**Supportive Services Plan for Residents**

**Staffing Plan & Budget**

**1. Description of Proposed Project and Owner’s Contact Information**

|  |  |
| --- | --- |
| Property Name:  |  |
| Property Address: |  |
| Name of project owner and if it is an LLC, name of managing member: |  |
| Owner’s primary contact person (name, title, organization, phone number and email): |  |
| Number of dwelling units: |  |
| Of the total units, how many will be permanent supportive housing units:  |  |
| Of the total units, how many units will be for families: |  |
| Of the total units, how many will be for individuals or couples: |  |
| Estimated date of closing construction financing (day/month/year): |  |
| Estimated date of first occupancy (day/month/year): |  |
| Estimated date of full occupancy (day/month/year): |  |

**2. Experience of Entity Primarily Responsible for Supportive Services**

Description of the Lead Service Provider—the organization that will be primarily responsible and accountable for overall management of supportive services—whether the project owner or another entity.

|  |  |
| --- | --- |
| Name of legal entity that is committed to be the Lead Service Provider: |  |
| Primary contact person for supportive services plan (name, title, phone number and email): |  |
| Number of units for which the proposed Lead Service Provider currently oversees and delivers services: |  |
| Number of transitional housing units/shelter beds for which the Lead Service Provider currently oversees and delivers services: |  |
| Number of non-residential homeless participants for which the Lead Service Provider currently oversees and delivers services:  |  |
| Year in which the Lead Service Provider first managed, coordinated or monitored supportive services with special needs clients in residential settings or otherwise: |  |
| Lead Service Provider’s mission statement:  |  |
| The special populations served during the past three years (check-offs).  | \_\_Chronically homeless\_\_Homeless veterans\_\_ Homeless families\_\_ Homeless youth\_\_Re-entry/Justice Involved \_\_With chronic mental illness\_\_With alcohol or drug addiction\_\_Survivors of domestic violence\_\_With physical or developmental disabilities, including HIV/AIDS\_\_Other homeless (Describe):\_\_Other (Describe): |
| Describe any programs terminated or major funding reduced or lost for supportive services in the past three years: |  |

**3. Categories of Special Needs Households Expected to Reside at the Property**

Estimate below the number of residents at full occupancy, dividing the numbers of residents into the special population categories below.

*Recognizing that some households will fall into two or more categories, estimate the numbers in each category based on the expected primary characteristics of individuals or households. The numbers in all categories must equal the total number of units. This information will be used by the program to help determine if the services listed in Section 4 below are appropriate for the expected resident population as a whole.*

|  |  |  |
| --- | --- | --- |
| **Special Populations**  | **Number of PSH units** | **Additional explanations (as needed)** |
| Chronically homeless |  |  |
| Homeless veterans |  |  |
| Homeless families |  |  |
| Homeless youth |  |  |
| Re-entry/Justice Involved |  |  |
| With chronic mental illness |  |  |
| With alcohol or drug addiction |  |  |
| Survivors of domestic violence |  |  |
| With physical or developmental disabilities, including HIV/AIDS (describe): |  |  |
| Other homeless (describe): |  |  |
| Other (describe): |  |  |
|  **Total number of PHS units** |  |  |

**4. Services to Be Provided to Residents**

Below, enter the name of a service provider (our own organization or a partner organization) for each supportive service that will be provided, and note for each service whether it is “In Budget” or “In-Kind” and whether it will be provided “On-Site” or “Off-Site.” NOTE: This was adapted from a “services menu” created by the Corporation for Supportive Housing and referred to by HUD. Include only major, essential supportive services and not incidental or occasional services.

| ***4.1. General Supportive Services*** | ***Name of Service Provider (Legal Entity) - Include Lead Service Provider and/or Others*** | ***Whether*** ***In Our Budget or In-kind*** | ***Whether Provided On-Site, Off-Site (or both)*** |  |
| --- | --- | --- | --- | --- |
|  |
|  |
|  |
|  |
| Tenant orientation/move-in assistance |  |  |  |  |
| Tenant’s rights education/tenants council |  |  |  |  |
| Case management |  |  |  |  |
| Program Manager: Service Coordination of all resident services  |  |  |  |  |
| Psychosocial assessment  |  |  |  |  |
| Individualized service planning |  |  |  |  |
| Individual counseling and support |  |  |  |  |
| Referrals to other services and programs |  |  |  |  |
| Crisis intervention |  |  |  |  |
| Peer mentoring |  |  |  |  |
| Support groups -Men’s group-Women’s group  |  |  |  |  |
| Recreational/socialization opportunities |  |  |  |  |
| Legal assistance |  |  |  |  |
| Transportation |   |  |  |  |
| Food sources |  |  |  |  |
| Other nutritional services, education  |  |  |  |  |
| Emergency financial assistance  |  |  |  |  |
| Traditional medicine |  |  |  |  |
| Cultural Activities |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

