Supportive Services

ESG 2018-2019

Georgia® Department of Community Affairs

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Supportive Services

- A **Supportive Services Only** project is defined by DCA to be a distinct initiative undertaken by a sub-grantee to provide supportive services **directly** to "homeless" and "at-risk" persons (by HUD definition). Services must be collaborative and available to a network of identified homeless service agencies throughout the service area.
- Funding for Services projects is being provided using State funds. Linkages should also be made to applicable mainstream projects such as SOAR, food stamps, TANF, etc. DCA awards funds for projects with the overall objective of assisting them into permanent housing.

Supportive Services

- Must set up projects, record services in HMIS
- Clients will be literally homeless or part of a homelessness prevention project
- Except for aftercare case management, service must be offered to clients being assisted by other ESG/CoC providers in the area
- Services must be reasonably accessible…low barriers to service
- Success stories…show us how your particular service project is successful in helping to end homelessness

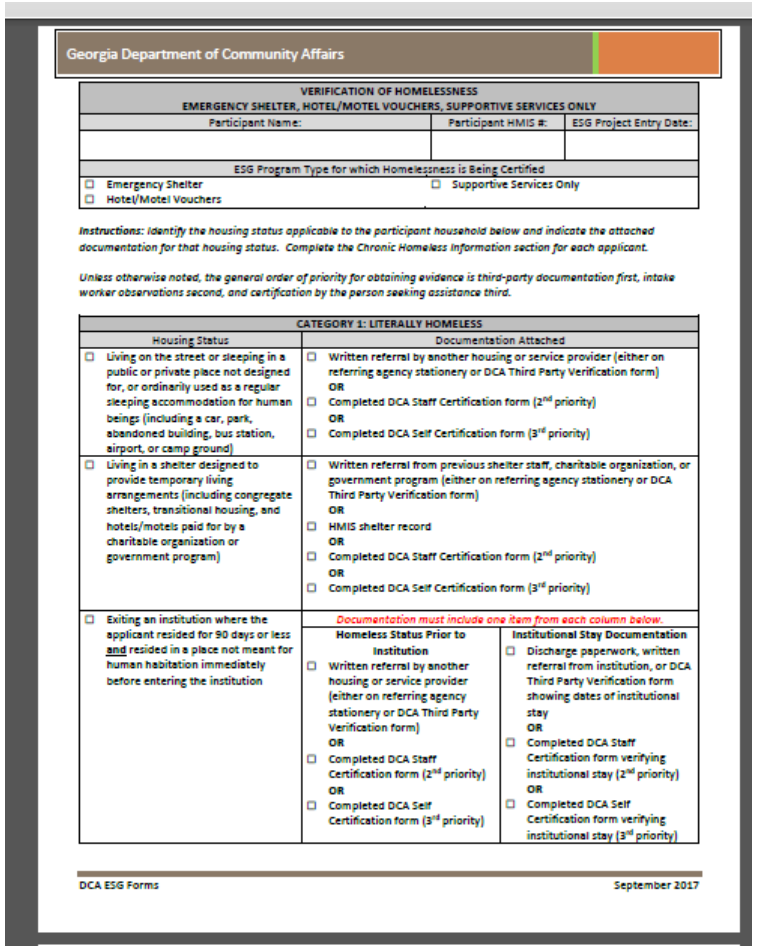
Supportive Services

- To be eligible for supportive services funding, persons served, or a majority of persons served, must **not** also be housed by another DCA ESG funded project within the same agency.
- Limited to employment, transportation, child care, aftercare case management, and SSI/SSDI Outreach And Recovery benefits services.
- Agency must demonstrate that mainstream services are not available for the project.
- These projects must be directly connected to projects moving clients into permanent housing.

Supportive Services + HMIS

- There should be a project on HMIS dedicated to your DCA ESG-funded Supportive Service project. All household members that your agency is providing assistance to should be enrolled and later discharged from the project **(including children)**.

DCA Housing Status Verification Form



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VERIFICATION OF HOMELESSNESS
EMERGENCY SHELTER, HOTEL/MOTEL VOUCHERS, SUPPORTIVE SERVICES ONLY

Participant Name:	Participant HMIS #:	ESG Project Entry Date:

ESG Program Type for which Homelessness is Being Certified

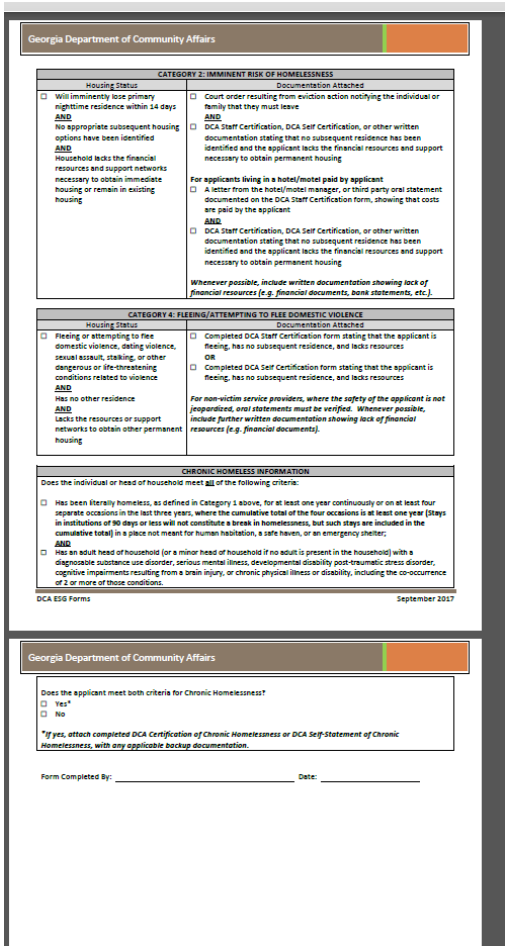
☐ Emergency Shelter ☐ Supportive Services Only
☐ Hotel/Motel Vouchers

Instructions: Identify the housing status applicable to the participant household below and indicate the attached documentation for that housing status. Complete the Chronic Homeless Information section for each applicant.

Unless otherwise noted, the general order of priority for obtaining evidence is third-party documentation first, intake worker observations second, and certification by the person seeking assistance third.

CATEGORY 1: LITERALLY HOMELESS	
Housing Status	Documentation Attached
☐ Living on the street or sleeping in a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings (including a car, park, abandoned building, bus station, airport, or camp ground)	☐ Written referral by another housing or service provider (either on referring agency stationery or DCA Third Party Verification form) **OR** ☐ Completed DCA Staff Certification form (2nd priority) **OR** ☐ Completed DCA Self Certification form (3rd priority)
☐ Living in a shelter designed to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels/motels paid for by a charitable organization or government program)	☐ Written referral from previous shelter staff, charitable organization, or government program (either on referring agency stationery or DCA Third Party Verification form) **OR** ☐ HMIS shelter record **OR** ☐ Completed DCA Staff Certification form (2nd priority) **OR** ☐ Completed DCA Self Certification form (3rd priority)
☐ Exiting an institution where the applicant resided for 90 days or less **and** resided in a place not meant for human habitation immediately before entering the institution	*Documentation must include one item from each column below.* **Homeless Status Prior to Institution** ☐ Written referral by another housing or service provider (either on referring agency stationery or DCA Third Party Verification form) **OR** ☐ Completed DCA Staff Certification form (2nd priority) **OR** ☐ Completed DCA Self Certification form (3rd priority) **Institutional Stay Documentation** ☐ Discharge paperwork, written referral from institution, or DCA Third Party Verification form showing dates of institutional stay **OR** ☐ Completed DCA Staff Certification form verifying institutional stay (2nd priority) **OR** ☐ Completed DCA Self Certification form verifying institutional stay (3rd priority)

DCA Housing Status Verification Form



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CATEGORY 2: IMMINENT RISK OF HOMELESSNESS

Housing Status	Documentation Attached
☐ Will imminently lose primary nighttime residence within 14 days **AND** No appropriate subsequent housing options have been identified **AND** Household lacks the financial resources and support networks necessary to obtain immediate housing or remain in existing housing	☐ Court order resulting from eviction action notifying the individual or family that they must leave **AND** ☐ DCA Staff Certification, DCA Self Certification, or other written documentation stating that no subsequent residence has been identified and the applicant lacks the financial resources and support necessary to obtain permanent housing **For applicants living in a hotel/motel paid by applicant** ☐ A letter from the hotel/motel manager, or third party oral statement documented on the DCA Staff Certification form, showing that costs are paid by the applicant **AND** ☐ DCA Staff Certification, DCA Self Certification, or other written documentation stating that no subsequent residence has been identified and the applicant lacks the financial resources and support necessary to obtain permanent housing ***Whenever possible, include written documentation showing lack of financial resources (e.g. financial documents, bank statements, etc.).***

CATEGORY 4: FLEEING/ATTEMPTING TO FLEE DOMESTIC VIOLENCE

Housing Status	Documentation Attached
☐ Fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions related to violence **AND** Has no other residence **AND** Lacks the resources or support networks to obtain other permanent housing	☐ Completed DCA Staff Certification form stating that the applicant is fleeing, has no subsequent residence, and lacks resources **OR** ☐ Completed DCA Self Certification form stating that the applicant is fleeing, has no subsequent residence, and lacks resources ***For non-victim service providers, where the safety of the applicant is not jeopardized, oral statements must be verified. Whenever possible, include further written documentation showing lack of financial resources (e.g. financial documents).***

CHRONIC HOMELESS INFORMATION

Does the individual or head of household meet **all** of the following criteria:

☐ Has been literally homeless, as defined in Category 1 above, for at least one year continuously or on at least four separate occasions in the last three years, **where the cumulative total of the four occasions is at least one year (Stays in institutions of 90 days or less will not constitute a break in homelessness, but such stays are included in the cumulative total)** in a place not meant for human habitation, a safe haven, or an emergency shelter;
AND
☐ Has an adult head of household (or a minor head of household if no adult is present in the household) with a diagnosable substance use disorder, serious mental illness, developmental disability post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions.

DCA ESG Forms September 2017

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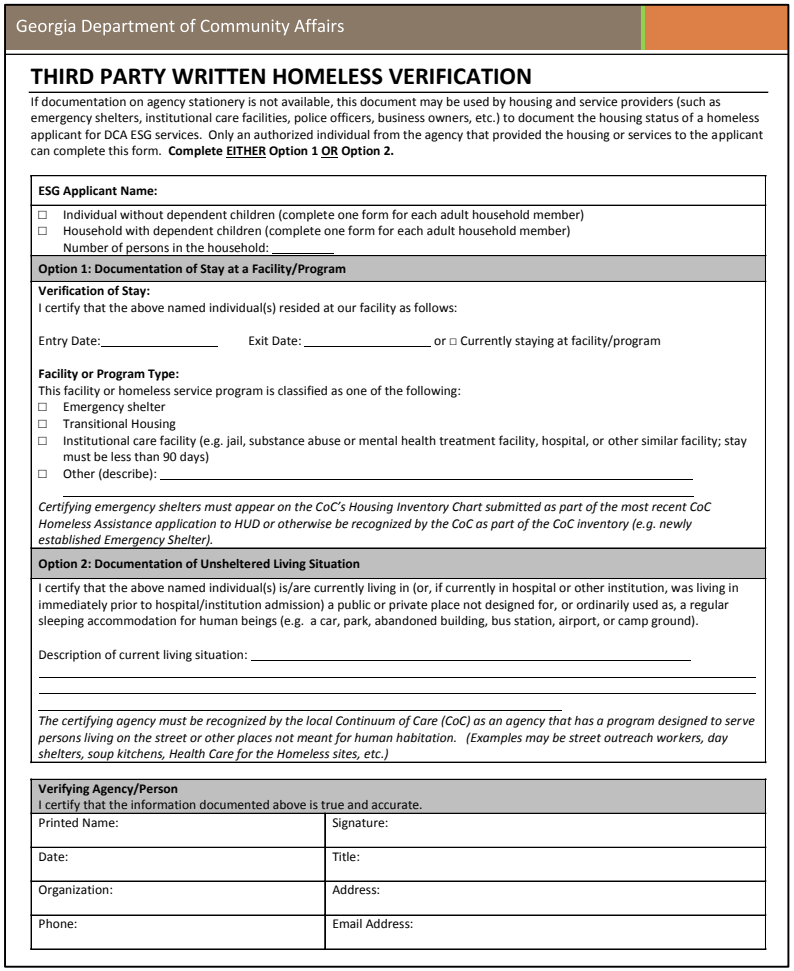
Does the applicant meet both criteria for Chronic Homelessness?
☐ Yes*
☐ No

If yes, attach completed DCA Certification of Chronic Homelessness or DCA Self-Statement of Chronic Homelessness, with any applicable backup documentation.

