

Grant Application Package

Opportunity Title:	Family Self-Sufficiency Program Coordinators
Offering Agency:	US Department of Housing and Urban Development
CFDA Number:	14.896
CFDA Description:	Family Self-Sufficiency Program
Opportunity Number:	FR-5800-N-08
Competition ID:	FSS-08
Opportunity Open Date:	04/23/2014
Opportunity Close Date:	05/29/2014
Agency Contact:	Questions regarding specific program requirements should be directed to FSS@hud.gov

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

Application Filing Name: 2014 Family Self-Sufficiency Program

Select Forms to Complete

Mandatory

Application for Federal Assistance (SF-424)	Complete
HUD Applicant-Recipient Disclosure Report	Complete
HUD Facsimile Transmittal	Complete

Optional

<input checked="" type="checkbox"/> Attachments	Complete
<input type="checkbox"/> Disclosure of Lobbying Activities (SF-LLL)	

Instructions

[Show Instructions >>](#)

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

Application for Federal Assistance SF-424

* 1. Type of Submission:

- ☐ Preapplication
☒ Application
☐ Changed/Corrected Application

* 2. Type of Application:

- ☒ New
☐ Continuation
☐ Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received:

Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

CA151

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:

El Dorado County Public Housing Authority

* b. Employer/Taxpayer Identification Number (EIN/TIN):

94-6000511

* c. Organizational DUNS:

9650673820000

d. Address:

* Street1:

2900 Fairlane Ct.

Street2:

* City:

Placerville

County/Parish:

El Dorado

* State:

CA: California

Province:

* Country:

USA: UNITED STATES

* Zip / Postal Code:

95667-4106

e. Organizational Unit:

Department Name:

Health & Human Services Agency

Division Name:

Community Services Division

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

Ms.

* First Name:

Sarah

Middle Name:

* Last Name:

DeStefano

Suffix:

Title:

Housing Program Coordinator

Organizational Affiliation:

* Telephone Number:

530-621-5538

Fax Number:

530-295-2582

* Email:

sarah.destefano@edcgov.us

Application for Federal Assistance SF-424

* 9. Type of Applicant 1: Select Applicant Type:

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

* 10. Name of Federal Agency:

US Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.896

CFDA Title:

Family Self-Sufficiency Program

* 12. Funding Opportunity Number:

FR-5800-N-08

* Title:

Family Self-Sufficiency Program Coordinators

13. Competition Identification Number:

FSS-08

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment

Delete Attachment

View Attachment

* 15. Descriptive Title of Applicant's Project:

2014 El Dorado County Public Housing Authority HCV Family Self-Sufficiency Program

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

Application for Federal Assistance SF-424**16. Congressional Districts Of:*** a. Applicant * b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:* a. Start Date: * b. End Date: **18. Estimated Funding (\$):**

* a. Federal	<input type="text" value="59,902.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="59,902.00"/>

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

- ☐ a. This application was made available to the State under the Executive Order 12372 Process for review on
- ☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- ☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**☐ Yes ☒ No

If "Yes", provide explanation and attach

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name:

Middle Name:

* Last Name:

Suffix:

* Title: * Telephone Number: Fax Number: * Email:  * Signature of Authorized Representative: * Date Signed:

Applicant/Recipient Disclosure/Update Report

U.S. Department of Housing
and Urban Development

OMB Number: 2510-0011
Expiration Date: 10/31/2012

Applicant/Recipient Information

* Duns Number: 9650673820000

* Report Type: INITIAL

1. Applicant/Recipient Name, Address, and Phone (include area code):

* Applicant Name:

El Dorado County Public Housing Authority

* Street1: 2900 Fairlane Ct.

Street2:

* City: Placerville

County: El Dorado

* State: CA: California

* Zip Code: 95667-4106

* Country: USA: UNITED STATES

* Phone: 530-621-5515

2. Social Security Number or Employer ID Number: 94-6000511

* 3. HUD Program Name:

Family Self-Sufficiency Program

* 4. Amount of HUD Assistance Requested/Received: \$ 59,902.00

5. State the name and location (street address, City and State) of the project or activity:

* Project Name: 2014 Family Self-Sufficiency Program

* Street1: 2900 Fairlane Ct.

Street2:

* City: Placerville

County: El Dorado

* State: CA: California

* Zip Code: 95667

* Country: USA: UNITED STATES

Part I Threshold Determinations

* 1. Are you applying for assistance for a specific project or activity? These terms do not include formula grants, such as public housing operating subsidy or CDBG block grants. (For further information see 24 CFR Sec. 4.3).



