Federal Grant Applications

The following are Applications for Federal Assistance received by the State Clearinghouse **July 16-30, 2010.** The State Clearinghouse reviews federally funded grants mandated by Executive Order 12372. The State Clearinghouse **does not** have information on federally funded grants. Information can be obtained by calling the federal agency funding the grant or by looking in the Catalog of Federal Domestic Assistance.

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

		2. DATE SUBMITTED	Applicant Identifier
1. TYPE OF SUBMISSION: Application ☐ Construction ☐ Non-Construction	Pre-application ☐ Construction ☑ Non-Construction	3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

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5. APPLICANT INFORMATION

Legal Name: Penn Valley Fire Protection District	Organizational Unit: Department:
Organizational DUNS: 006499396	Division:
Address: Street: P.O. Box 180, 10513 Spenceville Road	Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Mr. First Name: Gene
City: Penn Valley	Middle Name
County: Nevada	Last Name: Vander Plaats
State: CA Zip Code: 95946	Suffix: Fire Chief
Country: USA	Email: pvfpd.chief@sbcglobal.net
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 94-2848994	Phone Number (give area code): 530-432-2630 Fax Number (give area code): 530-432-4561
8. TYPE OF APPLICATION: ☑ New ☐ Continuation ☐ Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) ☐ ☐ Other (specify)	7. TYPE OF APPLICANT: (See back of form for Application Types) G. Special District Other (specify)
	9. NAME OF FEDERAL AGENCY: USDA Rural Development CA Community Facilities Loan
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 10-766 TITLE (Name of Program):	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: New Hi-Tech fire engine pumper
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Nevada County	
13. PROPOSED PROJECT Start Date: Ending Date: Engine is completed	14. CONGRESSIONAL DISTRICTS OF: a. Applicant 4th District b. Project Same

15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal	$ 237,568.00	a. Yes. ☐ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:
b. Applicant	$ 151,166.00	
c. State	$ .00	
d. Local	$ .00	b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372
e. Other	$ .00	☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
f. Program Income	$ .00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
g. TOTAL	$ 388,734.00	☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix: Mr.	First Name: Gene	Middle Name
Last Name: Vander Plaats		Suffix
b. Title: Fire Chief		c. Telephone Number (give area code): 530-432-2630
d. Signature of Authorized Representative: [signature]		e. Date Signed: 7-2-10

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

1. TYPE OF SUBMISSION: Application ☐ Construction ☐ Non-Construction	Pre-application ☑ Construction ☐ Non-Construction	2. DATE SUBMITTED	Applicant Identifier
		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: KNIGHTS LANDING COMMUNITY SERVICES DISTRICT	Organizational Unit: Department:
Organizational DUNS: 876866641	Division:
Address: Street: CR 116 & RAILROAD STREET (WELL LOCATION) P.O. BOX 548 (MAILING)	Name and telephone number of person to be contacted on matters involving this application (give area code): Prefix: MR. First Name: BRUCE
City: KNIGHTS LANDING	Middle Name MARTIN
County: YOLO	Last Name KAMILOS
State: CA Zip Code 95645	Suffix:
Country: U.S.A.	Email: bkamilos@lmce. net
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 5 6 - 2 6 2 6 6 6 4	Phone Number (give area code) 530-662-1755 Fax Number (give area code) 530-662-4602
8. TYPE OF APPLICATION: ☑ New ☐ Continuation ☐ Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) Other (specify)	7. TYPE OF APPLICANT: (See back of form for Application Types) SPECIAL DISTRICT Other (specify)
	9. NAME OF FEDERAL AGENCY: USDA
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 1 0 - 7 6 0 TITLE (Name of Program):	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: RAILROAD STREET COMMUNITY WATER WELL REPLACEMENT.
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): TOWN OF KNIGHTS LANDING	
13. PROPOSED PROJECT Start Date: 04/04/11 Ending Date: 08/19/11	14. CONGRESSIONAL DISTRICTS OF: a. Applicant DISTRICT 2 b. Project DISTRICT 2

15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal	$ 496,038.00	a. Yes. ☑ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:
b. Applicant	$	
c. State	$	
d. Local	$	b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372
e. Other	$	☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
f. Program Income	$	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
g. TOTAL	$ 496,038.00	☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix MR.	First Name BRUCE	Middle Name MARTIN
Last Name KAMILOS		Suffix
b. Title DISTRICT ENGINEER		c. Telephone Number (give area code) 530-662-1755
d. Signature of Authorized Representative		e. Date Signed

