

**HAMPDEN COUNTY CONTINUUM OF CARE**  
**City of Springfield**

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**REQUEST FOR PROPOSALS**

**To operate existing Continuum of Care program  
providing Permanent Supportive Housing  
to 8 chronically homeless families**

Total Available Funding: \$137,872

Successful applicant will be required to provide cash or in-kind match of \$9,992

**RFP Available: Monday, July 18, 2016**

**Bidder's Conference: Wednesday, July 27, 2016, 11 a.m.**  
Office of Housing, 1600 E. Columbus Ave., Springfield

**Applications Due: Friday, August 5, 2016, 4 p.m.**  
Office of Housing, 1600 E. Columbus Ave., Springfield

## INTRODUCTION

The City of Springfield is the Unified Funding Agency for Continuum of Care (CoC) Homeless Assistance Program funds from the U.S. Department of Housing and Urban Development (HUD). The City receives CoC funds directly from HUD and subcontracts with multiple agencies in the community that operate the CoC programs.

A subrecipient that operates an existing family permanent supportive housing program using CoC funds will no longer operate the program after August 31, 2016.

**The City seeks a new subrecipient program sponsor to operate the existing CoC program which provides permanent supportive housing for 8 families who meet the definition of chronically homeless at the time they enter the program.** The program currently operates under a one-year grant which will expire April 30, 2017. The program is eligible for continuing ongoing one-year renewals through the HUD CoC Program, and the City plans to submit a renewal application for level funding for the project in the CoC Collaborative Application due to HUD on September 14, 2016.

**The selected applicant will be expected to begin management of the existing program as of September 1, 2016.** The program currently has eight participant families living in apartment units located in Springfield, Massachusetts. The program rents the units, and has rental agreements with each participant.

## FUNDING AVAILABILITY

The CoC annual renewing grant amount for the existing program is \$137,872. The successful applicant will be required to provide a match of \$9,992, which may be cash or in-kind. The costs that are covered by the CoC grant are listed in the table below.

Leasing costs for 8 units Three 2-bedroom units @ \$924/mo Five 3- bedroom units @ \$1154/mo	\$102,463
Case manager	\$30,849
Administration	\$4560
TOTAL	\$137,872

## CoC PROGRAM REQUIREMENTS

The program provides CoC Program Permanent Supportive Housing to Chronically Homeless Families. HUD regulations governing the CoC Program are located at 24 CFR. 578.

The CoC Program rule provides relevant definitions at 24 CFR 578.37: **Permanent housing (PH)** is community-based housing, the purpose of which is to provide housing without a designated length of stay. PH includes **Permanent supportive housing for persons with disabilities (PSH)**. PSH can only provide assistance to individuals with disabilities and families in which one adult or child has a disability. Supportive services designed to meet the needs of the program participants must be made available to the program participants.

This PSH project is required to serve 100% families that are chronically homeless.

**“Chronically homeless”** is defined as:

- (1) An individual who: (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions which add up to a total of 12 months in the last 3 years; and (iii) Can be diagnosed with one or more of the following conditions: substance abuse disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability; or
- (2) an individual who has been residing in an institutional care facility, including a jail, mental health or substance abuse facility, hospital or other similar facility for fewer than 90 days and has met all the criteria in paragraph (1) of this definition before entering that facility; or
- (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

The project must be **low-barrier**, and must use a **Housing First** model.

**Low Barrier** means that participants will not be screened out for any of the following reasons: having too little or no income; active or history of substance abuse; criminal record; or a history of domestic violence (*e.g.* lack of a protective order, period of separation from abuser, or law enforcement involvement).

**Housing First** is a model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions. Projects using a housing first approach have supportive services; however, participation in those services must be based on the needs and desires of the program participant.

## **ELIGIBLE APPLICANTS**

Eligible applicants include non-profits, local and state government, and housing authorities.

## ELIGIBLE COSTS

The following guidance is provided regarding costs that are listed in the existing program budget.

**Leasing:** The costs of leasing scattered site units to provide housing to homeless persons.

*Leasing: Limits on rent costs.* Rents paid must be reasonable in relation to comparable space or units, and may not be more than the owner charges others for comparable units. Rents for residential units cannot exceed the HUD Fair Market Rent (FMR).

*Utilities.* Utilities are not a leasing line item. If utilities are not provided by the landlord, utility costs are an operating cost.