Yes



No

* 2. Have you received or do you expect to receive assistance within the jurisdiction of the Department (HUD), involving the project or activity in this application, in excess of \$200,000 during this fiscal year (Oct. 1-Sep. 30)? For further information, see 24 CFR Sec. 4.9



Yes



No

If you answered " No " to either question 1 or 2, **Stop!** You do not need to complete the remainder of this form.

However, you must sign the certification at the end of the report.

Part II Other Government Assistance Provided or Requested / Expected Sources and Use of Funds.

Such assistance includes, but is not limited to, any grant, loan, subsidy, guarantee, insurance, payment, credit, or tax benefit.

Department/State/Local Agency Name:

* Government Agency Name:

Government Agency Address:

* Street1:

Street2:

* City:

County:

* State:

* Zip Code:

* Country:

* Type of Assistance:

* Amount Requested/Provided: \$

* Expected Uses of the Funds:

Department/State/Local Agency Name:

* Government Agency Name:

Government Agency Address:

* Street1:

Street2:

* City:

County:

* State:

* Zip Code:

* Country:

* Type of Assistance:

* Amount Requested/Provided: \$

* Expected Uses of the Funds:

(Note: Use Additional pages if necessary.)

Add Attachment

Delete Attachment

View Attachment

Part III Interested Parties. You must decide.

1. All developers, contractors, or consultants involved in the application for the assistance or in the planning, development, or implementation of the project or activity and

2. Any other person who has a financial interest in the project or activity for which the assistance is sought that exceeds \$50,000 or 10 percent of the assistance (whichever is lower).

* Alphabetical list of all persons with a reportable financial interest in the project or activity (For individuals, give the last name first)

* Social Security No. or Employee ID No.

* Type of Participation in Project/Activity

* Financial Interest in Project/Activity (\$ and %)

			\$		%
			\$		%
			\$		%
			\$		%
			\$		%

(Note: Use Additional pages if necessary.)

Add Attachment

Delete Attachment

View Attachment

Certification

Warning: If you knowingly make a false statement on this form, you may be subject to civil or criminal penalties under Section 1001 of Title 18 of the United States Code. In addition, any person who knowingly and materially violates any required disclosures of information, including intentional non-disclosure, is subject to civil money penalty not to exceed \$10,000 for each violation.

I certify that this information is true and complete.

* Signature:

* Date: (mm/dd/yyyy)

Completed Upon Submission to Grants.gov

J. C. [Signature]

Aug 22, 2014

Facsimile Transmittal

1400 690341 - 2458

U. S. Department of Housing
and Urban Development
Office of Department Grants
Management and Oversight

OMB Number: 2525-0118
Expiration Date: 06/30/2011

Name of Document Transmitting: No faxes with this submission

1. Applicant Information:

Legal Name: El Dorado County Public Housing Authority

Address:

Street1: 2900 Fairlane Ct.

Street2:

City: Placerville

County: El Dorado

State: CA: California

Zip Code: 95667-4106

Country: USA: UNITED STATES

2. Catalog of Federal Domestic Assistance Number:

Organizational DUNS: 9650673820000

CFDA No.: 14.896

Title: Family Self-Sufficiency Program

Program Component:

3. Facsimile Contact Information:

Department: Health & Human Services Agency

Division: Community Services Division

4. Name and telephone number of person to be contacted on matters involving this facsimile.

Prefix: Ms.

First Name: Amy

Middle Name:

Last Name: Higdon

Suffix:

Phone Number: 530-642-4836

Fax Number:

5. Email: amy.higdon@edcgov.us

6. What is your Transmittal? (Check one box per fax)

☐ a. Certification ☐ b. Document ☐ c. Match/Leverage Letter ☒ d. Other

7. How many pages (including cover) are being faxed?

1

Form HUD-96011 (10/12/2004)

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	HUD_52651_EDCPHA_2014_HCVFSS	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	HUD_96010_EDCPHA_HCVFSS_FY20	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	EDCPHA_HCVFSS_Participants20	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

**Housing Choice Voucher
(HCV)/Public Housing (PH)
Family Self-Sufficiency (FSS)
Program Coordinator
Funding**

**U.S. Department of Housing
and Urban Development**
Office of Public and Indian
Housing

OMB Approval No. 2577-0178
Exp. 01/31/2017

Public reporting burden for this collection of information is estimated to average 1 hour. This includes the time for collecting, reviewing, and reporting the data. Information provided is to determine the eligibility of the applicant for funding for the salary of a program coordinator. HUD uses the information to determine eligibility of the applicant to receive funding. Information is required to obtain benefit under 24 CFR 982.302(b). The information is subject to the confidentiality requirements of the HUD Reform Legislation. This agency may not collect this information, and you are not required to complete this form unless it displays a currently valid OMB control number.