Form Completed By: _____ Date: _____

DCA Third Party Written Homeless Verification



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THIRD PARTY WRITTEN HOMELESS VERIFICATION

If documentation on agency stationery is not available, this document may be used by housing and service providers (such as emergency shelters, institutional care facilities, police officers, business owners, etc.) to document the housing status of a homeless applicant for DCA ESG services. Only an authorized individual from the agency that provided the housing or services to the applicant can complete this form. **Complete EITHER Option 1 OR Option 2.**

ESG Applicant Name:

☐ Individual without dependent children (complete one form for each adult household member)
☐ Household with dependent children (complete one form for each adult household member)
Number of persons in the household: _____

Option 1: Documentation of Stay at a Facility/Program

Verification of Stay:
I certify that the above named individual(s) resided at our facility as follows:

Entry Date:_____ Exit Date: _____ or ☐ Currently staying at facility/program

Facility or Program Type:
This facility or homeless service program is classified as one of the following:
☐ Emergency shelter
☐ Transitional Housing
☐ Institutional care facility (e.g. jail, substance abuse or mental health treatment facility, hospital, or other similar facility; stay must be less than 90 days)
☐ Other (describe): _____

Certifying emergency shelters must appear on the CoC's Housing Inventory Chart submitted as part of the most recent CoC Homeless Assistance application to HUD or otherwise be recognized by the CoC as part of the CoC inventory (e.g. newly established Emergency Shelter).

Option 2: Documentation of Unsheltered Living Situation

I certify that the above named individual(s) is/are currently living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g. a car, park, abandoned building, bus station, airport, or camp ground).

Description of current living situation: _____

The certifying agency must be recognized by the local Continuum of Care (CoC) as an agency that has a program designed to serve persons living on the street or other places not meant for human habitation. (Examples may be street outreach workers, day shelters, soup kitchens, Health Care for the Homeless sites, etc.)

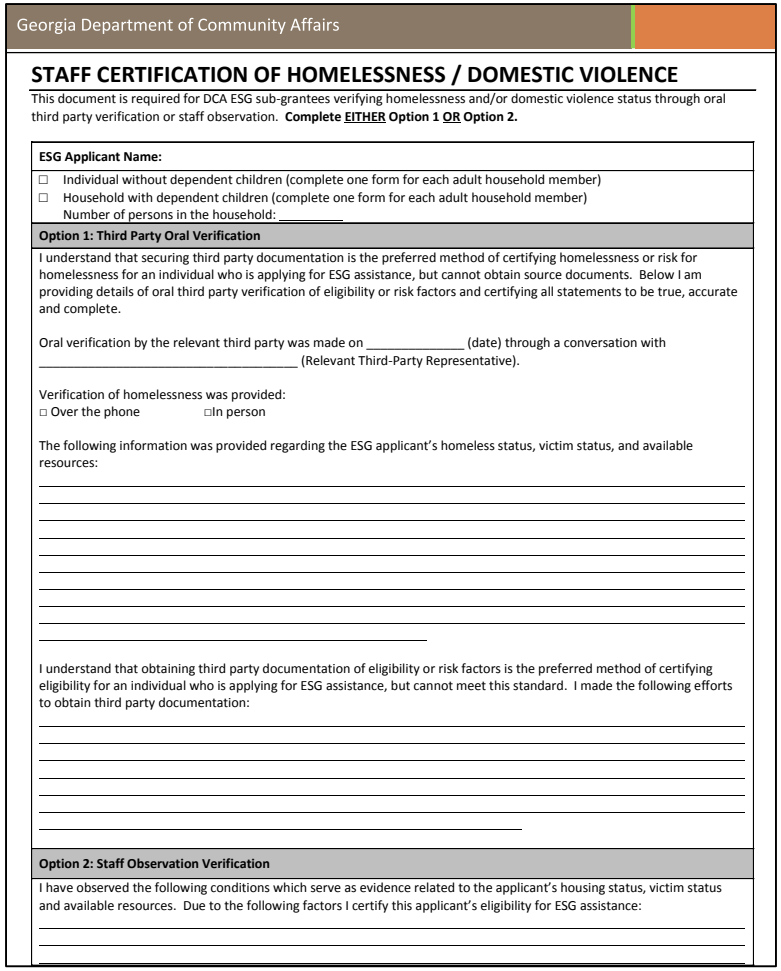
Verifying Agency/Person
I certify that the information documented above is true and accurate.

Printed Name:	Signature:
Date:	Title:
Organization:	Address:
Phone:	Email Address:

- This form is required for third party written verification when sufficient written verification is not otherwise available.

DCA Staff Certification of Homelessness and Domestic Violence

- This form is required for homeless certification by oral third party statements or staff observation.



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STAFF CERTIFICATION OF HOMELESSNESS / DOMESTIC VIOLENCE

This document is required for DCA ESG sub-grantees verifying homelessness and/or domestic violence status through oral third party verification or staff observation. **Complete EITHER Option 1 OR Option 2.**

ESG Applicant Name:

☐ Individual without dependent children (complete one form for each adult household member)
☐ Household with dependent children (complete one form for each adult household member)
Number of persons in the household: _____

Option 1: Third Party Oral Verification

I understand that securing third party documentation is the preferred method of certifying homelessness or risk for homelessness for an individual who is applying for ESG assistance, but cannot obtain source documents. Below I am providing details of oral third party verification of eligibility or risk factors and certifying all statements to be true, accurate and complete.

Oral verification by the relevant third party was made on _____ (date) through a conversation with _____ (Relevant Third-Party Representative).

Verification of homelessness was provided:
□ Over the phone □In person

The following information was provided regarding the ESG applicant's homeless status, victim status, and available resources:

I understand that obtaining third party documentation of eligibility or risk factors is the preferred method of certifying eligibility for an individual who is applying for ESG assistance, but cannot meet this standard. I made the following efforts to obtain third party documentation:

Option 2: Staff Observation Verification

I have observed the following conditions which serve as evidence related to the applicant's housing status, victim status and available resources. Due to the following factors I certify this applicant's eligibility for ESG assistance:

DCA Self Certification of Homelessness and Domestic Violence

Georgia Department of Community Affairs

SELF CERTIFICATION OF HOMELESSNESS / DOMESTIC VIOLENCE

This is to certify that the below named individual or household is currently homeless based on the check mark, other included information, and signature indicating their current living situation. **The entire form must be completed.**

ESG Applicant Name:

☐ Individual without dependent children (complete one form for each adult household member)
☐ Household with dependent children (complete one form for each adult household member)
Number of persons in the household: _____

Self-Certification

ESG applicant check only one:

☐ I [and my children, if applicable] am/are currently homeless and living on the street (e.g. a car, park, abandoned building, bus station, airport, or camp ground).

☐ I [and my children, if applicable] am/are the victim(s) of domestic violence and am/are fleeing from abuse, have not identified a subsequent residence, and lack the resources or support networks, e.g., family, friends, faith-based, or other social networks, needed to obtain housing where my/our safety would not be jeopardized.

☐ I [and my children] am/are being evicted from the housing we are presently staying in and must leave this housing within the next 14 days.

I certify that I have insufficient financial resources and support networks; *e.g.,* family, friends, faith-based or other social networks, immediately available to obtain housing or to attain housing stability without ESG assistance. I certify that the information above and any other information I have provided in applying for ESG assistance is true, accurate and complete.

ESG Applicant Signature: _____ Date: _____

ESG Staff Due Diligence

I understand that third-party verification is the preferred method of certifying homelessness/risk for homelessness/victim status for an individual who is applying for ESG assistance. I understand self-declaration is only permitted when I have attempted to but cannot obtain third party verification.

Documentation of attempts made for third party verification:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ESG Staff Signature: _____ Date: _____

- This form is required for client self declaration of homelessness or domestic violence.

Client Intake Form (Adult)

Georgia Department of Community Affairs

HMIS Project Intake Form

Emergency Shelter & Street Outreach (Including PATH)

Step 1: Universal Data Collection

Please complete the following basic client information and note that all fields with an * are required fields. Universal Data Elements are required for all project participants. The response "Data Not Collected" means the question was not asked of the client and will report as missing on reports.

Basic Client Information:*

First Name:*_____ Last Name:*_____

Middle Name: _____ Suffix: _____

Name Data Quality:*
- ☐ Full Name Reported
- ☐ Partial, Street Name or Code Name Reported
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Social Security Number:*
- ☐ _____
- ☐ Full SSN Reported
- ☐ Approximate or Partial SSN Reported
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Birthdate:*_____
- ☐ Full DOB Reported
- ☐ Approximate or Partial DOB Reported
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Ethnicity:*
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Race:* *(Select All That Apply)*
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Gender:*
- ☐ Male
- ☐ Female
- ☐ Transgender Female to Male
- ☐ Transgender Male to Female
- ☐ Client Doesn't Identify Male, Female or Transgender
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

If Female, Pregnancy Status:*
- ☐ Yes
  - ☐ Due Date:_____
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Disabling Condition:*
- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Veteran Status:*
- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Relationship to Head of Household:*
- ☐ Self
- ☐ Son
- ☐ Daughter
- ☐ Dependent Child
- ☐ Spouse
- ☐ Foster Child
- ☐ Grandchild
- ☐ Other Family Member
- ☐ Other Non-Family Member

Contact Information:

Address:_____ City/State/Zip:_____

Email:_____ Home Phone:_____

Work Phone:_____ Message Phone:_____

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Step 2: Project Enrollment

Complete the project enrollment information and please note all fields with an * are required fields. Complete additional forms for each household member to be enrolled.

Assessment Date:*_____ Street Outreach Project Entry Date:*_____

Case Assignment:*:_____ Street Outreach Engagement Date:*_____

(ONLY REQUIRED FOR PATH PARTICIPANTS):

Project Entry Date:* _____ *(Date of 1st Contact)*

Date of PATH Engagement: _____ *(Interactive client relationship; results in deliberate assessment)*

Date of PATH Status Determined: _____

Client Became Enrolled in PATH: ☐ Yes ☐ No *(Client formally consents to participate in PATH program services)*

Reason Not Enrolled in PATH:
- ☐ Client was found ineligible for PATH
- ☐ Client not enrolled for other reason(s)

Step 3: Entry Assessments

Complete the following entry assessments and please note all fields with an * are required fields.