*Security deposits and first and last month's rent.* Grant funds may be used to pay security deposits, in an amount not to exceed two months of actual rent, as well as last month's rent.

### Supportive Services

The eligible costs of supportive services that address the special needs of the program participants. Supportive services must be necessary to assist program participants obtain and maintain housing, and the program agencies must conduct an annual assessment of the service needs of the program participants and adjust services accordingly.

### Project Administration

The Project Sponsor may use up to 3.5% of the full project budget for administrative costs.

## MATCHING FUNDS

The successful applicant must match all grant funds, except for leasing funds, with no less than 25% of funds or in-kind contributions from other sources. Guidance regarding cash and in-kind match is at 24 CFR 578.73. Any cash match must be used for the costs of activities that are eligible CoC Program costs.

The portion of rent paid by project participants must be used to cover program expenses and may be counted as match funds.

## HOMELESS MANAGEMENT INFORMATION SYSTEM

The successful project applicants must participate in the CoC's Homeless Management Information System (HMIS).

## COORDINATED ASSESSMENT/ENTRY

The successful applicant must participate in the CoC's coordinated assessment system. This system has created a single list of chronically homeless families in Hampden County, each of which has been screened using a screening tool known as the Family Vulnerability Index-Service

Prioritization Decision Assistance Tool (VI-SPDAT). Families on the list are prioritized according to how high they score on the assessment, with the most vulnerable families being prioritized first for housing.

### **APPLICATION PROCESS**

**The deadline for submittal of applications is August 5, 2016 at 4:00 pm.**

Please submit one copy of each of the following to the Office of Housing, 160 E. Columbus Ave., Springfield:

1. The **Family PSH Application**, available starting on page 5 of this announcement.
2. Submittal of **CoC Application Required Documents** listed on page 7 of this announcement.

## FAMILY PSH APPLICATION

Organization Legal Name: \_\_\_\_\_

Tax ID: \_\_\_\_\_ DUNS Number: \_\_\_\_\_

Other/former names for the organization: \_\_\_\_\_

Project Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Provide the following information:

	Name	Title	Phone	Email
<b>Program Contact-</b> Person managing the project on a daily basis				
<b>Finance Contact-</b> Person able to provide budget information				
<b>Application Contact-</b> Person writing this application				
<b>Authorized Contact-</b> Person authorized to sign contracts				

I CERTIFY THAT I AM AUTHORIZED TO REPRESENT THE ABOVE NOTED ORGANIZATION AND THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT AND THAT IT CONTAINS NO FALSIFICATIONS, MISREPRESENTATIONS, INTENTIONAL OMISSIONS OR CONCEALMENT OF MATERIAL FACTS. I FURTHER CERTIFY THAT NO CONTRACTS HAVE BEEN AWARDED, FUNDS COMMITTED OR CONSTRUCTION BEGUN ON THE PROPOSED PROJECT AND THAT NONE WILL BE DONE PRIOR TO ISSUANCE OF A RELEASE OF FUNDS BY THE CITY OF SPRINGFIELD.

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**SIGNATURE OF AUTHORIZED PERSON LISTED ABOVE**

**DATE**

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**PRINT NAME**

## Experience and Capacity

1. Has your organization **ever received a federal grant**, either directly from a federal agency or through a State/local agency? Please list most relevant federal grants, including federal agency, grant amount, and year of award.
2. Describe your organization's **experience in serving families that are homeless**, and in providing permanent supportive housing to persons with disabilities..
3. Describe your organization's **experience administering rental assistance**.
4. Describe your organization's basic **organization and management structure**. Include evidence of internal and external coordination and an adequate financial accounting system.

## Family PSH Required Documents

Please submit each of the following:

- \_\_\_\_\_ Documentation of 501(c)(3) status
- \_\_\_\_\_ Documentation of Match
- \_\_\_\_\_ Agency Articles of Incorporation
- \_\_\_\_\_ Current List of Board of Directors with identification of Officers and terms
- \_\_\_\_\_ Certified Organization Audit/Financial Statements of most recent year:
  - Copy of OMB A-133 Audit (Required if \$500,000 or more in aggregate Federal funds expended); or
  - Financial statements audited by a CPA (if not bound by the requirements of OMB A-133)
- \_\_\_\_\_ Agency Financial Management Policies and Procedures
- \_\_\_\_\_ Agency Procurement Policies and Procedure

The following completed forms (which are attached):