PART I: General Information. (To be completed by all applicants.)

Applicant Category: <input type="checkbox"/> PHAs Not Currently administering FSS <input checked="" type="checkbox"/> PHAs Currently administering FSS Type of FSS Program: <input type="checkbox"/> HCV FSS <input type="checkbox"/> PH FSS	Moving-to-Work PHA? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No State or Regional PHA? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	DUNS Number of Applicant: 965067382	Funding Request for Fiscal Year: 2014
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A. PHA Legal Name (For joint applicants, lead PHA name): El Dorado County Public Housing Authority

Address: 2900 Fairlane Court

City: Placerville County: El Dorado

State: CA Zip Code: 95667

PHA Number of Applicant: CA151

B. Legal Name of Joint Applicant PHA. (If applicable.)

Address:

City: County:

State: Zip Code:

PHA Number of Applicant:

Legal Name of Joint Applicant PHA. (If applicable.)

Address:

City: County:

State: Zip Code:

PHA Number of Applicant:

Note: Please use the table on page 7, Appendix A below to list any additional co-applicants.

C. Evidence demonstrating salary comparability to similar positions in the local jurisdiction for each position requested is on file at the PHA.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
--	---

D. Contact information for person most familiar with the application:

Name: Sarah DeStefano Telephone Number: 530-621-5538

Email Address: sarah.destefano@edcgov.us

Name: Amy Higdon Telephone Number: 530-642-4836

Email Address: amy.higdon@edcgov.us

PART II: Funding/Positions Requested by PHAs that are Currently Administering FSS Programs

A. Previously Funded Positions

Position Number	Salary Requested Per Position under this NOFA (Including Fringe Benefits)**	Indicate whether Full-Time or Part-Time	FY Last Funded	Salary Amount Last Funded	Is Applicant's Request Above Percentage Allowed in the NOFA (if applicable)? 'Y' or 'N'
1.	\$59,902	Full-Time	2013		
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
Total Salary Requested:	59,902				

B. New Positions – Positions not funded previously under a NOFA.

Position Number	Salary Requested Per Position under this NOFA (Including Fringe Benefits)**	Indicate whether Full-Time or Part-Time
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Total Salary Requested:		

Note: Please use the tables on page 8, Appendix A below if you need additional space for previously funded and/or new positions.

C. Total Requested

1.	1.0	Total number of positions requested in Part II (enter 0.5 for part-time positions)
2.	\$59,902	Total salary requested in Part II (add totals from Part II.A and Part II.B)

** Salary awards will not exceed the cap per position stated in the most recent NOFA.

D. Total number of families under FSS contract during the NOFA target period.

PART III: Requests for PHAs that are NOT currently administering FSS Programs**A. FSS Action Plan Information:**

NA	The number of FSS program slots in the HUD-approved Action Plan. (For Joint applications, provide total approved slots for all joint applicant PHAs.)
----	---

B. Position/Salary Requested:

Position Number:	Salary Requested under this NOFA (Including Fringe Benefits) **	Indicate whether Full-Time or Part-Time
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
Total Salary Requested:		

C. Total Requested.

1.		Total number of positions requested in Part III (enter 0.5 for part-time positions)
2.		Total salary requested in Part III

** Salary awards will not exceed the cap per position stated in the most recent NOFA.

INSTRUCTIONS:

Part I. Funding Request for Fiscal Year:

Enter the Fiscal Year (FY) that corresponds to the NOFA you are applying under. For example, if you are applying for funds under the FY 2013 HCV FSS NOFA, enter 2013 on the "Funding Request for Fiscal Year" box.

Part II.A. Previously Funded Positions:

- Please see the NOFA for more information on whether column 6 "Is Applicant's Request Above Percentage Allowed in the NOFA" is applicable (i.e. whether the NOFA allows for funding increases). If requesting an increase above the percentage allowed in the NOFA, please include a justification and other requirements as instructed in the NOFA.
- See the NOFA for more information on whether applicants may qualify for part-time positions beyond the initial position (for example, whether applicants may qualify for 1.5 positions).
- See the examples below which help illustrate how to enter the information on this table.