Housing Status* *(Based on housing condition just prior to project entry)*
- ☐ Category 1 – Homeless
- ☐ Category 2 – At Imminent Risk of Losing Housing
- ☐ Category 3 – Homeless Only Under Other Federal Statutes
- ☐ Category 4 – Fleeing Domestic Violence
- ☐ At Risk of Homelessness
- ☐ Stably Housed - Rent
- ☐ Stably Housed – Own
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Other
- ☐ Data Not Collected

Type of Residence:*

HOMELESS SITUATION
- ☐ Place not meant for habitation (a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Safe Haven
- ☐ Interim Housing

INSTITUTIONAL SITUATION
- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, Prison or Juvenile Detention Center
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric Hospital or Other Psychiatric Facility
- ☐ Substance Abuse Treatment Facility or Detox Center

TRANSITIONAL AND PERMANENT HOUSING SITUATION
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Owned by client, no ongoing housing subsidy

Client Intake Form (Adult)

Georgia Department of Community Affairs

Barriers:*	Barrier Present?	Receiving Services/Treatment?	Condition is Indefinite?	Documentation on File?
Alcohol Abuse	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No
Developmental Disability	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No
Drug Abuse	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No
Mental Health	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No
Physical Disability	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No
Chronic Health Condition	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Yes ☐ No

HMIS Barriers Assessment:*

If client reports "Alcohol Abuse, Drug Abuse and/or Mental Health" as present barriers, complete the following:

How confirmed:

- ☐ Unconfirmed; presumptive or self-report
- ☐ Confirmed through assessment and clinical evaluation
- ☐ Confirmed by prior evaluation or clinical records

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(ONLY REQUIRED FOR PATH PARTICIPANTS)

Connection with SOAR:*

☐ Yes ☐ No
☐ Client Doesn't Know ☐ Client Refused

Domestic Violence Assessment of Victim:*

Is client a victim of domestic violence:*

☐ Yes ☐ No
☐ Client Doesn't Know ☐ Client Refused
☐ Data Not Collected

Currently Fleeing:*

☐ Yes ☐ No
☐ Client Doesn't Know ☐ Client Refused
☐ Data Not Collected

If yes, when experience occurred:*

☐ Within the past three months
☐ Three to six months ago (excluding 6 months exactly)
☐ Six months to one year ago (excluding 1 year exactly)
☐ One year ago or more
☐ Client Doesn't Know
☐ Client Refused
☐ Data Not Collected

Financial Assessment:* Cash Income:* ☐ Yes ☐ No

- ☐ Earned Income $_____
- ☐ Private Disability Insurance $_____
- ☐ Unemployment Insurance $_____
- ☐ Worker's Compensation $_____
- ☐ Pension From Former Job (VA Included) $_____
- ☐ Supplemental Security Income $_____
- ☐ Social Security Disability Income $_____
- ☐ Retirement (Social Security) $_____
- ☐ Alimony $_____
- ☐ VA Service-Connected Disability $_____
- ☐ VA Non Service-Connected Disability $_____
- ☐ TANF $_____
- ☐ Child Support $_____
- ☐ Other Income $_____

Non Cash Benefits:* ☐ Yes ☐ No

- ☐ Food Stamps/Money for Food on Benefits Card $_____
- ☐ Special Supplemental Nutrition Program (WIC)
- ☐ TANF Child Care Services
- ☐ TANF Transportation Services
- ☐ Other TANF Funded Services
- ☐ Section 8, Public Housing, Other Rental Asst. (PSH) $_____
- ☐ Temporary Rental Assistance (RRH) $_____
- ☐ Other Source

(ONLY REQUIRED FOR PATH PARTICIPANTS)

Date of Contact:*_____

Contact with:_____

Enrollment:*_____

Contact Service:*

- o Assessments: PATH Screening/Assessment
- o Case Management: PATH – Case Management
- o Health/Medical: PATH – Referral Primary Health Services
- o Mental Health/Counseling: PATH – Referral Community Mental Health
- o Prevention/Outreach: PATH – Outreach
- o Substance Abuse: PATH – Referral Substance Abuse Treatment

Current Location:*

- ☐ Place Not Meant for Habitation
- ☐ Service Setting, Non-Residential
- ☐ Service Setting, Residential

Client Intake Form (Adult)

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- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent Housing for Formerly Homeless Persons (a CoC project; HUD legacy programs; or HOPWA PH)
- ☐ Rental by client, with no ongoing housing subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Transitional Housing for Homeless Persons (Including Homeless Youth)
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Length of stay in the prior living situation:*

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than one month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Approximate date homelessness started:*_____

Regardless of where they stayed last night – number of times the client has been on the streets, in ES, or SH in the past three years including today:*

- ☐ One Time
- ☐ Two Times
- ☐ Three Times
- ☐ Four Times
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Total number of months homeless on the street, in ES, or SH in the past three years:*

- ☐ One month (this time is the first month)
- ☐ 2-12 months
  - ☐ Number of months (2-12):*_____
- ☐ More than 12 months
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

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Covered by Health Insurance:*

- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Type:*

- ☐ Private - COBRA
- ☐ Private – Employer
- ☐ Private – Individual
- ☐ Medicare
- ☐ Medicaid
- ☐ State Children's Health Insurance Program (S-CHIP; not Medicaid or HIP)
- ☐ Military Insurance
- ☐ Other Public
- ☐ State Funded (HIP or HIP 2.0)
- ☐ Indian Health Service (Native American)
- ☐ Other_____

Status:*

- ☐ Active
  - ☐ Start Date:_____
  - ☐ End Date:_____
- ☐ No
  - ☐ Applied; decision pending
  - ☐ Applied; client not eligible
  - ☐ Client did not apply
  - ☐ Insurance type N/A for this client
  - ☐ Client Doesn't Know
  - ☐ Client Refused
  - ☐ Data Not Collected

Veterans Assessment:*

Military Branch:*

- ☐ Army
- ☐ Air Force
- ☐ Navy
- ☐ Marines
- ☐ Coast Guard
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Discharge Status:*

- ☐ Honorable
- ☐ General under honorable conditions
- ☐ Bad Conduct
- ☐ Dishonorable
- ☐ Under Other Than Honorable Conditions (OTH)
- ☐ Uncharacterized
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Service Entry Date:*_____ Service Exit Date: _____

Select Theatre(s) of Operation(s):* *(May not apply to client)*

- ☐ World War II (September 1940-July 1947)
- ☐ Vietnam War (August 1964-April 1975)
- ☐ Persian Gulf War (Operation Desert Storm) (August 1991-September 10, 2001)
- ☐ Afghanistan (Operation Enduring Freedom)
- ☐ Iraq (Operation Iraqi Freedom)
- ☐ Iraq (Operation New Dawn)
- ☐ Other Peace-keeping operations or military interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)
- ☐ Korean War (June 1950-January 1955)

Status:*

- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Client Intake Form (Adult)

Georgia Department of Community Affairs

- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent Housing for Formerly Homeless Persons (a CoC project; HUD legacy programs; or HOPWA PH)
- ☐ Rental by client, with no ongoing housing subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Transitional Housing for Homeless Persons (Including Homeless Youth)
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Length of stay in the prior living situation:*

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than one month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Approximate date homelessness started:*_____

Regardless of where they stayed last night – number of times the client has been on the streets, in ES, or SH in the past three years including today:*

- ☐ One Time
- ☐ Two Times
- ☐ Three Times
- ☐ Four Times
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Total number of months homeless on the street, in ES, or SH in the past three years:*

- ☐ One month (this time is the first month)
- ☐ 2-12 months
  - ☐ Number of months (2-12):*_____
- ☐ More than 12 months
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Georgia Department of Community Affairs

Covered by Health Insurance:*

- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Type:*

- ☐ Private - COBRA
- ☐ Private – Employer
- ☐ Private – Individual
- ☐ Medicare
- ☐ Medicaid
- ☐ State Children's Health Insurance Program (S-CHIP; not Medicaid or HIP)
- ☐ Military Insurance
- ☐ Other Public
- ☐ State Funded (HIP or HIP 2.0)
- ☐ Indian Health Service (Native American)
- ☐ Other_____

Status:*

- ☐ Active
  - ☐ Start Date:_____
  - ☐ End Date:_____
- ☐ No
  - ☐ Applied; decision pending
  - ☐ Applied; client not eligible
  - ☐ Client did not apply
  - ☐ Insurance type N/A for this client
  - ☐ Client Doesn't Know
  - ☐ Client Refused
  - ☐ Data Not Collected

Veterans Assessment:*

Military Branch:*

- ☐ Army
- ☐ Air Force
- ☐ Navy
- ☐ Marines
- ☐ Coast Guard
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Discharge Status:*

- ☐ Honorable
- ☐ General under honorable conditions
- ☐ Bad Conduct
- ☐ Dishonorable
- ☐ Under Other Than Honorable Conditions (OTH)
- ☐ Uncharacterized
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Service Entry Date:*_____ Service Exit Date: _____

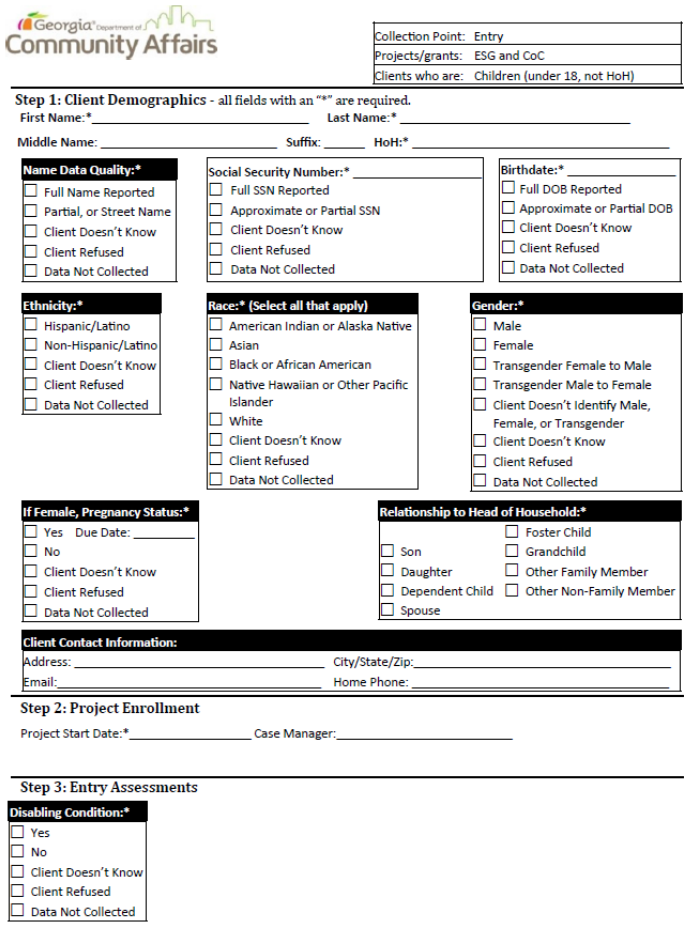
Select Theatre(s) of Operation(s):* *(May not apply to client)*

- ☐ World War II (September 1940-July 1947)
- ☐ Vietnam War (August 1964-April 1975)
- ☐ Persian Gulf War (Operation Desert Storm) (August 1991-September 10, 2001)
- ☐ Afghanistan (Operation Enduring Freedom)
- ☐ Iraq (Operation Iraqi Freedom)
- ☐ Iraq (Operation New Dawn)
- ☐ Other Peace-keeping operations or military interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)
- ☐ Korean War (June 1950-January 1955)

Status:*

- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Client Intake Form (Child)



Georgia Department of Community Affairs

Collection Point:	Entry
Projects/grants:	ESG and CoC
Clients who are:	Children (under 18, not HoH)

Step 1: Client Demographics - all fields with an "*" are required.

First Name:* _____ Last Name:* _____

Middle Name: _____ Suffix: _____ HoH:* _____

Name Data Quality:*
- ☐ Full Name Reported
- ☐ Partial, or Street Name
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Social Security Number:* _____
- ☐ Full SSN Reported
- ☐ Approximate or Partial SSN
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Birthdate:* _____
- ☐ Full DOB Reported
- ☐ Approximate or Partial DOB
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Ethnicity:*
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Race:* (Select all that apply)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Gender:*
- ☐ Male
- ☐ Female
- ☐ Transgender Female to Male
- ☐ Transgender Male to Female
- ☐ Client Doesn't Identify Male, Female, or Transgender
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

If Female, Pregnancy Status:*
- ☐ Yes Due Date: _____
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Relationship to Head of Household:*
- ☐ Son
- ☐ Daughter
- ☐ Dependent Child
- ☐ Spouse
- ☐ Foster Child
- ☐ Grandchild
- ☐ Other Family Member
- ☐ Other Non-Family Member

Client Contact Information:

Address: _____ City/State/Zip: _____

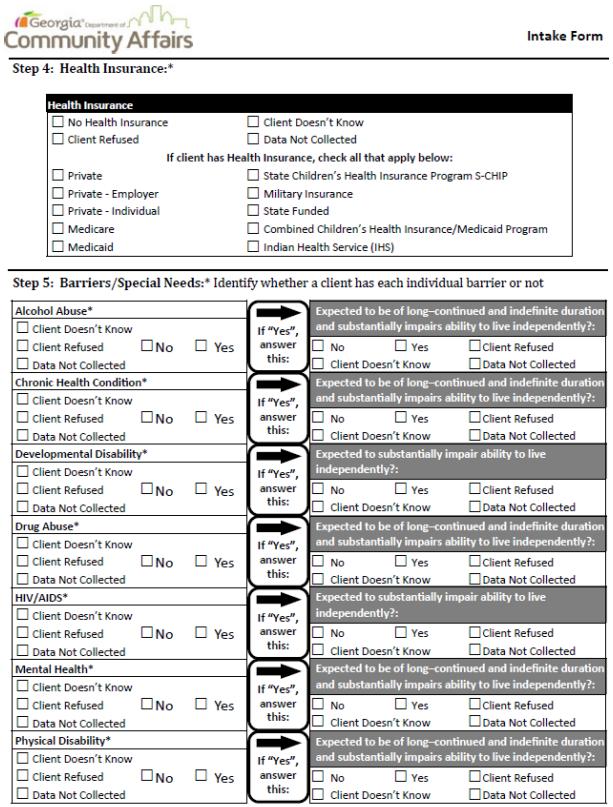
Email: _____ Home Phone: _____

Step 2: Project Enrollment

Project Start Date:* _____ Case Manager: _____

Step 3: Entry Assessments

Disabling Condition:*
- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected



Georgia Department of Community Affairs — Intake Form

Step 4: Health Insurance:*

Health Insurance
- ☐ No Health Insurance
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

If client has Health Insurance, check all that apply below:
- ☐ Private
- ☐ State Children's Health Insurance Program S-CHIP
- ☐ Private - Employer
- ☐ Military Insurance
- ☐ Private - Individual
- ☐ State Funded
- ☐ Medicare
- ☐ Combined Children's Health Insurance/Medicaid Program
- ☐ Medicaid
- ☐ Indian Health Service (IHS)

Step 5: Barriers/Special Needs:* Identify whether a client has each individual barrier or not

	If "Yes", answer this:	Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently?:
Alcohol Abuse* ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ No ☐ Yes	☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Chronic Health Condition* ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ No ☐ Yes	☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Developmental Disability* ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ No ☐ Yes	Expected to substantially impair ability to live independently?: ☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Drug Abuse* ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ No ☐ Yes	☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
HIV/AIDS* ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ No ☐ Yes	Expected to substantially impair ability to live independently?: ☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Mental Health* ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ No ☐ Yes	☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected
Physical Disability* ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ No ☐ Yes	☐ No ☐ Yes ☐ Client Refused ☐ Client Doesn't Know ☐ Data Not Collected

HMIS Client Consent to Share Form

Georgia Homeless Management Information System (GA HMIS) Collaborative
Client Consent to Share Information

The Georgia Homeless Management Information System ("GA HMIS") is an online database that is used to collect information (data) about clients accessing housing and homeless services throughout the State of Georgia. Organizations that receive homeless funding from the US Department of Housing and Urban Development (HUD) and other federal and state partners are required to collect and store basic information about the persons who receive their services. This organization participates in the GA HMIS and by requesting and accepting services from them you are providing consent to enter your personal information into the GA HMIS. This information is utilized to determine your needs and provide supportive services to you and your household, and information is shared with other organizations that use this database, based on your signed consent.

What type of information may be shared in the HMIS?

We collect general and Protected Personal Information about you and record it in GA HMIS. The information shared through HMIS is dependent on your situation, and may include, but is not limited to:

- Your basic identifying information (including name, Social Security Number, date of birth, gender, race/ ethnicity, marital and family status, household relationships, contact information, veteran status, disability status);
- Your history of homelessness and housing (including your current housing status, present and/ or prior living situation, and where and when you have accessed services);
- Your income information (sources and amounts of household income, employment information, work skills) and other resources, such as non-cash or public benefits;
- Your legal history/information;
- Your general, self-reported medical history including any mental health and substance abuse issues or HIV status (detailed medical or treatment information will never be shared, however), and type of health insurance;
- Your reasons for seeking services, your service needs, and the outcomes of services provided to you;
- Your emergency contact information;
- Other information needed for eligibility of certain types of projects (such as military history, educational background, employment background, sexual orientation, etc.)

How do you benefit from sharing your information?

The information you provide to GA HMIS helps us coordinate the most effective services for you and/or your family. By sharing your information, you may be able to avoid being screened more than once, get faster and more personalized services, and minimize how many times you have to tell your "story." Collecting this information also gives us a better understanding of homelessness in your local area and the effectiveness of the services provided in your area.

Who may be given access to your information?

The GA HMIS participating organizations may have access to your data on a need-to-know basis. These organizations may include homeless service providers, other social services organizations, housing providers, healthcare providers and administrators of the system. In other rare cases, such as when required by law, or for purposes of research, your information may be shared outside of the GA HMIS participating organizations (but never to the general public). For more information, please request a copy of our privacy policy.

How is your personal information protected?

Your information in the HMIS is secured by passwords and encrypted transmission technology. In addition, each participating organization and system user must sign an agreement to maintain the security and confidentiality of the information. Your information is protected by the federal HMIS Privacy Standards. In some instances, depending on the services provided by a participating organization, your information may also be protected by additional Federal and/or State regulations, which may require additional written consent prior to any disclosure.

By signing this form, you understand that:

- You have the right to receive services even if you do not agree to share your information.
- Consenting to share your information does not automatically guarantee you services.
- You have the right to receive a copy of this consent form.
- Your consent allows your record to be updated by any participating organization with which you interact without you being required to sign another consent form.
- Your consent does not expire, but you may cancel your consent at any time, by completing the Client Revocation of Consent to Share Information form. You further understand that any cancellation of this consent will not retroactively change information that has already been disclosed or actions already taken under your previous authorization.
- The GA HMIS Privacy Policy contains more detailed information about how your information may be used and disclosed.
- Upon your request, we are required to provide you with, as applicable:
  - A copy of the Client Revocation of Consent to Release Information;
  - A copy of the GA HMIS Privacy Policy;
  - A copy of your full HMIS records (apart from case notes) within five (5) business days of your request;
  - A current list of participating organizations that have access to your data.
- If you find inaccurate or incomplete Protected Personal Information in your records, you have the right to request a correction.
- Aggregate or statistical data that is released from HMIS will not disclose any of your Protected Personal Information.
- You have the right to file a grievance against any organization you feel has violated your confidentiality.
- If you need to be referred to another agency for services, certain information may need to be forwarded through HMIS to facilitate a referral. If you do not provide consent to share your information, it may negatively affect participating providers from addressing your service needs in a coordinated fashion.
- You are not waiving any rights protected under Federal and/or Georgia law.

SIGNATURE AND ACKNOWLEDGEMENT

Your signature below indicates that you have read (or have been read) this client consent form and have received answers to your questions. Please indicate your sharing preference by choosing one of the options below:

☐ I consent to allow my information, and that of my minor children (if applicable, as listed below), to be shared via the GA HMIS as described in this consent form.

☐ I consent to allow my basic identifying information, and that of my minor children (if applicable, as listed below), to be shared via the GA HMIS; however, I wish to limit the sharing of other information as specified in the Client Consent to Share Information – Supplemental form.

☐ I do not consent to allow my information to be shared via the GA HMIS. I understand that this choice may negatively affect the quality of services the GA HMIS participating providers are able to provide.

Client/ Legal Guardian Name (Please print):_____DOB:_____Last 4 digits of SS_____

Signature_____Date _____

Minor Children (if any):

Client Name:_____DOB:_____Last 4 digits of SS_____

Client Name:_____DOB:_____Last 4 digits of SS_____

Client Name:_____DOB:_____Last 4 digits of SS_____

For Agency Personnel Use Only:

_____ _____

Print Name of Organization **Print Name of Organization Staff**

_____ _____

Signature of Organization Staff **Date**

Monitoring

Monitoring will be conducted. Agencies will be contacted prior to the on-site review for a mutually convenient date and time. The purpose of on-site monitoring visits are to:

- Review grantee performance with sound fiscal management and accounting practices
- Identify areas in need of improvement
- Forge a working partnership between DCA and grantee through clear communication and support

Monitoring

- Client Data and Eligibility
- Implementation of Organizational Policies and Procedures
- Reimbursement Review
- Fair Housing & Equal Opportunity (FHEO) Compliance
- Language Access Plan
- VAWA
- Equal Access Rule
- Habitability Inspection Forms

Contacts

Marion Goulbourne

ESG Program Coordinator

Marion.Goulbourne@dca.ga.gov

404-679-5293

LaDrina Jones

ESG Program Compliance Officer

LaDrina.Jones@dca.ga.gov

470-303-9865

John Shereikis

Special Needs Housing Manager

John.Shereikis@dca.ga.gov

470-747-9331

Questions?

Thank You!

ESG Financial Overview

Georgia® Department of Community Affairs

September 2018

Heather Smith, Grants Consultant

Discussion Topics

- Reimbursement Process
- Reimbursement Request Forms and Instructions
- Processing Reimbursement Requests
- Payment Notices
- Budget Amendments
- Match Requirements

ESG Reimbursement Process

- Reimbursement requests should cover eligible expenses incurred from July 1, 2018 through June 30, 2019 (September 30, 2019 for RRH and Prevention)
- Reimbursement requests should be submitted monthly if possible and quarterly at the latest
- Match must be reported on each request for reimbursement and there is a space on the reimbursement form to record the match.
- Reimbursement requests should be mailed to Heather Smith. Faxed or emailed reimbursement requests are not accepted at this time.

ESG Reimbursement Process

Items Required for Reimbursement Request:

- Two pages; a Reimbursement Request Form and a Summary of Reimbursable Items by Line Item
- You must complete both pages in their entirety – ALL FIELDS
- An updated Reimbursement Request Form and a payment notice will be emailed to you once the payment has been processed by DCA
- Do not submit another reimbursement request until you have received your payment notice with you updated reimbursement form by email

ESG Reimbursement Process

- Prior to processing each reimbursement request, client level data will be reviewed for the reporting period beginning July 1, 2018 through the approximate date of your request.
- Each grantee should attach their client track data report to the ESG reimbursement request form as the last page of each request.
- Any deficiencies of 5% or more, in any one data field, will be reported to you with your returned reimbursement request and data must be cleaned before the reimbursement can be returned for processing.
- Domestic Violence Shelters (DV) must include a copy of the APRICOT data with each reimbursement request that follows the same reporting period.

ESG Reimbursement Process (Desk Audit)

- A desk audit is a request for supporting documentation by the person processing the reimbursement request
- This request can be sent via email or postal mail and will include all necessary documents to be returned
- Timely return of the requested supporting documentation is important for processing and payment

ESG Reimbursement Process

Common reasons for returned requests –

- Inappropriate signatures on Reimbursement Request Form
- Signatory on Reimbursement Cover Page is also listed as a "Vendor" in Column H of the Summary of Reimbursable Items. Any listed Vendors or Employees in Column H of the Summary of Reimbursable Items by Line Item Form **are not allowed to sign the cover page of the reimbursement request form.**
- Failure to include service dates or date ranges in Column K
- Failure to include case number (ie. Client track #) in Column B, when applicable
- Ineligible activities
- Reimbursement Amount Requested in Column L exceeds Check or Transaction Amount in Column G
- Using the wrong form or not including all necessary forms
- Poor HMIS data quality
- **Final request** for the year is not submitted/postmarked by the due date, July 31, 2019. At least two email notices are sent to all grantees regarding the grant close-out each year. Keep those email addresses up-to-date!

Reimbursement Requests Forms and Instructions

Georgia® Department of Community Affairs

October 2018

Heather Smith, Grants Consultant

Forms You Will Use

HESG RAPID REHOUSING AND PREVENTION REIMBURSEMENT REQUEST

Return Completed Request to: Office of Homelessness and Special Needs Housing Dept. of Community Affairs (DCA) 60 Executive Park South, NE Atlanta, GA 30329-2231	**Key to Source of Funds (See Block 1):** *E = Federal ESG Program (CFA# 14.231) HTF = State Housing Trust Fund	Questions For DCA Staff? PH: 404 679 0632 (Heather) FAX: 404 679 0669 EM:Heather.Smith@dca.ga.gov

1

Organization **Name Of Your Organization** — Effective Date: 7/1/2017 — Completion Date: 9/30/2018

Program Name: — **ContRact.ID** 18CXXX — State FY 2018 — Program: ESGP

Program Type: Esg Rapid Rehousing — Program Code: — Funding Source: (see "Key" above) 18E

2

As of 8/20/2018: Original Amount — Current Amount $25,000 — Total Paid: $0 — Balance: $25,000

Please Note: If this information is inconsistent with Organization's records, please notify DCA Immediately!