- \_\_\_\_\_ Notarized Tax Certification Affidavit
- \_\_\_\_\_ Conflict of Interest Statement
- \_\_\_\_\_ Debarment Certificate
- \_\_\_\_\_ Internal Control Questionnaire
- \_\_\_\_\_ CoC Program Project Sponsor Certifications

The following agency policies:

- \_\_\_\_\_ Code of Conduct and Conflict of Interest;
- \_\_\_\_\_ Drug-Free Workplace;
- \_\_\_\_\_ Affirmatively Furthering Fair Housing;
- \_\_\_\_\_ Reasonable Accommodation and Accessibility for Persons with Disabilities;
- \_\_\_\_\_ Nondiscrimination and Equal Employment; and
- \_\_\_\_\_ Confidentiality.



**Notarized Tax Certification Form**

Individual Social Security Number \_\_\_\_\_

State Identification Number \_\_\_\_\_

Federal Identification Number \_\_\_\_\_

Company: \_\_\_\_\_

P.O.Box (if any): \_\_\_\_\_ Street Address Only: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

List address(es) of all other property owned by company in Springfield: \_\_\_\_\_

*Please identify if the bidder/proposer is a:*

Corporation \_\_\_\_\_

Individual \_\_\_\_\_ Name of Individual: \_\_\_\_\_

Partnership \_\_\_\_\_ Names of all Partners: \_\_\_\_\_

Limited Liability Company \_\_\_\_\_ Names of all Managers: \_\_\_\_\_

Limited Liability Partnership \_\_\_\_\_ Names of Partners: \_\_\_\_\_

Limited Partnership \_\_\_\_\_ Names of General Partners: \_\_\_\_\_

You must complete the following certifications and have the signature(s) notarized on the lines below. Any certification that does not apply to you, write N/A in the blanks provided.

**FEDERAL TAX CERTIFICATION**

I \_\_\_\_\_ certify under the pains and penalties of perjury that \_\_\_\_\_, to the best of my knowledge and belief, has/have complied with all United States Federal taxes required by law.

\_\_\_\_\_  
Bidder/Proposer Authorized Person's Signature Date

**CITY OF SPRINGFIELD TAX CERTIFICATION (IF APPLICABLE)**

I \_\_\_\_\_ certify under the pains and penalties of perjury that \_\_\_\_\_, to the best of my knowledge and belief, has/have complied with all City of Springfield taxes required by law (has/have entered into a Payment Agreement with the City).

\_\_\_\_\_  
Bidder/Proposer Authorized Person's Signature Date

**COMMONWEALTH OF MASSACHUSETTS TAX CERTIFICATION**

Pursuant to M.G.L. c. 62C '49A, I \_\_\_\_\_ certify under the pains and penalties of perjury that \_\_\_\_\_, to the best of my knowledge and belief, has/have filed all state tax returns and has/have complied with all state taxes required by law.

\_\_\_\_\_  
Bidder/Proposer

\_\_\_\_\_  
Authorized Person's Signature

\_\_\_\_\_  
Date

**Notary Public**

COMMONWEALTH OF MASSACHUSETTS

\_\_\_\_\_, SS

\_\_\_\_\_, 20\_\_

Then personally appeared before me [name]\_\_\_\_\_, [title]\_\_\_\_\_ of [company name]\_\_\_\_\_, being duly sworn, and made oath that he/she has read the foregoing document, and knows the contents thereof; and that the facts stated therein are true of his/her own knowledge, and stated the foregoing to be his/her free act and deed and the free act and deed of [company name]\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_

**CONFLICT OF INTEREST STATEMENT**

No staff or Board of Director of the \_\_\_\_\_ will financially benefit from performing their prescribed duties other than receiving their normal compensation per salary of contract. Additionally no staff member of Board of Director can use or take possession of any of the \_\_\_\_\_ resources without express approval of its Board of Director's Chairperson. All transactions conducted by staff and the Board of Directors must be arms' length transactions, whose sole intent is to enhance the role and the mission of \_\_\_\_\_.