Example 1: PHA is requesting 2 full-time positions at \$55,000 each that were last funded in FY2011 for \$55,000 each. The requested amount is the same as the amount last funded because the NOFA does not allow for funding increases.

Position Number	Salary Requested Per Position under this NOFA (Including Fringe Benefits)**	Indicate whether Full-Time or Part-Time	FY Last Funded	Salary Amount Last Funded	Is Applicant's Request Above Percentage Allowed in the NOFA (if applicable)? 'Y' or 'N'
1.	\$55,000	Full-time	2011	\$55,000	
2.	\$55,000	Full-time	2011	\$55,000	
3.					
Total Salary Requested:	\$110,000				

Example 2: PHA is requesting 1 full-time position at \$45,000 and 1 full-time position at \$50,000. Each position was last funded in FY 2012 for these same amounts. The requested amount is the same as the amounts last funded because the NOFA does not allow for funding increases.

Position Number	Salary Requested Per Position under this NOFA (Including Fringe Benefits)**	Indicate whether Full-Time or Part-Time	FY Last Funded	Salary Amount Last Funded	Is Applicant's Request Above Percentage Allowed in the NOFA (if applicable)? 'Y' or 'N'
1.	\$45,000	Full-time	2012	\$45,000	
2.	\$50,000	Full-time	2012	\$50,000	
3.					
Total Salary Requested:	\$95,000				

INSTRUCTIONS (CONTINUED)

Example 3: PHA is requesting 1 part-time position at \$30,000 for a position that was last funded in FY 2012 for the same amount. The requested amount is the same as the amount last funded because the NOFA does not allow for funding increases.

Position Number	Salary Requested Per Position under this NOFA (Including Fringe Benefits)**	Indicate whether Full-Time or Part-Time	FY Last Funded	Salary Amount Last Funded	Is Applicant's Request Above Percentage Allowed in the NOFA (if applicable)? 'Y' or 'N'
1.	\$30,000	Part-time	2012	\$30,000	
2.					
3.					
Total Salary Requested:	\$30,000				

Part II.B. New Positions: Positions not funded previously under a NOFA.

- See the NOFA for more information on whether new positions (positions not funded previously under a NOFA) are allowed and whether applicants may qualify for part-time positions beyond the initial position (for example, whether an applicant can qualify for 1.5 positions).
- Please see the examples below which help illustrate how to enter the information on this table.

Example 1: PHA is requesting 2 new full-time positions at \$55,000 each:

Position Number	Salary Requested Per Position under this NOFA (Including Fringe Benefits)**	Indicate whether Full-Time or Part-Time
1.	\$55,000	Full-time
2.	\$55,000	Full-time
3.		
Total Salary Requested:	\$110,000	

Example 2: PHA is requesting 1 new full-time position at \$45,000 and 1 new full-time position at \$50,000:

Position Number	Salary Requested Per Position under this NOFA (Including Fringe Benefits)**	Indicate whether Full-Time or Part-Time
1.	\$45,000	Full-time
2.	\$50,000	Full-time
3.		
Total Salary Requested:	\$95,000	

INSTRUCTIONS (CONTINUED)

Part III. Requests for PHAs that are NOT currently administering FSS Programs:

See the NOFA for more information on whether Part III is applicable (i.e. whether PHAs not currently administering an FSS program are eligible to apply).

Part III.B. Position/Salary Requested:

Please see the examples below which help illustrate how to enter the information on this table.

Example 1: PHA is requesting 1 new full-time position at \$55,000:

Position Number:	Salary Requested under this NOFA (Including Fringe Benefits) **	Indicate whether Full-Time or Part-Time
1.	\$55,000	Full-time
2.		
3.		
Total Salary Requested:	\$55,000	

Example 2: PHA is requesting 1 new part-time position at \$30,000:

Position Number:	Salary Requested under this NOFA (Including Fringe Benefits) **	Indicate whether Full-Time or Part-Time
1.	\$30,000	Part-time
2.		
3.		
Total Salary Requested:	\$30,000	

APPENDIX A: USE ONLY IF ADDITIONAL SPACE IS NEEDED

Part I.B. Legal Name of Joint Applicant PHAs.