3

Request No. _______ Name: ______________________ Phone: __________ View All Related Payment Records

4

Item	**Budget**	**Received to Date**	**Amount Requested***
Financial Assistance Costs			
01 Application Fees			
02 Security Deposits			
03 Last Month's Rent			
04 Utility Deposits			
05 Utility Payments			
06 Moving Costs			
Financial Assistance Subtotal:			
Service Costs			
07 Housing Search and Placement			
08 Case Management			
09 Mediation			
10 Legal Services			
11 Credit Repair			
Services Subtotal:			
Short and Medium Term Rental Assistance			
12 Short and Medium Term Rental Assistance			
Total:			

Cumulative Match for Period Covered (Do not include HUD SHP or S+C) - (7/1/2017 through this request): Total $

5 **Certification by specific persons who are Board Authorized Representatives (must be signed by two representatives specifically authorized by organization's board of directors):**

By my signature below, I certify that: 1) I am authorized to make legally binding certifications on behalf of the organization named above; 2) the cost items for which reimbursement is being requested have not been and will not be submitted to any other funding entity, either for reimbursement or as documentation of the expenditure of funds advanced; 3) the portions of expenses for which reimbursement is being requested were incurred for the activity as described above, exclusively for the benefit of "eligible persons," as defined under the terms of the Program Participation Agreement; 4) the "Total Funds Expended or Obligated" sum named above was derived from the financial accounting records of the organization, and documentation in support of that figure is available upon request; 5) the organization is maintaining on a daily basis the statistical data necessary to report program benefit, as currently outlined by DCA, 6) the organization is in full compliance with all of our obligations and responsibilities under the Program Participation Agreement, and I am aware of no pending events or activities that would violate any term or terms of that Program Participation Agreement, and 7) the information contained in this report is true and correct.

Signature: ______________________ Date: ________

Type Name and Title: ______________________

Signature: ______________________ Date: ________

Page __ of __ Pages Type Name and Title: ______________________

Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: ______________________ Reimbursement Request No.: ________

Program Name: ______________________ Grant Number: ________

A Item	B Case Number of Appl.	C Env. Review Unit Address	D Site ID Exhibit E	E Date of Transaction or Payment	F Control or Check Number	G Check or Transaction Amount	H Payee (Vendor)	I Description of Item or Service	J Eligible Activity No. (See Agmt Exhibit A By Line Item)	K Service Dates or Period	L Reimbursement Amt Requested Rounded to nearest $1
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Subtotal This Page $0

Grand Total of Request ________

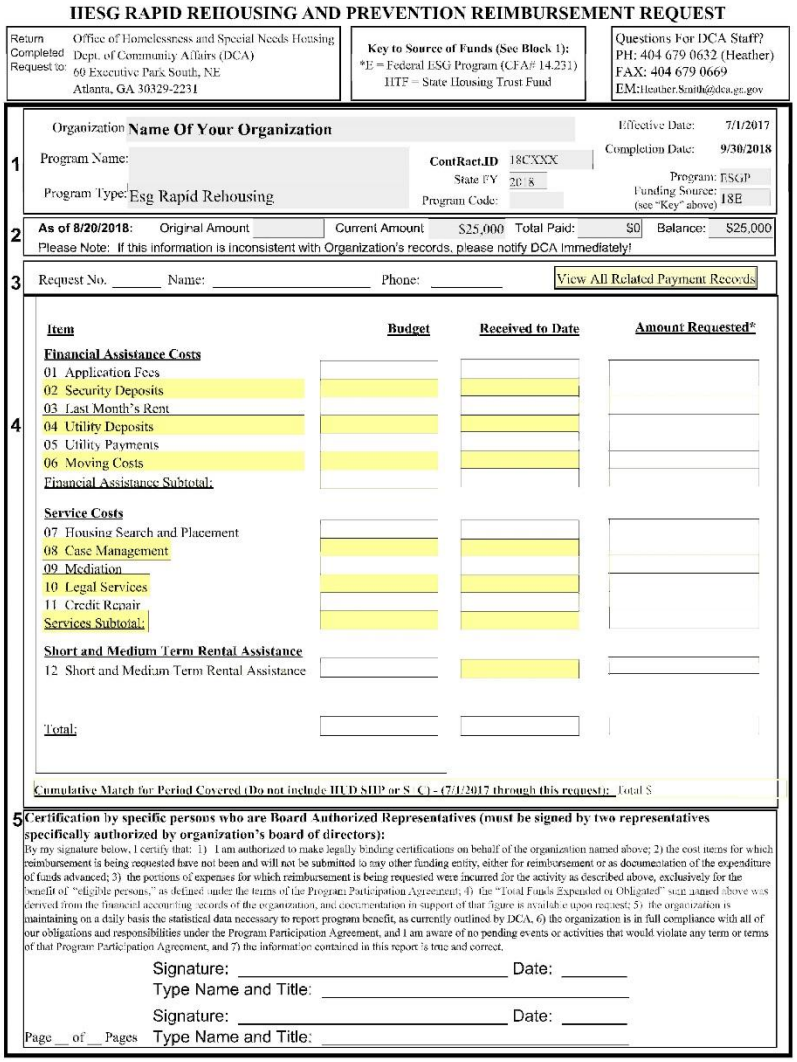
Signature of Preparer: ______________________

Date: ____________

Type Name and Title: ______________________

Page _____ of _____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Reimbursement Request Form (Page 1)



IIESG RAPID REHOUSING AND PREVENTION REIMBURSEMENT REQUEST

Return Completed Request to: Office of Homelessness and Special Needs Housing, Dept. of Community Affairs (DCA), 60 Executive Park South, NE, Atlanta, GA 30329-2231

Key to Source of Funds (See Block 1): *E = Federal ESG Program (CFA# 14.231); HTF = State Housing Trust Fund

Questions For DCA Staff? PH: 404 679 0632 (Heather); FAX: 404 679 0669; EM: Heather.Smith@dca.ga.gov

1 Organization: Name Of Your Organization — Effective Date: 7/1/2017; Completion Date: 9/30/2018
Program Name: — ContRact.ID: 18CXXX — State FY: 20 8 — Program Code: — Program: ESGP — Funding Source: (see "Key" above) 18E
Program Type: Esg Rapid Rehousing

2 As of 8/20/2018: Original Amount — Current Amount $25,000 — Total Paid: $0 — Balance: $25,000
Please Note: If this information is inconsistent with Organization's records, please notify DCA immediately!

3 Request No. _____ Name: _____ Phone: _____ View All Related Payment Records

4

Item	Budget	Received to Date	Amount Requested*
Financial Assistance Costs			
01 Application Fees			
02 Security Deposits			
03 Last Month's Rent			
04 Utility Deposits			
05 Utility Payments			
06 Moving Costs			
Financial Assistance Subtotal:			
Service Costs			
07 Housing Search and Placement			
08 Case Management			
09 Mediation			
10 Legal Services			
11 Credit Repair			
Services Subtotal:			
Short and Medium Term Rental Assistance			
12 Short and Medium Term Rental Assistance			
Total:			

Cumulative Match for Period Covered (Do not include HUD SHP or S_C) - (7/1/2017 through this request): Total $

5 **Certification by specific persons who are Board Authorized Representatives (must be signed by two representatives specifically authorized by organization's board of directors):**

By my signature below, I certify that: 1) I am authorized to make legally binding certifications on behalf of the organization named above; 2) the cost items for which reimbursement is being requested have not been and will not be submitted to any other funding entity, either for reimbursement or as documentation of the expenditure of funds advanced; 3) the portions of expenses for which reimbursement is being requested were incurred for the activity as described above, exclusively for the benefit of "eligible persons," as defined under the terms of the Program Participation Agreement; 4) the "Total Funds Expended or Obligated" sum named above was derived from the financial accounting records of the organization, and documentation in support of that figure is available upon request; 5) the organization is maintaining on a daily basis the statistical data necessary to report program benefit, as currently outlined by DCA, 6) the organization is in full compliance with all of our obligations and responsibilities under the Program Participation Agreement, and I am aware of no pending events or activities that would violate any term or terms of that Program Participation Agreement, and 7) the information contained in this report is true and correct.

Signature: _____ Date: _____
Type Name and Title: _____
Signature: _____ Date: _____
Page __ of __ Pages Type Name and Title: _____

Section 1:

- All pertinent information for grant

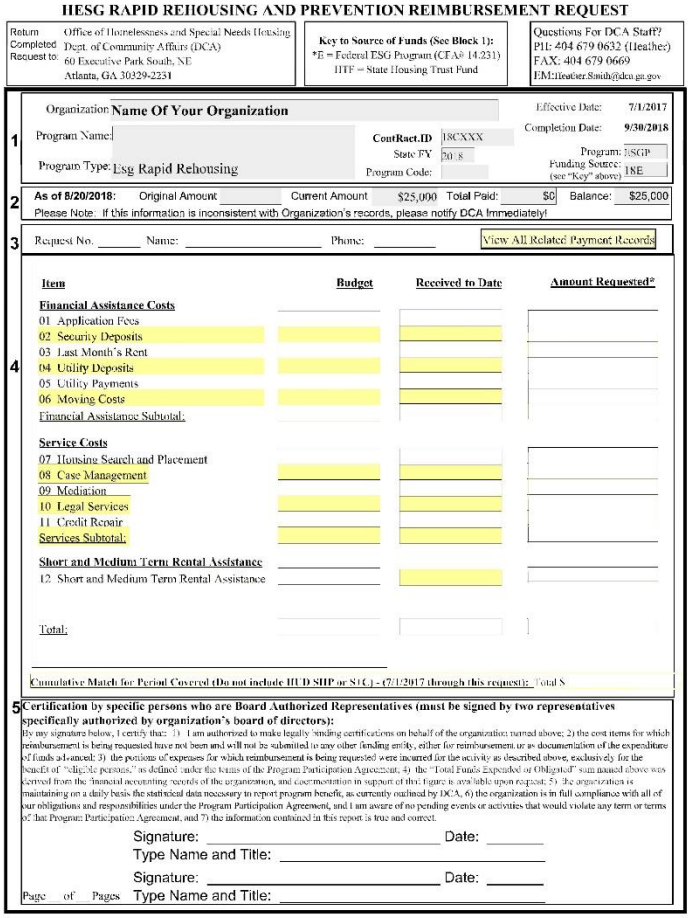
Section 2:

- Grant funds information

Section 3:

- Must be completed prior to request submission; please number requests consecutively

Reimbursement Request Form (Page 1)



HESG RAPID REHOUSING AND PREVENTION REIMBURSEMENT REQUEST

Return Completed Request to: Office of Homelessness and Special Needs Housing, Dept. of Community Affairs (DCA), 60 Executive Park South, NE, Atlanta, GA 30329-2231

Key to Source of Funds (See Block 1): *E = Federal ESG Program (CFA# 14.231); HTF = State Housing Trust Fund

Questions For DCA Staff? PH: 404 679 0632 (Heather); FAX: 404 679 0669; EM: Heather.Smith@dca.ga.gov

1 Organization: Name Of Your Organization — Effective Date: 7/1/2017; Completion Date: 9/30/2018
Program Name:
Program Type: Esg Rapid Rehousing
ContRact.ID: 18CXXX; State FY: 20 18; Program Code:
Program: HSGP; Funding Source: (see "Key" above) 18E

2 As of 8/20/2018: Original Amount ____ Current Amount $25,000 Total Paid: $0 Balance: $25,000
Please Note: If this information is inconsistent with Organization's records, please notify DCA Immediately!