Dated: \_\_\_\_\_

\_\_\_\_\_  
(signature of authorized agent)

\_\_\_\_\_  
(printed name of agent)

\_\_\_\_\_  
(title of agent)

**IF YOU DO NOT ALREADY HAVE A CONFLICT OF INTEREST STATEMENT, YOU MAY USE THE INFORMATION PROVIDED HERE. HOWEVER, THE CERTIFICATE MUST BE PRINTED ON YOUR ORGANIZATION'S LETTERHEAD AND SIGNED BY AN AUTHORIZED AGENT.**

**DEBARMENT CERTIFICATE**

In accordance with 24 CFR 24.100 through 24.714, \_\_\_\_\_ hereby certifies that neither the agency nor any of its principal employees has been disbarred, suspended or voluntarily excluded by any Governmental agency from receiving Federal financial assistance and non-financial assistance and benefits.

By signing this Certificate, the organization expressly understands and acknowledges that any person or entity that has been debarred or suspended is not eligible to receive Federal financial and non-financial assistance and benefits under Federal programs and activities.

Dated: \_\_\_\_\_

\_\_\_\_\_  
(signature of authorized agent)

\_\_\_\_\_  
(printed name of agent)

\_\_\_\_\_  
(title of agent)

***This Certificate must be printed on agency letterhead.***

## Internal Control Questionnaire

DATE \_\_\_\_\_

NAME OF OPERATING AGENCY \_\_\_\_\_

ADDRESS OF OPERATING AGENCY \_\_\_\_\_

TAX ID OF OPERATING AGENCY \_\_\_\_\_

TEL # \_\_\_\_\_ FAX # \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

TITLE OF PROJECT \_\_\_\_\_

PROJECT LOCATION \_\_\_\_\_

AMOUNT OF FUNDING \_\_\_\_\_

SOURCE OF FUNDING:           Continuum of Care Program

1. Name and Title of individual(s) signing Schedule of Reimbursable expenses request and checks:

    A. REIMBURSABLE EXPENSE REQUEST \_\_\_\_\_

    B. CHECK SIGNATURE \_\_\_\_\_

2. Name of person responsible for maintaining records for this contract (list title also).

\_\_\_\_\_

3. Name of person who is responsible for:

    A. Maintaining payrolls \_\_\_\_\_

    B. Maintaining Time Sheets \_\_\_\_\_

    C. Reconciling Bank Statements \_\_\_\_\_

    D. Preparing Statement of Project Costs \_\_\_\_\_

    E. Preparing Checks \_\_\_\_\_

    F. Purchasing \_\_\_\_\_

4. Name of person who will maintain the following books of record (at least)

    1. Cash receipts and Disbursements Ledger \_\_\_\_\_

2. Voucher Register\_\_\_\_\_

3. Project Cost Ledger\_\_\_\_\_

5. Name of Employees Bonded:

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6. Does the agency maintain a purchase requisition system, and who authorizes purchases?

7. Who signs all vouchers ready for payment?

8. What is included or needed for authorization to disburse checks (e.g., voucher, purchase order, receiving slip)?

9. Who is responsible for hiring personnel?

10. Who is responsible for submitting time sheets of employees?

11. What controls are in place for equipment purchases?

I HEREBY ATTEST THAT THE ABOVE INFORMATION IS ACCURATE AND CORRECT.

\_\_\_\_\_  
Signature of Authorized Representative for Agency

\_\_\_\_\_  
Date

## CoC Program Project Sponsor Certifications

In accordance with the applicable statutes and the regulations governing the Continuum of Care Program regulations, the Agency \_\_\_\_\_ certifies that:

### Confidentiality Regarding Domestic Violence

- It will maintain the confidentiality of records pertaining to any individual or family that was provided family violence prevention or treatment services through the project;
- It will maintain confidentiality of the addresses or locations of family violence projects, except with written authorization of the person responsible for such project;

### Access to Education and Related Services

- The Agency will establish policies and practices that are consistent with, and do not restrict, the exercise of these rights provided by subtitle B of title VII of the Act and other laws relating to the provision of educational and related services to individuals and families experiencing homelessness;
- If the Agency provides housing or services to families, the Agency will designate a staff person to be responsible for ensuring that children served in the program are enrolled in school and connected to appropriate services in the community, including early childhood programs such as Head Start, part C of the Individuals with Disabilities Education Act, and programs authorized under subtitle B of title VII of the Act;

### No Debarment

- The Agency, its officers, and employees are not debarred or suspended from doing business with the federal government; and

### Provision of Information to HUD

- The Agency agrees to provide information, such as data and reports, as required by HUD.

Dated: \_\_\_\_\_

\_\_\_\_\_  
(signature of authorized agent)

\_\_\_\_\_  
(printed name of agent)

\_\_\_\_\_  
(title of agent)