Legal Name of Joint Applicant PHA. (If applicable.)	
Address:	
City:	County:
State:	Zip Code:
PHA Number of Applicant:	
Legal Name of Joint Applicant PHA. (If applicable.)	
Address:	
City:	County:
State:	Zip Code:
PHA Number of Applicant:	
Legal Name of Joint Applicant PHA. (If applicable.)	
Address:	
City:	County:
State:	Zip Code:
PHA Number of Applicant:	
Legal Name of Joint Applicant PHA. (If applicable.)	
Address:	
City:	County:
State:	Zip Code:
PHA Number of Applicant:	
Legal Name of Joint Applicant PHA. (If applicable.)	
Address:	
City:	County:
State:	Zip Code:
PHA Number of Applicant:	

APPENDIX A (continued)**Part II.A. Previously Funded Positions.**

Position Number	Salary Requested Per Position under this NOFA (Including Fringe Benefits)**	Indicate whether Full-Time or Part-Time	FY Last Funded	Salary Amount Last Funded	Is Applicant's Request Above Percentage Allowed in the NOFA (if applicable)? 'Y' or 'N'
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					
31.					
32.					
33.					
34.					
35.					
36.					
Total Salary Requested:					

Part II.B. Additional Positions.

Position Number	Salary Requested Per Position under this NOFA (Including Fringe Benefits)**	Indicate whether Full-Time or Part-Time
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
Total Salary Requested:		

2014 eLogic Model® Information Coversheet



Instructions

When completing this section, there are "mandatory" fields that must be completed. These fields are highlighted in yellow. The required data must be entered correctly to complete an eLogic Model®. Applicant Legal Name must match box 8a in the SF-424 in your application. Enter the legal name by which you are incorporated and pay taxes. Only complete the CCR Doing Business As Name field if your registration at CCR includes an entry in Doing Business as: (DBA). Enter the DUNS # as entered into box 8c of the SF-424 Application for Federal Assistance form. Enter the City where your organization is located. This information must match the SF-424 data in your application. Use the dropdown to enter the State where your organization is located. This information must match the SF-424 data in your application. Enter the Grantee Contact Name and the Grantee email address in the fields provided. Enter the eLogic Model® Contact Name and their email address in the fields provided. When completing the Project Information Section, applicants except Indian Tribes must enter their Project Name, Project Location City/County/Parish, and State. If there are multiple locations, enter the location where the majority of the work will be done. Indian tribes, including multi-state tribes should enter the City or County associated with their business address location. For Indian Tribes, enter the state applicable to the business address of the Tribal entity.

Program Information

HUD Program	FSS
Program CFDA #	14.896

Grantee Information

Applicant Legal Name	El Dorado County Public Housing Authority		
SAM.GOV Doing Business As Name			
DUNS Number	965067382		
City	Placerville		
State	CALIFORNIA		
Zip Code	95667	- 4106	
Grantee Contact Name	Don Ashton		
Grantee Contact email	don.ashton@edcgov.us		
Logic Model Contact Name	Sarah DeStefano		
Logic Model Contact email	sarah.destefano@edcgov.us		

Project Information

Project Name	2014 El Dorado County Public Housing Authority HCV Family Self-Sufficiency Program		
Project Location City/County/Parish	Placerville, El Dorado County		
Project Location State	CALIFORNIA		
Zip Code	95667	- 4106	

Additional Information for Reporting (Leave Blank At the Time of Application)

HUD Award Number	
------------------	--

Worksheet



Applicant Legal Name El Dorado County Public Housing Authority
CCR Doing Business As Name 0

HUD Program

FSS

Reporting Period

Projection

Reporting Start Date

01/01/2015

DUNS No.