| ***4.2. Independent Living Skills*** | ***Name of Service Provider (Legal Entity) - Include Lead Service Provider and/or Others*** | ***Whether*** ***In Our Budget*** ***or In-kind*** | ***Whether Provided On-Site or Off-Site*** |
| --- | --- | --- | --- |
| Communication skills  |  |  |  |
| Conflict resolution/mediation training  |  |  |  |
| Personal financial management & budgeting |  |  |  |
| Credit counseling |  |   |  |
| Representative payee |  |  |  |
| Entitlement assistance/benefits counseling |   |  |  |
| Training in cooking/meal preparation |  |  |  |
| Training in personal hygiene and self-care |  |  |  |
| Training in housekeeping |  |  |  |
| Training in use of public transportation |  |  |  |
| Assistance with activities of daily living |  |  |  |
| Other (specify): |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ***4.3. Health/Medical Services*** | ***Name of Service Provider (Legal Entity) - Include Lead Service Provider and/or Others*** | ***Whether*** ***In Our Budget or In-kind*** | ***Whether Provided On-Site or Off-Site*** |
| Routine medical care |  |  |  |
| Specialty medical care |  |  |  |
| Medication management or monitoring |  |  |  |
| Health and wellness education |  |  |  |
| Nursing/visiting nurse care |  |  |  |
| Home health aide services |  |  |  |
| Personal care |  |  |  |
| HIV/AIDS services |  |  |  |
| Pain management |  |  |  |
| Dental hygiene  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ***4.4. Mental Health Services*** | ***Name of Service Provider (Legal Entity) - Include Lead Service Provider and/or Others*** | ***Whether*** ***In Our Budget or In-kind*** | ***Whether Provided On-Site or Off-Site*** |
| Individual psychosocial assessment |  |  |  |
| Individual counseling |  |  |  |
| Group therapy |  |  |  |
| Support groups (specify below) |  |  |  |
| Peer mentoring/support  |  |  |  |
| Medication management/monitoring  |  |  |  |
| Education about mental illness |  |  |  |
| Education about psychotropic medication |  |  |  |
| Psychiatric assessment |  |  |  |
| Psychiatric services  |  |  |  |
| Liaison with psychiatrist  |  |  |  |
| Psychiatric staff (i.e. – nurse) |  |  |  |
| Other (specify): |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ***4.5. Substance Abuse Services*** | ***Name of Service Provider (Legal Entity) - Include Lead Service Provider and/or Others*** | ***Whether*** ***In Our Budget or In-kind*** | ***Whether Provided On-Site or Off-Site*** |
| Recovery readiness services (tenants with active addictions) |  |  |  |
| Relapse prevention and recovery planning |  |  |  |
| Substance abuse counseling (individual) |  |  |  |
| Substance abuse counseling (group) |  |  |  |
| Methadone maintenance |  |  |  |
| Harm-reduction services (specify) |  |  |  |
| Peer support groups (i.e. - AA/NA/CA) |  |  |  |
| Sober recreational activities |  |  |  |
| Detoxification treatment and In-patient Rehabilitation |  |  |  |
| Rehabilitation program (out-patient) |  |  |  |
| Other (specify): |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  ***4.6. Employment Services*** | ***Name of Service Provider (Legal Entity) - Include Lead Service Provider and/or Others*** | ***Whether*** ***In Our Budget or In-kind*** | ***Whether Provided On-Site or Off-Site*** |
| Job skills training (certificate programs) |  |  |  |
| Job skills training (non-certificate services) |  |  |  |
| Employment and training specialist |  |  |  |
| Job readiness training: resumes, interviewing skills |  |  |  |
| Job retention services — support, coaching |  |  |  |
| Job development/job placement services |  |  |  |
| Opportunities for tenants to volunteer |  |  |  |
| Apprenticeship programs |  |  |  |

| ***4.7. Services for Families*** | ***Name of Service Provider (Legal Entity) - Include Lead Service Provider and/or Others*** | ***Whether*** ***In Our Budget or In-kind*** | ***Whether Provided On-Site or Off-Site*** |
| --- | --- | --- | --- |
| Support group for parents |  |  |  |
| Support group for children |  |  |  |
| Support group for families |  |  |  |
| Assistance in accessing entitlements  |  |  |  |
| Parenting/child development classes |  |  |  |
| All-day child care |  |  |  |
| After-school care |  |  |  |
| Temporary child care during parent’s illness, detox, etc. |  |  |  |
| Tutoring children |  |  |  |
| Children’s Program Director  |  |  |  |
| Referral to other children’s services (specify): |  |  |  |
| Domestic violence services |  |  |  |
| Family advocacy: |  |  |  |
| Family reunification: |  |  |  |
| Children’s activities/recreation funding for transportation, equipment and fees |  |  |  |