3 Request No. ____ Name: ____ Phone: ____ View All Related Payment Records

4

Item	Budget	Received to Date	Amount Requested*
Financial Assistance Costs			
01 Application Fees			
02 Security Deposits			
03 Last Month's Rent			
04 Utility Deposits			
05 Utility Payments			
06 Moving Costs			
Financial Assistance Subtotal:			
Service Costs			
07 Housing Search and Placement			
08 Case Management			
09 Mediation			
10 Legal Services			
11 Credit Repair			
Services Subtotal:			
Short and Medium Term Rental Assistance			
12 Short and Medium Term Rental Assistance			
Total:			

Cumulative Match for Period Covered (Do not include HUD SHP or S+C) - (7/1/2017 through this request): Total $

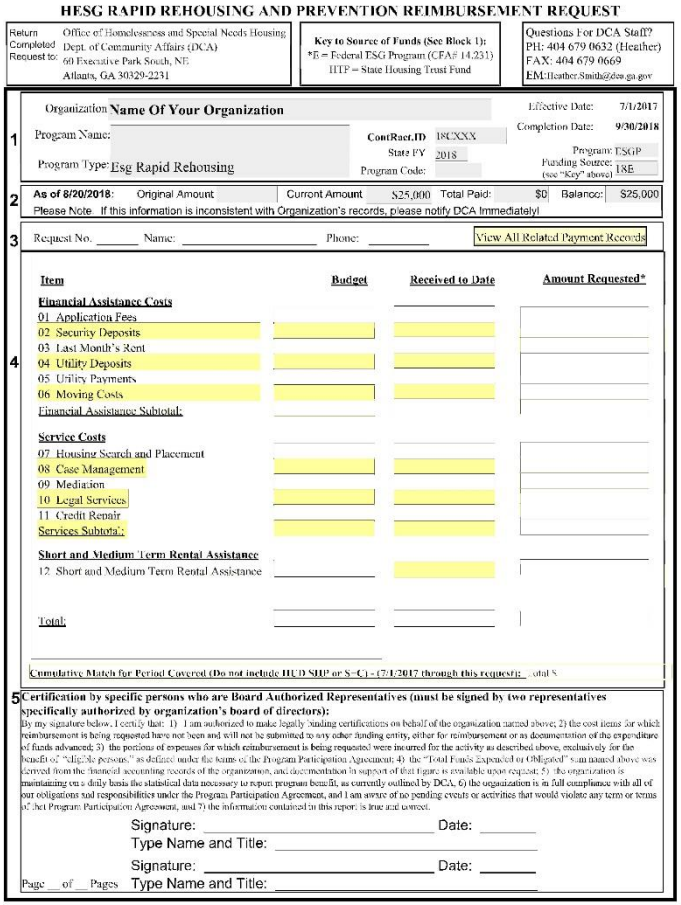
5 **Certification by specific persons who are Board Authorized Representatives (must be signed by two representatives specifically authorized by organization's board of directors):**
By my signature below, I certify that: 1) I am authorized to make legally binding certifications on behalf of the organization named above; 2) the cost items for which reimbursement is being requested have not been and will not be submitted to any other funding entity, either for reimbursement or as documentation of the expenditure of funds advanced; 3) the portions of expenses for which reimbursement is being requested were incurred for the activity as described above, exclusively for the benefit of "eligible persons," as defined under the terms of the Program Participation Agreement; 4) the "Total Funds Expended or Obligated" sum named above was derived from the financial accounting records of the organization, and documentation in support of this figure is available upon request; 5) the organization is maintaining on a daily basis the statistical data necessary to report program benefit, as currently outlined by DCA; 6) the organization is in full compliance with all of our obligations and responsibilities under the Program Participation Agreement, and I am aware of no pending events or activities that would violate any term or terms of that Program Participation Agreement; and 7) the information contained in this report is true and correct.

Signature: ____ Date: ____
Type Name and Title: ____
Signature: ____ Date: ____
Page ___ of ___ Pages Type Name and Title: ____

Section 4:

- All information under "Budget" will be prepopulated with the approved budget amounts.
- All information under "Received to Date" will prepopulate after 1st request is approved
- Organizations complete all information under "Amount Requested Per Attached Summary" in whole dollars
- "Cumulative Match for Period Covered" should be completed with the cumulative match amount for each request (ie. 1st request $3500, 2nd request $5700, etc)

Reimbursement Request Form (Page 1)



HESG RAPID REHOUSING AND PREVENTION REIMBURSEMENT REQUEST

Return Completed Request to: Office of Homelessness and Special Needs Housing, Dept. of Community Affairs (DCA), 60 Executive Park South, NE, Atlanta, GA 30329-2231

Key to Source of Funds (See Block 1): *E = Federal ESG Program (CFA# 14.231) HTF = State Housing Trust Fund

Questions For DCA Staff? PH: 404 679 0632 (Heather) FAX: 404 679 0669 EM:Heather.Smith@dca.ga.gov

1 Organization: Name Of Your Organization — Effective Date: 7/1/2017 — Completion Date: 9/30/2018
Program Name: — ContRacr.ID: 18CXXX — State FY: 2018 — Program Code: — Program: ESGP — Funding Source: 18E (see "Key" above)
Program Type: Esg Rapid Rehousing

2 As of 8/20/2018: Original Amount — Current Amount: $25,000 — Total Paid: $0 — Balance: $25,000
Please Note: If this information is inconsistent with Organization's records, please notify DCA Immediately!

3 Request No. _____ Name: _____ Phone: _____ View All Related Payment Records

4

Item	Budget	Received to Date	Amount Requested*
Financial Assistance Costs			
01 Application Fees			
02 Security Deposits			
03 Last Month's Rent			
04 Utility Deposits			
05 Utility Payments			
06 Moving Costs			
Financial Assistance Subtotal:			
Service Costs			
07 Housing Search and Placement			
08 Case Management			
09 Mediation			
10 Legal Services			
11 Credit Repair			
Services Subtotal:			
Short and Medium Term Rental Assistance			
12 Short and Medium Term Rental Assistance			
Total:			

Cumulative Match for Period Covered (Do not include HUD SHP or S+C) - (7/1/2017 through this request): Total $

5 **Certification by specific persons who are Board Authorized Representatives (must be signed by two representatives specifically authorized by organization's board of directors):**
By my signature below, I certify that: 1) I am authorized to make legally binding certifications on behalf of the organization named above; 2) the cost items for which reimbursement is being requested have not been and will not be submitted to any other funding entity, either for reimbursement or as documentation of the expenditure of funds advanced; 3) the portions of expenses for which reimbursement is being requested were incurred for the activity as described above, exclusively for the benefit of "eligible persons," as defined under the terms of the Program Participation Agreement; 4) the "Total Funds Expended or Obligated" s an named above was derived from the financial accounting records of the organization, and documentation in support of that figure is available upon request; 5) the organization is maintaining on a daily basis the statistical data necessary to report program benefit, as currently outlined by DCA; 6) the organization is in full compliance with all of our obligations and responsibilities under the Program Participation Agreement, and I am aware of no pending events or activities that would violate any term or terms of that Program Participation Agreement, and 7) the information contained in this report is true and correct.

Signature: _____ Date: _____
Type Name and Title: _____
Signature: _____ Date: _____
Page __ of __ Pages Type Name and Title: _____

Section 5:

- 2 signatures are required for each request and must be original signatures, no photocopies will be accepted
- Signatures must match those on Exhibit C: Resolution
- Please sign in ***blue*** ink and ensure printed name/title are legible
- This is always Page 1 of #, dependent upon how many summary pages are included

Summary Page

Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: ______ Reimbursement Request No.: ______

Program Name: ______ Grant Number: ______

A	B	C	D	E	F	G	H	I	J	K	L
Item	Case Number (if Appl.)	Env. Review Unit Address	Site ID Exhibit B	Date of Transaction or Payment	Control or Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	Eligible Activity No. (See Agmt Exhibit A By Line Item)	Service Date or Period	Reimbursement Amt Requested Rounded to nearest $1
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer: ______

Date: ______

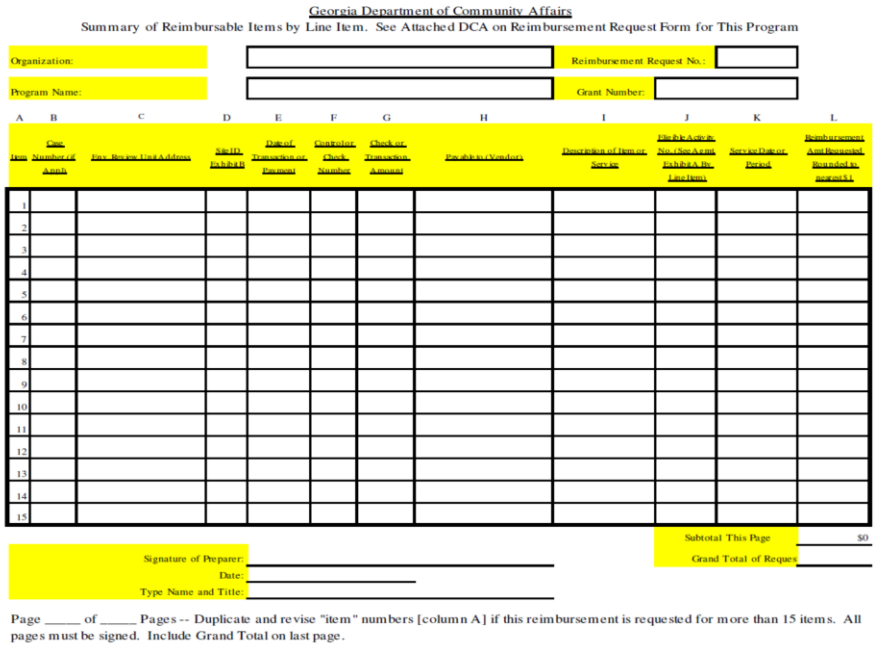
Type Name and Title: ______

Page ____ of ____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Summary of Reimbursable Items:

- Please include Organization, Program Name (if applicable), Reimbursement Request No., & Grant Number on all Summary Pages
- Please do not change the number of Line Items (Column A) to more than 15 per page
- Original signature, in ***blue*** ink required (Suggested)
- Please provide a subtotal on each page and the grand total on final page

Summary Page – Emergency Shelter Only



Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: | Reimbursement Request No.:

Program Name: | Grant Number:

A	B	C	D	E	F	G	H	I	J	K	L
Item	Case Number of Assis.	Env. Review Unit Address	Site ID. Exhibit B	Date of Transaction or Payment	Controler Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	File/Rpt Activity No. (See Assmt Exhibit A By Line Item)	Service Date or Period	Reimbursement Amt Requested, Rounded to nearest $1
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer:

Date:

Type Name and Title:

Page _____ of _____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Column B:

- Case Number (Client Track Number) is required for any item specific to a client; ie. Rent payment, utility payment, hotel/motel voucher, etc. Please list the client track number in this column. For all DV shelters, please list the client keys from the comparable database system in column B.

Column C:

- Environmental Address; Please list the ER Address that applies to the shelter.

Summary Page

Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: ______ Reimbursement Request No.: ______

Program Name: ______ Grant Number: ______

A	B	C	D	E	F	G	H	I	J	K	L
Item	Case Number (if Appl)	Env. Review Unit Address	Site ID Exhibit B	Date of Transaction or Payment	Control or Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	Eligible Activity No. (See Agmt Exhibit A By Line Item)	Service Date or Period	Reimbursement Amt Requested Rounded to nearest $1
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer: ______

Date: ______

Type Name and Title: ______

Page ____ of ____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

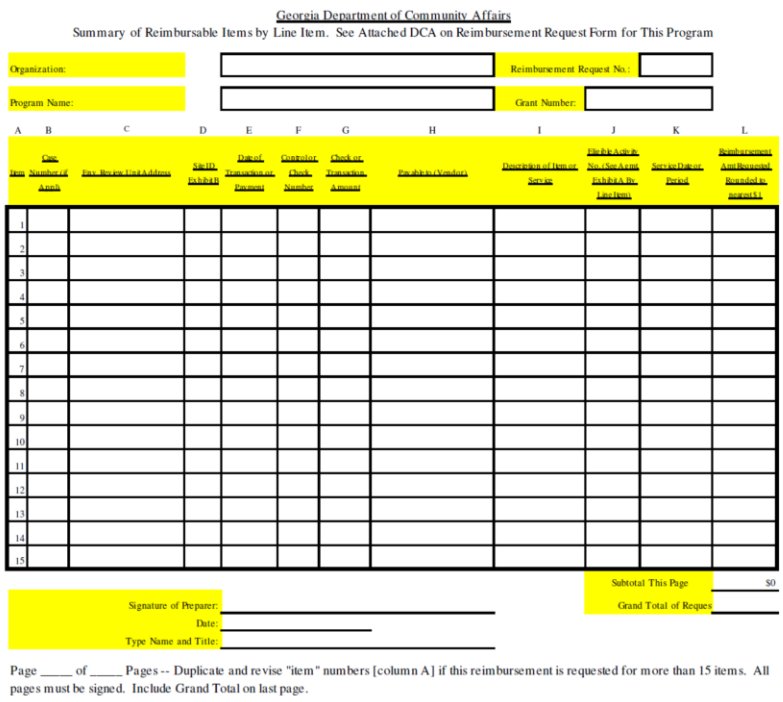
Column E:

- Required for all items requested for reimbursement; use the date of the check or transaction (credit card, direct deposit, etc…)

Column F:

- Required for all items requested for reimbursement; ACH, Direct Deposit, & other acronyms are acceptable for a "Control Number" as applicable. Please list the last four of the check number that was used for payment of the transaction.