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Standard Form 424 (Rev.9-2003)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
Preapplication	New	A
× Application	Continuation	* Other (Specify)
Changed/Corrected Application	× Revision	

* 3. Date Received:	4. Applicant Identifier:
	SCRRA

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:
5802	

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JUL 19 2010
STATE CLEARING HOUSE

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Southern California Regional Rail Authority

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
9 3 4 3 5 1 6 6 3	836140475

d. Address:

* Street1: 700 South Flower Street
Street2: Suite 2600
* City: Los Angeles
County:
* State: California
Province:
* Country: USA
* Zip / Postal Code: 90017-4101

e. Organizational Unit:

Department Name:	Division Name:
Capital Planning & Prog Mgmt	

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

Prefix: Ms. * First Name: Joanna
Middle Name: Starr
* Last Name: Capelle
Suffix:

Title: Grants & Development Manager

Organizational Affiliation:
Southern California Regional Rail Authority

* Telephone Number: (213) 247-8049 Fax Number: (213) 452-0421

* Email: capellej@scrra.net

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

N. Other (Specify)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

Joint Powers Authority

*** 10. Name of Federal Agency:**

Federal Transit Administration

11. Catalog of Federal Domestic Assistance Number:

2 0 5 0 0

CFDA Title:

Federal Transit-Formula Grant

*** 12. Funding Opportunity Number:**

CA-05-0235-01

* Title:

FY 09, FY 10 Rehab OCTA, SBAG, VCTC, RCTC

13. Competition Identification Number:

Title:

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

Cities from Lancaster and Chatsworth through Los Angeles to San Clemente and San Bernardino, in Los Angeles, Orange, San Bernardino Counties, State of California

*** 15. Descriptive Title of Applicant's Project:**

Rehabilitation of the Metrolink track, signals, communications, structures and equipment in Los Angeles, Orange and San Bernardino Counties

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant 22-49 * b. Program/Project 22-49

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

Add Attachment

17. Proposed Project:

* a. Start Date: 07/01/2009 * b. End Date: 08/26/2012

18. Estimated Funding ($):

* a. Federal	13,632,669.00
* b. Applicant	
* c. State	
* d. Local	3,408,167.00
* e. Other	
* f. Program Income	
* g. TOTAL	17,040,836.00

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

x a. This application was made available to the State under the Executive Order 12372 Process for review on 07/16/2010 .

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.)**

Yes x No Explanation

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)**

x **** 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: Mr. * First Name: John

Middle Name: E

* Last Name: Fenton

Suffix:

* Title: Chief Executive Officer

* Telephone Number: (213) 452-0258 Fax Number: (213) 452-0452

* Email: fentonj@scrra.net

* Signature of Authorized Representative: John E. Fenton * Date Signed: 7/14/10

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Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

2. DATE SUBMITTED Water System Upgrade	Applicant Identifier Trinity County Fair	
3. DATE RECEIVED BY STATE	State Application Identifier	
4. DATE RECEIVED BY FEDERAL AGENCY MAY 12 2010	Federal Identifier 887066671	

1. TYPE OF SUBMISSION:

Application: ☑ Construction ☐ Non-Construction

Pre-application: ☐ Construction ☐ Non-Construction

5. APPLICANT INFORMATION

Legal Name: Trinity County

Organizational Unit:

Department:

Organizational DUNS: 076109412

Division:

Address:

Street: PO Box 1613

City: Weaverville

County: Trinity

State: California

Zip Code: 96093

Country: United States

Name and telephone number of person to be contacted on matters involving this application (give area code)

Prefix:

First Name: Dero

Middle Name

Last Name: Forslund

Suffix:

Email: dforslund@trinitycounty.org

Phone Number (give area code): (530)623-1217

Fax Number (give area code): (530) 623-8365

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6. EMPLOYER IDENTIFICATION NUMBER *(EIN)*: 94-6000544

8. TYPE OF APPLICATION:

☑ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)

Other (specify)

7. TYPE OF APPLICANT: (See back of form for Application Types)

B. County

Other (specify)

9. NAME OF FEDERAL AGENCY: USDA Rural Development

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 10-766

TITLE (Name of Program): Community Facilities Grant Program

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:

Installation of a non-treated water line connection to assist with emergency services operations in the region and reduce the impact of operations on local water treatment facility.

