



**HOMEAID ATLANTA PROJECT APPLICATION**

**Date:** \_\_\_\_\_

**I. ORGANIZATION INFORMATION**

Name of Service Provider/Agency: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Agency Website: \_\_\_\_\_

Agency Email: \_\_\_\_\_

Chief paid executive and title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Chief Board officer and title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Name & title of person submitting request: \_\_\_\_\_

Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

**II. PROJECT INFORMATION**

Name of Proposed Project: \_\_\_\_\_

Project Address (if known): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Project Website: \_\_\_\_\_

Project Email: \_\_\_\_\_

Contact Person for Project: \_\_\_\_\_

Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

**Type of Project (Please check all that apply of the following):**

- Emergency (1 to 5 nights)
- Transitional (1 to 6 months)
- Long Term Transitional (7 months to 24 months)
- Permanent Supportive Housing (2 years or more)
- Other (explain)

**III. SCREENING CRITERIA**

**Which one will this proposed project do?**

- Add beds
- Preserve beds
- Upgrade the facilities of the shelter
- Add additional space (non-bedroom); please list the areas being added: \_\_\_\_\_

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**What is your agency's mission?** \_\_\_\_\_

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**What is the primary population currently served? (Please choose the top three populations)**

- People that are homeless as a result of job loss
- People that are homeless as a result of catastrophic illness
- Women in crisis pregnancy
- Abused children
- Homeless youth
- Victims of domestic violence and/or spousal desertion
- Veterans
- People living with chronic diseases
- People battling substance abuse
- Foster youth
- Emancipated youth
- Pregnant minors and their children
- Fragile infants
- People who are mentally ill
- People exiting from correctional facility
- Elderly
- Chronically homeless
- Other (please list)

*Please check all the support services your agency provides:*

- Outreach
- Case Management
- Life Skills (outside of case management)
- Alcohol or drug abuse services
- Mental health services
- HIV/AIDS-related services
- Other health care services
- Education
- Housing placement
- Employment assistance
- Child care
- Transportation assistance
- Legal
- Other (please list):

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**IV. AGENCY DESCRIPTION**

**You must be a 501(c)(3) organization to apply for assistance from HomeAid.**

Federal ID No.: \_\_\_\_\_

- (Please attach verification)

How long has the agency been in operation? \_\_\_\_\_

Does your organization have an existing strategic plan or business plan? \_\_\_\_\_

(If so, please attach)

**Board of Directors Information:**

Number of persons serving on the Board of Directors: \_\_\_\_\_

Number of directors making financial contributions to the organization in past fiscal year: \_\_\_\_\_

Total amount of directors' financial contributions to organization in past fiscal year: \_\_\_\_\_

Please attach a current Board of Director roster.

**Organizational Capacity:**

Number of paid staff: \_\_\_\_\_

Full-time paid staff: \_\_\_\_\_

Part-time paid staff: \_\_\_\_\_

Number of volunteers/year (approximately): \_\_\_\_\_

Estimate of total volunteer hours received during the past year: \_\_\_\_\_

What percentage of clients gained self-sufficiency after completing your program last year? \_\_\_\_\_

How many clients are served each year through your agency? \_\_\_\_\_

From time to time, HomeAid Atlanta requests a partner service provider to ask a client or graduate to speak at a HomeAid function. Would you be willing to ask this of one of your residents or graduates? \_\_\_\_\_

**V. PROJECT CONSTRUCTION INFORMATION (Please complete to the best of your ability)**

**Will the majority of work being done be:**

- Renovation
- New construction
- Combination of both

Square footage of proposed project: \_\_\_\_\_

How many shelter beds will be added or preserved as a result of this proposed project? \_\_\_\_\_

If it doesn't add beds, but creates services, how many people will be served per year? \_\_\_\_\_

Type of clientele served by the proposed project, please select all that will be served:

- |   |  |
|---|--|
| <input type="checkbox"/> People that are homeless as a result of job loss             | <input type="checkbox"/> People living with HIV/AIDS               |
| <input type="checkbox"/> People that are homeless as a result of catastrophic illness | <input type="checkbox"/> People battling substance abuse           |
| <input type="checkbox"/> Women in crisis pregnancy                                    | <input type="checkbox"/> Foster youth                              |
| <input type="checkbox"/> Abused children  | <input type="checkbox"/> Emancipated youth                         |
| <input type="checkbox"/> Homeless youth   | <input type="checkbox"/> Pregnant minors and their children        |
| <input type="checkbox"/> Victims of domestic violence and/or spousal desertion        | <input type="checkbox"/> Fragile infants                           |
| <input type="checkbox"/> Veterans   | <input type="checkbox"/> People who are mentally ill               |
|   | <input type="checkbox"/> People exiting from correctional facility |
|   | <input type="checkbox"/> Elderly                                   |
|   | <input type="checkbox"/> Chronically homeless                      |