Summary Page



Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: | Reimbursement Request No.:

Program Name: | Grant Number:

A	B	C	D	E	F	G	H	I	J	K	L
Item	Case Number of Assis	Fire Review Unit Address	Site ID Exhibit B	Date of Transaction or Payment	Contractor Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	Eligible Activity No. (See Attmt Exhibit A By Line Item)	Service Date or Period	Reimbursement Amt Requested, Rounded to nearest $1
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer:

Date:

Type Name and Title:

Page _____ of _____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Column G:

- Required for all items requested for reimbursement
- The $ amount entered should equal the total amount of the check or transaction, not necessarily the $ amount requested for reimbursement on the grant.

Summary Page

Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: ______ Reimbursement Request No.: ______

Program Name: ______ Grant Number: ______

A	B	C	D	E	F	G	H	I	J	K	L
Item	Case Number (if Appl)	Env. Review Unit Address	Site ID Exhibit B	Date of Transaction or Payment	Control or Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	Eligible Activity No. (See Agmt Exhibit A By Line Item)	Service Date or Period	Reimbursement Amt Requested Rounded to nearest $1
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer: ______

Date: ______

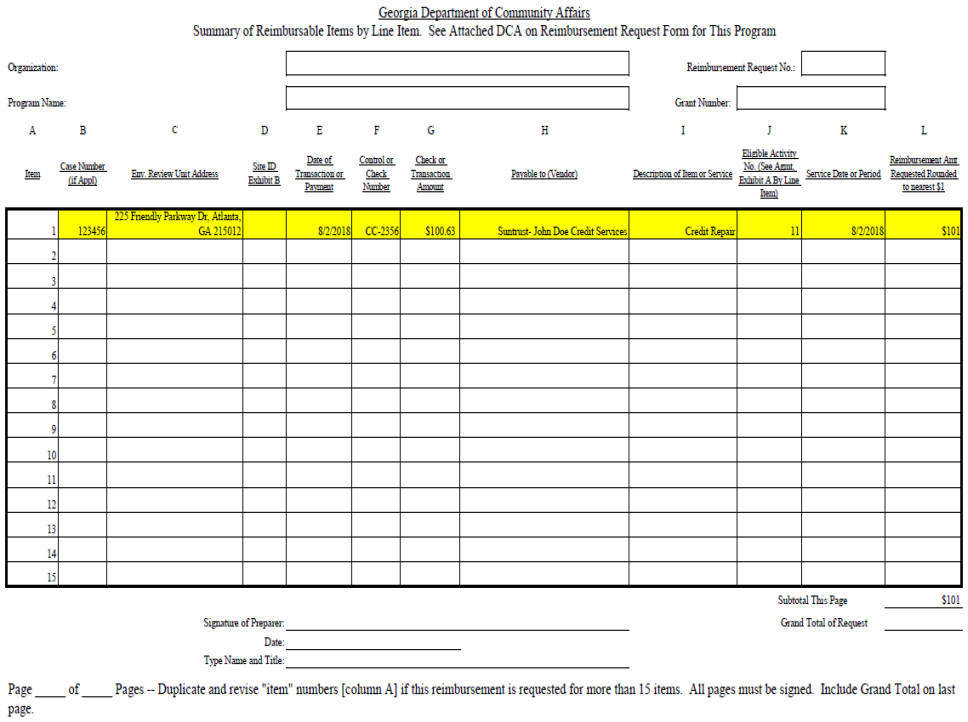
Type Name and Title: ______

Page ____ of ____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Column H:

- Required for all items requested for reimbursement
- Please complete with the exact name check or transaction is payable to
- **If a person, employee, or vendor is listed in Column H, they cannot be a signatory on Page 1**

Summary Page



Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: _____ Reimbursement Request No.: _____

Program Name: _____ Grant Number: _____

	A	B	C	D	E	F	G	H	I	J	K	L
	Item	Case Number (if Appl)	Env. Review Unit Address	Site ID Exhibit B	Date of Transaction or Payment	Control or Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	Eligible Activity No. (See Amnt. Exhibit A By Line Item)	Service Date or Period	Reimbursement Amt. Requested Rounded to nearest $1
1		123456	225 Friendly Parkway Dr, Atlanta, GA 215012		8/2/2018	CC-2356	$100.63	Suntrust- John Doe Credit Services	Credit Repair	11	8/2/2018	$101
2												
3												
4												
5												
6												
7												
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9												
10												
11												
12												
13												
14												
15												

Subtotal This Page $101

Grand Total of Request _____

Signature of Preparer: _____

Date: _____

Type Name and Title: _____

Page ____ of ____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Credit Card Transactions

- When a credit card is used for a transaction, please make sure that the credit card bill has been paid for that transaction before requesting reimbursement from DCA. Please keep on file all statements and receipts that pertain to the requested line item.
- **Line items are only eligible for reimbursement after the agency has paid the bill for that line item to their credit card company.**
- In Column H, list the name of the bank of the credit card and list the name of the store/vendor where the credit card was used.
- In Column F, list CC and the last four of the check # or ACH that was used to pay the credit card bill for the requested line item. Please see the example.

Summary Page

Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: _____ Reimbursement Request No.: _____

Program Name: _____ Grant Number: _____

	A	B	C	D	E	F	G	H	I	J	K	L
	Item	Case Number (if Appl)	Env. Review Unit Address	Site ID Exhibit B	Date of Transaction or Payment	Control or Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	Eligible Activity No. (See Agmt. Exhibit A By Line Item)	Service Date or Period	Reimbursement Amt Requested Rounded to nearest $1
1	123456	225 Friendly Parkway Dr. Atlanta, GA 215012		8/2/2018	CC-2356	$100.63	Suntrust- John Doe Credit Services	Credit Repair	11	8/2/2018	$101	
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

Subtotal This Page $101

Grand Total of Request _____

Signature of Preparer: _____

Date: _____

Type Name and Title: _____

Page _____ of _____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Summary Page

Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: ______ Reimbursement Request No.: ______

Program Name: ______ Grant Number: ______

A	B	C	D	E	F	G	H	I	J	K	L
Item	Case Number (if Appl.)	Env. Review Unit Address	Site ID Exhibit B	Date of Transaction or Payment	Control or Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	Eligible Activity No. (See Agmt Exhibit A By Line Item)	Service Date or Period	Reimbursement Amt Requested Rounded to nearest $1
1											
2											
3											
4											
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9											
10											
11											
12											
13											
14											
15											

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer: ______

Date: ______

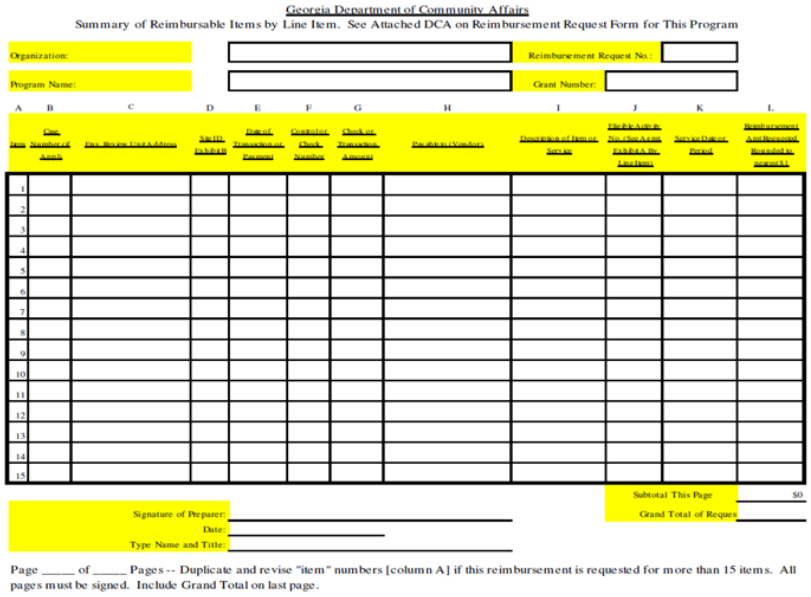
Type Name and Title: ______

Page _____ of _____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Column I:

- Required for all items requested for reimbursement
- Identify type of activity; ie. Rent, utility payment, payroll, supplies, etc…
- **If "Supplies" or office equipment are requested for reimbursement, the organization must include a list and receipts of all supplies/equipment purchased (attach separate sheet)**

Summary Page



Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: | Reimbursement Request No.:

Program Name: | Grant Number:

A Item	B Case Number of Assist.	C Pay-To-Your-Order Address	D Sec/ID Exhibit B	E Date of Transaction or Payment	F Computer Check Number	G Check or Transaction Amount	H Payable to Vendors	I Description of Item or Service	J Exhibit A Activity No. (See Assist Exhibit A) By Function	K Service Dates or Period	L Reimbursement Amt Requested, Rounded to Dollars
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer:

Date:

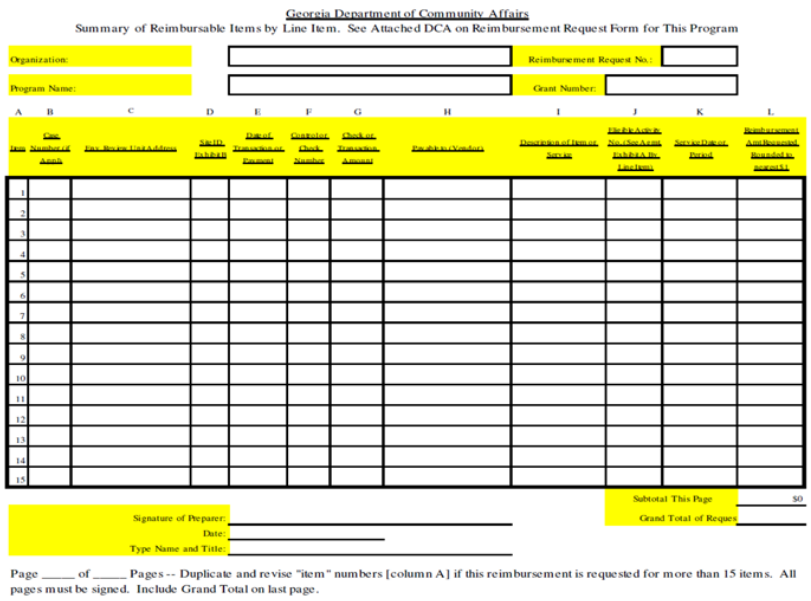
Type Name and Title:

Page _____ of _____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Column J:

- Required for all items requested for reimbursement
- Please use appropriate number from: Approved Budget Exhibit A or cover page for reimbursement; ie. *1* for Case Management, *10* for Transportation, *12* for Rents, *19* for Supplies, etc…

Summary Page



Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization:

Reimbursement Request No.:

Program Name:

Grant Number:

	A	B	C	D	E	F	G	H	I	J	K	L
	Item	Case Number of Assist.	Fam. Receive Unit Address	Sec/ID Exhibit	Date of Transaction or Payment	Corporate Check Number	Check or Transaction Amount	Payable to Vendors	Description of Item or Service	File/Ex Archive No. (See Assist Exhibit No. Function)	Service Date or Period	Reimbursement Amt Requested, Rounded to Dollars
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer:

Date:

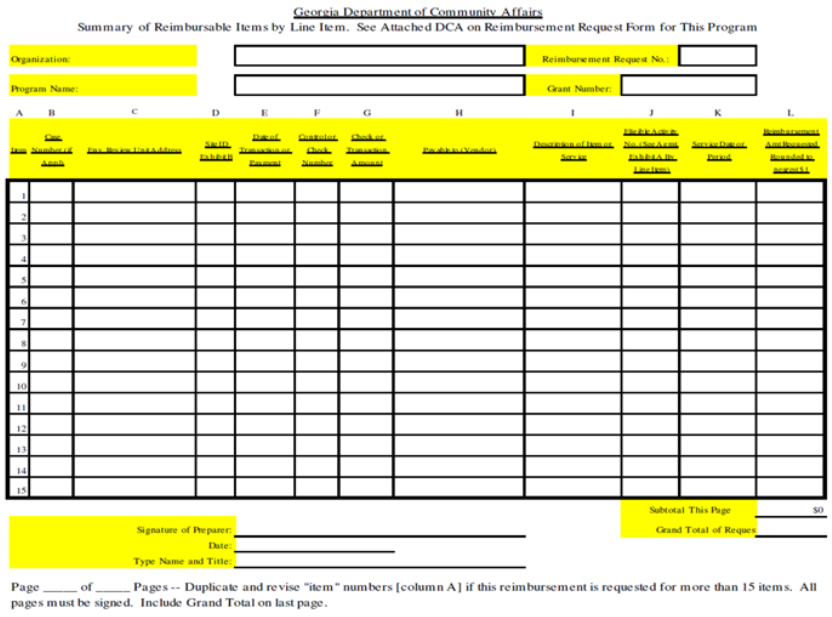
Type Name and Title:

Page _____ of _____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Column K:

- Required for all items requested for reimbursement
- For rent payments this should be the month for which the rent is paid
- For utility payments this must be the date range on the bill (ie. July 5-Aug 4, 2018)
- For payroll costs this should be the pay period (ie. July 1-15, 2018)

Summary Page



Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: | Reimbursement Request No.:

Program Name: | Grant Number:

A	B	C	D	E	F	G	H	I	J	K	L
Item	Case Number of Assets	Pay Review Unit Address	SS# ID: Exhibit B	Date of Transaction or Payment	Cashier Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	Eligible Activity No. (See Assets Exhibit A by Line Item)	Service Date or Period	Reimbursement Amt Requested, Rounded to nearest $1
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer:

Date:

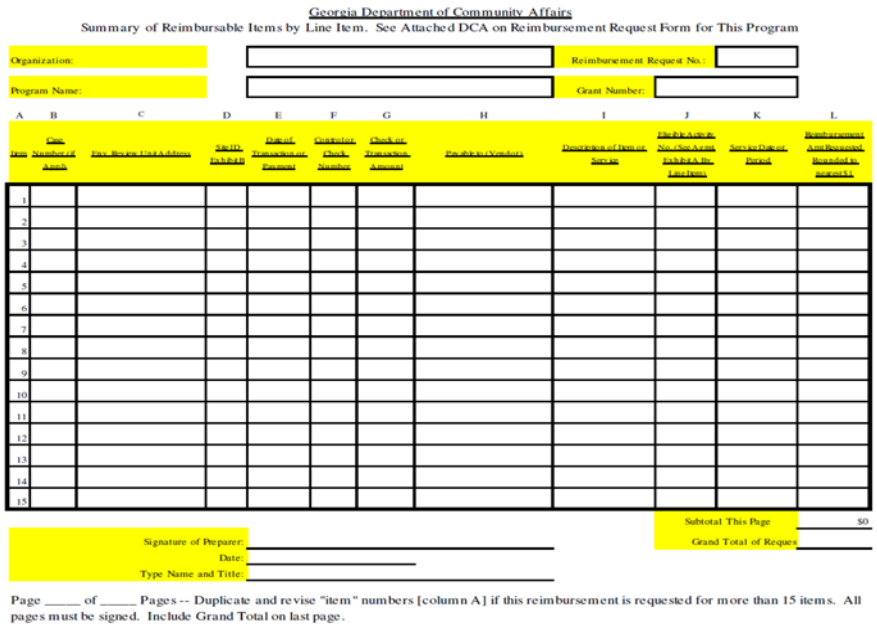
Type Name and Title:

Page _____ of _____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Column L:

- Required for all items requested for reimbursement; must be rounded to the nearest dollar
- For a "Check or Transaction Amount" (Column F) amount of $.00-$.49 round down, amount $.50-$.99 round up
- Amount cannot exceed the "Check or Transaction Amount" (Column G), with exception made for rounding up

Summary Page



Georgia Department of Community Affairs

Summary of Reimbursable Items by Line Item. See Attached DCA on Reimbursement Request Form for This Program

Organization: | Reimbursement Request No.:

Program Name: | Grant Number:

	A	B	C	D	E	F	G	H	I	J	K	L
	Item	Case Number of Assist.	Pay-to-the-Order-Of & Address	Sec ID Exhibit B	Date of Transaction or Payment	Originator Check Number	Check or Transaction Amount	Payable to (Vendor)	Description of Item or Service	Eligible Activity No. (See Attch Exhibit A Re. Line Item)	Service Date or Period	Reimbursement Amt Requested, Rounded to nearest $1
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

Subtotal This Page $0

Grand Total of Reques

Signature of Preparer:

Date:

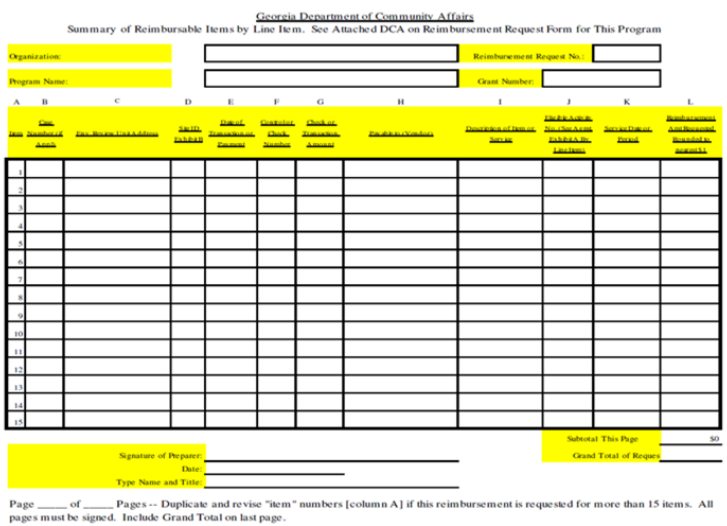
Type Name and Title:

Page _____ of _____ Pages -- Duplicate and revise "item" numbers [column A] if this reimbursement is requested for more than 15 items. All pages must be signed. Include Grand Total on last page.

Helpful Hints

- When requesting Employer Paid Taxes use a separate line and ensure the proper Vendor is listed, ie. Dept. of Revenue, Office of the Treasury, etc…
- When requesting Employer Paid Benefits please ensure the proper Vendor is listed, ie. Metlife, Aetna, Aflac, etc…
- Any Employer Paid Benefits are not paid directly to your employee and should not list the employee as the Vendor

Summary Page



Final Notes:

- Please change the Item Numbers (Column A) to reflect consecutive numbering; ie. If you have 2 summary pages the item numbers on the 2nd page should begin at 16 and end at 30
- Please number the pages appropriately; ie. Page 2 of 4, page 3 of 4, etc…
- Use only the DCA supplied form; please do not create a different Excel form

Processing Reimbursement Requests

- Once a reimbursement request is received by the Office of Homeless and Special Needs Housing it follows a process for review, approval, and funds issuance
- Please allow up to 25 business days for this process once a reimbursement request is received
- Unless informed otherwise, it is not necessary for an organization to send supporting documentation with a reimbursement request; if additional information is needed to process a request the organization will be notified via postal mail or email
- It is important to respond as quickly as possible to requests for additional information

Payment Notices

Your reimbursement request in the amount of $XX,XXX has been processed and will be deposited directly into your bank. Reimbursement for eligible costs incurred through September 30, 2019 is available until the deadline of October 31, 2019. All reimbursement requests must be received by that date. An updated reimbursement request form is attached for use with your next request.

This is the only notice you will receive regarding this payment. For verification that the deposit has been made, please contact your bank within the next two weeks.

If you need assistance, do not hesitate to call me direct at 404-679-0632 or email me.

Georgia Department of Community Affairs

Learn more about our commitment to fair housing.

Heather Smith
Grants Consultant
Georgia Department of Community Affairs
60 Executive Park South, NE
Atlanta, Georgia 30329

Direct 404-679-0632
Heather.Smith@dca.ga.gov

- Upon approval of a reimbursement request an organization will receive a payment notice & an updated Reimbursement Request Form (Page 1) via email
- The payment notice will contain the information shown as well as any additional pertinent information related to the request
- **Please do not mail in another reimbursement request until you receive the payment notice with your new reimbursement form.**
- **Please do not staple reimbursement requests forms that you mail in to us. We request that you paper clip the request forms or leave them as is.**

ESG Budget Amendments

Budget review is a component of the competitive application process. Budget amendments may be considered *IF* the change does not effect the competitiveness of the application.

To make a change to the program budget, you must:

- Prepare a letter/email of explanation detailing why the request is necessary/requested
- Attach a copy of a Blank Reimbursement Form with your requested new budget totals. Cross out the original budget totals on the form and write in the new budget totals that you want to change.
- Mail or Email the request to Heather Smith and Marion Goulbourne
- Marion Goulbourne will review your budget revision for approval. If an approval is granted, then a new reimbursement form will be emailed to you with the new budget totals on the form.

ESG Budget Amendment Deadlines- RRH/Prevention

- **ONE** budget revision can be submitted **ONE** time per each quarter of your grant period. The last day to submit budget revisions for RRH and Prevention is August 31, 2019. **NO BUDGET REVISIONS WILL BE ACCEPTED after August 31, 2019** for RRH and Prevention Grants.

Quarter	Deadlines for Submission
1st (July-Sept)	September 30, 2018
2nd (Oct-Dec)	December 31, 2018
3rd (Jan-Mar)	March 31, 2019
4th (Apr-June)	June 30, 2019
Final	August 31, 2019

ESG Budget Amendment Deadlines-Emergency Shelter, Hotel/Motel, HMIS, Outreach,

- **ONE** budget revision can be submitted **ONE** time per each quarter of your grant period. The last day to submit budget revisions for ESG grants that end on 6/30 is May 31, 2019. **NO BUDGET REVISIONS WILL BE ACCEPTED after May 31, 2019** for ESG grants with a contract end date of 6/30/19.

Quarter	Deadlines for Submission
1st (July-Sept)	September 30, 2018
2nd (Oct-Dec)	December 31, 2018
3rd (Jan-Mar)	March 31, 2019
Final	May 31, 2019

ESG Records Retention Requirements

- (y) *Period of record retention. All* records pertaining to each fiscal year of ESG funds must be retained for the greater of 5 years or the period specified below. Copies made by microfilming, photocopying, or similar methods may be substituted for the original records.

- (1) Documentation of each program participant's qualification as a family or individual at risk of homelessness or as a homeless family or individual and other program participant records must be retained for 5 years after the expenditure of all funds from the grant under which the program participant was served;

See 24 CFR Part 576 - Federal Register /Vol. 76, No. 233 /Monday, December 5, 2011 /Rules and Regulations 75993

ESG Match Requirements

Grantees must complete a Match report prior to payment of the final reimbursement. The Match report will be sent to each grantee, via email, prior to June 30, 2019. The required information includes –

- Other non-ESG HUD Funds
- Other Federal Funds
- State Government
- Local Government
- Private Funds
- Other

ESG Match Requirements

- Failure to complete a Match report will result in reimbursement requests not being processed and payments being delayed; a delay may also occur in the return of your executed contract for the following grant year (if selected for award)
- All Rapid Re-Housing and Prevention grantees will be required to submit a Match report for match amounts expended as of June 30, 2019

Grantee/Grantor Oversight

- DCA relies on ESG grantees to maintain an active partnership in using resources in a responsive and accountable manner.

- DCA is responsible for ensuring that grants are administered in accordance with the requirements of all applicable laws and regulations.

Contact Information

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- Email: heather.smith@dca.ga.gov

- Christy Walker, Grants Compliance Manager
- Email: Christy.walker@dca.ga.gov

Questions