness**”

An individual 24 years of age or younger whose status or circumstances indicate a significant danger of experiencing homelessness in the near future, and:

* Is exiting a publicly funded institution or system of care.
* Whose primary caregivers are currently homeless or have previously been homeless.
* Who experiences serious or sustained conflict with the individual’s caregivers that is likely to result in family separation.

**ELIGIBLE ACTIVITIES**

* Street and community-based outreach
* Emergency shelter for youth and drop-in programs for youth
* Short (up to 3 months) or medium-term (up to 24 months) rental assistance for youth
* Case management for youth
* Other activities eligible for HSP that are geared specifically towards eligible youth
* Other activities serving youth who are homeless or at-risk of homelessness, pending Department approval

**HSP YOUTH SUBGRANTEE APPLICATION**

**Section I. GENERAL INFORMATION**

|  |  |
| --- | --- |
| Legal Name of Applicant: |  |
| Federal Tax Employer ID: |  |
| DUNS Number: |  |
|  | |
| ***Address of the Main Agency Location:*** | |
| Address: |  |
| City/County, State, Zip: |  |
|  | |
| ***Main Mailing Address:*** | |
| Address: |  |
| City/County, State, Zip: |  |
|  | |
| ***Grant Contact Information:*** | |
| First Name: |  |
| Last Name: |  |
| Phone: |  |
| Ext.: |  |
| Email: |  |
|  | |
| ***Executive Director Contact Information:*** | |
| First Name: |  |
| Last Name: |  |
| Phone: |  |
| Ext.: |  |
| Email: |  |

**Section II. AGENCY INFORMATION**

**Current Projects and Programs**

1. Describe the history, mission, and vision of your agency.

1. Explain your agency's efforts to reduce homelessness within your community. Describe how you currently engage with youth to develop program policy, recruitment and hiring procedures.
2. Describe case management and supportive services provided by your program. Also describe how your agency connects and coordinates with other providers in order to ensure that clients have access to any other services that they may need.
3. Describe the steps you have taken to meet the needs of overrepresented or particularly vulnerable groups, including: (1) black, indigenous, and people of color, (2) lesbian, gay bi-sexual and transgender youth, (3) minors, (4) victims of human trafficking and intimate partner violence, (5) youth with disabilities, (6) pregnant and parenting youth, and (7) immigrant youth.
4. If you received FY2022 Youth HSP funding, describe the FY2022 outcomes for youth-funded activities, including HMIS data for clients served and exits to permanent housing.
5. If you received HSP funding in FY22, list the number of participants you served with FY22 HSP funding, by funding category:

|  |  |
| --- | --- |
| Street and Community-Based Outreach: | Homelessness Prevention: |
| Emergency Shelter: | Permanent Supportive Housing CM: |
| Rapid Re-Housing: |  |

**Continuum of Care**

1. Does your agency currently participate in your local Continuum of Care meetings? If yes, please describe your current level of involvement, including the number of meetings attended in the prior twelve months.
2. Describe how your agency participates (or will participate) in the Continuum of Care’s Coordinated Entry process for client intake and prioritization.
3. Describe how your agency will help the Continuum of Care to meet the goals of the Homelessness Solutions Program, including moving clients into permanent housing and assisting them in maintaining it, and reducing the length of time people are homeless.

**Homeless Management Information System (HMIS)**

1. Is your agency currently entering client-level program data into HMIS? If your agency is not entering into HMIS, what is your agency's plan and timeline to begin using HMIS or comparable database?

1. Grantees must be in compliance with HMIS requirements at the time of the application. Has your agency received any HMIS or comparable database concerns or findings since January 2017? If yes, discuss how your agency addressed these concerns or findings, including any corrective action.

**Section III. PROPOSAL INFORMATION**

**Youth Program Overview**

1. Provide a detailed description of the **specific services** that will be funded by the FY23 application, and the **number of participants you will serve in the program.**
2. What are the outcomes that your program will achieve? How will your program prevent or end homelessness?
3. If applying for *housing stabilization* funds, describe your experience with locating permanent housing, providing financial and rental assistance, and using case management to support client housing stability. If applying for *outreach or case management* *services*, describe your experience providing those services to unaccompanied youth.

1. Are you planning to serve unaccompanied minors with HSP funding? If yes, are all unaccompanied minors that you serve registered with the State? ([Registration Link](https://docs.google.com/forms/d/e/1FAIpQLSfFdBuNY5ZVot_uIZMCZEocIyqBw0bO0rXcLWLGbW44htN6gQ/viewform?vc=0&c=0&w=1))

\_\_\_\_\_ Yes \_\_\_\_\_ No

**Funding Request**

|  |  |  |
| --- | --- | --- |
| **Program Activity** | **Number of Clients Served** | **Amount** |
| Outreach |  | $ |
| Emergency Shelter |  | $ |
| Rapid Re-Housing |  | $ |
| Rapid Re-Housing – Staff Costs |  | $ |
| Supportive CM Staff Costs |  | $ |
| Homeless Prevention Services |  | $ |
| TOTAL Funding Request |  | $ |

\*\*Please ensure your Total Funding Request matches your cover sheet.

**Program Renewal with Budget Increase**

1. Agencies applying for a budget increase with a renewal program, describe any proposed increases to existing projects budgeted under competitive funding through this HSP application, and how these increases will impact the total numbers served under each activity, total bed availability and services offered. New applicants, please skip this question.

**Matching Funds**

1. Please demonstrate how your agency's request will meet the 25% renewal match requirement, including cash and non-cash contributions. For FY23, the 25% match requirement is waived for all new projects.

|  |
| --- |
|  |

**Past Performance**

1. Has your agency previously been awarded funds from any of the six programs included in the Homelessness Solutions Program (ESG, RAP, ETHS, HW-CS, SLH, HNP) within the past three years? If “yes,” list grant type and year(s) those funds were awarded.

|  |  |  |
| --- | --- | --- |
| **Funding Type** | **Year** | **Amount** |
|  |  |  |
|  |  |  |

1. Has your agency been awarded any funds through Maryland DHCD **other than** HSP funds (e.g., Community Development Block Grant funds) within the last three years? If “yes,” list program(s) and year(s) those funds were awarded.

|  |  |  |
| --- | --- | --- |
| **Funding Type** | **Year** | **Amount** |
|  |  |  |
|  |  |  |

**Section IV. SIGNED CERTIFICATION**

“I certify that I have reviewed this application and that, to the best of my knowledge and belief, all of the information provided in this application is true.”

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

Signature of Authorized Representative Date

Print Name Title