965067382

Project Name

County Public Housing Authority HCV Family Self-Sufficiency Program

Reporting End Date

12/31/2015

FY 2014

HUD Goals	Policy Priority	Needs	Services/Activities	Measures			Outcomes	Measures			Evaluation Tools
1	2	3	4	5			6	7			
Policy	Planning	Programming	Projection	Annual	Extension	Impact	Projection	Annual	Extension	Accountability	
3c	1a	There is a need to link new FSS program participants to services and economic opportunities that will lead to employment and economic self-sufficiency.	Child Care-Families linked to Child Care Services	Households			Education-Associates degree obtained	Persons			A. Tools for Measurement
	1b		5			2					
	1c										
	4c										
	5a	There is a need to maintain on-going linkages to services and economic opportunities for existing FSS program participants in order to support their transition to employment and economic self-sufficiency.	Education-Participation in Adult Basic Education	Persons			Education-Bachelors degree obtained	Persons			Program specific form(s)
	5c		4			1					
			Education-Participation in ESL classes	Persons			Education-Adult Basic Education-Completed	Persons			Program specific form(s)
			1			2					
			Education-Participation in High School/GED program	Persons			Education-Certification from technical school	Persons			Program specific form(s)
			4			1					
			Education-Participation in Post secondary classes	Persons			Education-ESL-Completed	Persons			Agency database
			2			1					
			Employment-Job retention activities	Persons			Education-GED/High School diploma obtained	Persons			Agency database
			4			2					
			Financial Literacy-Escrow accounts established	Persons			Employment-Employment obtained (including apprenticeship)	Persons			Agency database
			6			5					
			Financial Literacy-Tax Preparation assistance provided	Persons			Employment-Employment increased from part-time to full-time (32+ hours)	Persons			Employment records
			25			3					
			Financial Literacy-IDA accounts (not escrow) established	Persons			Employment-Promotion/new job resulting in increased hourly wage	Persons			Employment records
			0			3					
			Financial Literacy-Individualized Counseling	Persons			Employment-Maintain employment greater than one year	Persons			Employment records
			25			4					
			Financial Literacy-Classroom Setting	Persons				Persons			Quarterly

Worksheet



Applicant Legal Name El Dorado County Public Housing Authority
 CCR Doing Business As Name 0

HUD Program

FSS

Reporting Period

Projection

Reporting Start Date

01/01/2015

DUNS No. 965067382

Project Name

County Public Housing Authority HCV Family Self-Sufficiency Program

Reporting End Date

12/31/2015

FY 2014

HUD Goals	Policy Priority	Needs	Services/Activities	Measures			Outcomes	Measures			Evaluation Tools
1		2	3	4			5	6			7
Policy		Planning	Programming	Projection	Annual	Extension	Impact	Projection	Annual	Extension	Accountability
			Financial Education (participation)	10			Employment-Employer-Provided health benefits obtained	3			
			Health-Referral for health care services (physical/dental)	Persons			Financial Literacy-EITC received	Households			Upon incident
				25				1			
			Health-Referral for mental health services	Persons			Housing-Increased earned income results in no longer needing rental assistance	Households			Upon incident
				3				1			E. Processing of Data
			Health-Referral for substance abuse services	Persons			Housing-Purchased home with HCV Homeownership Assistance	Households			Relational database
				6				0			
			Housing-Homeownership counseling	Persons			Housing-Purchased home without HCV Homeownership Assistance	Households			Relational database
				2				1			
			Service Coordination-New families enrolled (new CoPs)	Households							Statistical database
				5							
			Service Coordination-Families continuing to receive service coordination	Households							
				30							
			Service Coordination-Families graduated	Households							
				3							
			Service Coordination-Individuals served (unduplicated count)	Persons							
				25							
			Training-Job Preparation/Counseling (soft skills)-Enrolled	Persons							
				15							
			Training-Job Preparation/Counseling	Persons							

Worksheet



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HUD Goals	Policy Priority	Needs	Services/Activities	Measures			Outcomes	Measures			Evaluation Tools
1		2	3	4			5	6			7
Policy		Planning	Programming (soft skills)-Completed	Projection	Annual	Extension	Impact	Projection	Annual	Extension	Accountability
			Training-Job Training (for specific job/type of job)-Enrolled	5							
			Training-Job Training (for specific job/type of job)-Completed	3							
			Training-Parenting/Household Skills/Life Skills (non-job training)-Enrolled	2							
			Training-Parenting/Household Skills/Life Skills (non-job training)-Completed	10							
			Transportation-Transportation services to enable service provision/employment	5							
				4							

El Dorado County Public Housing Authority
HCV FSS Participants Active 1/1/13-12/1/13

HCV FSS Participant Name	
1	Aguilera, Maria
2	Antonetti, Lisa
3	Burns, Katrina
4	Creamer, Andrea
5	Deaton, Shellie
6	Dunning, Terry
7	Freschi, Donald
8	Furtato, Kassandra
9	Garcia, Matha
10	Gardia, Nicole
11	Giles, Diana
12	Hansen, Michelle
13	Jones, Nina
14	Kilgore, Maurice
15	Lopes, Jason
16	Marquez, Kathy
17	Mayrbaur, Ninon
18	Nesbitt, Kimberly
19	Palmer, Lora
20	Prince, Michelle
21	Ramos, Nanette
22	Silva, Jason
23	Smail, Sheree
24	Stringer, Jerimiah
25	Tavares, Lisa
26	Wombwell, Rebecca
27	Young, Gloria