Briefly describe the nature of the proposed project (Attach additional pages if needed):

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Please answer the following questions to the best of your ability (you are not required to have these in place at time of application. It is for review purposes only):

Do you own or control the site? Yes  No

If you control, but do not own the site, please explain:

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Are all needed entitlements (other than building permit) in place for the intended use? Yes  No

Has the project undergone Planning Department Review? Yes  No

Does the project require a Variance or Special Use Permit? Yes  No

Does the project require review by any other peripheral organizations (i.e., an architectural review committee, a neighborhood review board, etc.)? Yes  No

Do you have renderings/photos? Yes  No   
(Please attach)

Do you have site plans showing the building on the site? Yes  No   
(Please attach)

Do you have an engineered site plan? Yes  No   
(Please attach)

Do you have architectural plans completed? Yes  No   
(Please attach)

If yes, have the plans been approved by all required local government agencies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you need help with architectural or engineering plans?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you already submitted for building permits?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	(Please attach)	

**VI. PROJECT FINANCIAL INFORMATION (Please answer to the best of your ability)**

Estimated construction cost: \_\_\_\_\_  
 (Including construction, permit fees, school fees and other project costs)

Please list the anticipated sources of revenue for the construction of the project: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What percent of this revenue is currently in hand? If not 100%, please provide a breakdown of fundraising activities planned for the project and their timing: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please provide an annual budget for the operation of the programs conducted at the project: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How do you anticipate the on-going operations to be funded? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**VII. ORGANIZATIONAL FINANCIAL INFORMATION**

**Please provide the following regarding your agency:**

- Most recent audited financials
- Current year budget
- Year to Date actual financial results

**VIII. INSURANCE INFORMATION**

**Please check if you have the following insurance in place:**

- Directors and Officers
- Errors and Omission
- General Liability
- Workers Compensation
- Auto Insurance

Please attach a copy of your current insurance certificate.

## **IX. ADDITIONAL INFORMATION**

*Please attach additional information you feel would be helpful for our evaluation -- e.g. annual report, organization newsletter, brochures, etc.*

## **X. SERVICE PROVIDER COVENANTS**

- A. Service Provider acknowledges its obligation to give due credit to HomeAid Atlanta in any and all press releases, public announcements, award programs or other publicity about the project. Service Provider agrees to obtain HomeAid Atlanta's approval for any and all press releases, public announcements, awards programs or other publicity about the project. Any such publicity that is not disapproved within seven (7) days shall be considered approved.
- B. Service Provider acknowledges its obligation to send notice to its donor base promptly after this application is approved advising them of the contribution HomeAid Atlanta has agreed to make to the project. Such notice shall be shown to and approved by HomeAid Atlanta's executive director prior to such mailing.
- C. Service Provider acknowledges its obligation to install and maintain a plaque or similar marker recognizing HomeAid Atlanta's contribution to the project and featuring the HomeAid logo. Such commemorative marker shall be displayed in a prominent location at the completed project.
- D. Service Provider acknowledges and agrees that it bears the ultimate financial responsibility for the completion of the project and that HomeAid Atlanta's contribution to the project is limited to in-kind donations of materials and labor. Accordingly, Service Provider has diligently and thoroughly investigated and disclosed above all available and potential funding for the project.
- E. Service Provider acknowledges and agrees to provide, when requested and where reasonable, information to HomeAid Atlanta and HomeAid America, on client success rates, client service numbers, and program evaluation information.

## **XI. CERTIFICATION**

- A. Service Provider certifies that it does not engage in unlawful discrimination of any kind with respect to the persons benefited by Service Provider's activities.
- B. The undersigned hereby certifies that all information given by the Service Provider in this application is true and correct as of the date hereof.
- C. The undersigned hereby certifies that the Service Provider has read this Project Assistance Application and the Service Provider agrees that, should the project be approved, the Service Provider will abide by the covenants contained herein.
- D. The undersigned is duly authorized to execute this document on behalf of the Service Provider as of the date written below.

This application must be signed by a board officer (lay person) and the staff officer to whom future questions and correspondence may be addressed. Signatories attest to the accuracy of the information.

Submitted this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Board Officer of Service Provider

By: \_\_\_\_\_

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

Title: \_\_\_\_\_

Staff Officer of Service Provider

By: \_\_\_\_\_

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

Title: \_\_\_\_\_

**If you completed this application using Adobe Acrobat typeable PDF, please print before sending in case changes do not save. If changes do not save, scan and e-mail or fax.**

**Please return to: [info@homeaidatlanta.org](mailto:info@homeaidatlanta.org) or fax 770.934.8363**

**OR mail to:**

**HomeAid Atlanta**

**1 Dunwoody Park S, Suite 200**

**Atlanta, GA 30338**

***Thank you!***

**Staff contact: Mandy Crater, Executive Director 678.775.1401**