*Continue to next page*

**5. Case Management**

a. **Staffing standards and roles**: Describe the training, certifications and experience required for the case manager(s). Describe how often and for how long they are expected to meet with a typical resident. Describe the expected liaison and advocacy role of the case manager(s) with partner agencies Describe any direct services the case manager(s) are required to provide to residents such as crisis intervention assistance, budget counseling, or other direct services.

b. **Services plans with expected outcomes**: Describe how the case management staff work alongside residents to mutually create individualized plans for the services to be provided and expected outcomes those services and a resident’s own efforts. Describe how—and how often—the case management staff track progress toward those outcomes and discusses that progress with each resident.

c. **Supervision:** Describe how often each case manager typically meets with his/her supervisor(s) to discuss progress and what topics, data and issues are typically discussed. Describe how, if applicable, the outcome-tracking described in (b) and (c) relate to the performance reviews of the case manager(s). Describe, if applicable, whether and how lack of progress with a case manager’s resident caseload would result in a reprimand or termination.

*Continue to next page***6. Outcomes:**

a. Describe intended outcomes for the project, such as, but not limited to:

b. Describe how outcomes will be defined, tracked, reported and utilized for continued improvement.

c. Describe how the Lead Service Provider will set expected quarterly or annual outcomes for case management staff and residents regarding outcomes.

*Continue to next page*

**7. Supportive Services Staffing Plan and Budget Forecast for First 12 Months of Full Operations**

Complete the tables below, only for the staffing and costs of the Lead Service Provider. **The budget must include only supportive services costs and no property management costs.** Note: “% FTE” will exceed 100% for more than 1 staff person. Value of in-kind services is not included.

|  |  |  |  |
| --- | --- | --- | --- |
| **Staffing** |   |   |   |
| Job Functions | Our Job Titles | % FTE | Annual Cost |
| Overall management/coordination |   |   |   |
| Case management |   |   |   |
| Peer Support |   |   |   |
| Other: describe |   |   |   |
| Other: describe |   |   |   |
| Other: describe |   |   |   |
|  Subtotals, Personnel Costs |   |   | $0  |
|  Fringe Benefits |   |   | $0  |
|  Subtotal, Personnel Costs |   |   | $0  |
|  |  |  |
|  |  |  |
| **Other Program Costs** |   |   | Annual Cost |
| Client financial assistance |   |   |   |
| Client transportation |   |   |   |
| Food/refreshments for client events |   |   |   |
| Other: describe |   |   |   |
| Other: describe |   |   |   |
| Other: describe |   |   |   |
| Other: describe |   |   |   |
|  Subtotal, Other Program Costs |   |   | $0 |
|  |  |  |  |
|  |  |  |  |
| **Other Direct Costs and Indirect Overhead Costs (pro-rate for this project)** |   | Annual Cost |
| Office rent |   |   |   |
| Phone, internet |   |   |
| Equipment and equipment maintenance |   |   |
| Office supplies and postage |   |   |   |
| Mileage and parking (staff) |   |   |   |
| Training and development |   |   |   |
| Insurance (apart from employee benefits) |   |   |
|  |  |  |
| **Other Direct Costs and Indirect Overhead Costs (pro-rate for this project)**  | Annual Cost |
| Accounting |   |   |   |
| Audit |  |  |  |
| Legal |   |   |   |
| Other: describe |   |   |   |
| Other: describe |   |   |   |
| Other: describe |   |   |   |
|  Subtotal, Other Costs |   |   | $0 |
|  |  |  |  |
| Total Annual Budget |   |   | $0 |

**8. Projected Sources of Funding for Supportive Services**

Below are listed all projected sources of funding that are expected to be used to pay for the direct costs of services described in Section 5 above. If sources of funds do not equal uses of funds in any year, explain in the narrative below. If applicable, identify use of net income from rental operations and non-deferred developer fees as separate sources of funds.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Forecast of Expenses (Year 1 Taken from Budget)** | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Annual inflation factor of \_\_\_\_% applied to Years 2-5 |   |   |   |   |   |
|  |  |  |  |  |  |  |
| **Forecast of Sources** |   |  |  |  |  |  |
| Name of Funder/Source | Year 1 Status (e.g. committed, applied for) | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |
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|   |   |   |   |   |   |   |
|  Total Annual Sources Forecast | $0 | $0 | $0 | $0 | $0 |
|  |  |  |  |  |  |  |
|  Surplus/Deficit by Year |   | $0 | $0 | $0 | $0 | $0 |