12. AREAS AFFECTED BY PROJECT *(Cities, Counties, States, etc.)*:

Town of Hayfork, Trinity County

13. PROPOSED PROJECT

Start Date: July 2010

Ending Date: December 2010

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant: 02

b. Project: 02

15. ESTIMATED FUNDING:

a. Federal	$ 90,000.00
b. Applicant	$ 30,000.00
c. State	$ .00
d. Local	$ .00
e. Other	$ .00
f. Program Income	$ .00
g. TOTAL	$ 120,000.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. Yes. ☑ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON

DATE:

b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix	First Name Dero	Middle Name
Last Name Forslund		Suffix
b. Title County Administrative Officer		c. Telephone Number (give area code) (530) 623-1217
d. Signature of Authorized Representative		e. Date Signed 4-27-2010

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

RECEIVED JUL 19 2010 STATE CLEARING HOUSE

* 3. Date Received: 07/19/10
~~Completed by Grants.gov upon submission.~~

4. Applicant Identifier: METRO GOLD LINE

5a. Federal Entity Identifier: 6579 ID

* 5b. Federal Award Identifier: CA-04-0041-01

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: METRO GOLD LINE FOOTHILL EXTENSION CONSTRUCTION AUTHORITY

* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4731722

* c. Organizational DUNS: 361 500 924

d. Address:

* Street1: 406 E. HUNTINGTON DRIVE
Street2: SUITE 202
* City: MONROVIA
County:
* State: CA
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 91016

e. Organizational Unit:

Department Name:

Division Name:

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

Prefix: MR.
* First Name: CRANDAL
Middle Name:
* Last Name: JUE
Suffix:

Title: CHIEF FINANCIAL OFFICER

Organizational Affiliation:

* Telephone Number: (626) 471-9050
Fax Number: (626) 471-9049

* Email: CJUE@FOOTHILLEXTENSION.ORG

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

NGMS Agency

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

*** 12. Funding Opportunity Number:**

MBL-SF424FAMILY-ALLFORMS

* Title:

MBL-SF424Family-AllForms

13. Competition Identification Number:

Title:

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

*** 15. Descriptive Title of Applicant's Project:**

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant 26, 29, 32 * b. Program/Project 26, 29, 32

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 10/1/09 * b. End Date: 9/30/12

18. Estimated Funding ($):

* a. Federal	3,260,400 -
* b. Applicant	
* c. State	
* d. Local	815,100 -
* e. Other	
* f. Program Income	
* g. TOTAL	4,075,500 -

*** 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.)**

☐ Yes ☒ No Explanation

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:	MR.
* First Name:	CRAIG
Middle Name:	
* Last Name:	JUE
Suffix:	
* Title:	CFO
* Telephone Number:	(626) 471.9050
Fax Number:	(626) 471.9049
* Email:	CJUE@FOOTHILLXTENSION.ORG
* Signature of Authorized Representative:	Completed by Grants.gov upon submission.
* Date Signed:	Completed by Grants.gov upon submission.

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Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

1. TYPE OF SUBMISSION: Application ☒ Construction ☐ Non-Construction; Pre-application ☐ Construction ☐ Non-Construction	2. DATE SUBMITTED July 19, 2010	Applicant Identifier
	3. DATE RECEIVED BY STATE	State Application Identifier
	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: City of Watsonville	Organizational Unit:
	Department: Airports
Organizational DUNS: 6304146604	Division:
Address: Street: 100 Aviation Way	Name and telephone number of person to be contacted on matters involving this application (give area code)
	Prefix: Mr. / First Name: Donald
City: Watsonville	Middle Name E.
County: Santa Cruz	Last Name French
State: California / Zip Code 95076	Suffix:
Country: USA	Email: dfrench@ci.watsonville.ca.us
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 94-6000451	Phone Number (give area code) (831) 728-6075 / Fax Number (give area code) (831) 763-4058

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8. TYPE OF APPLICATION: ☒ New ☐ Continuation ☐ Revision. If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) ☐ ☐ Other (specify)	7. TYPE OF APPLICANT: (See back of form for Application Types) C. Municipal. Other (specify)
	9. NAME OF FEDERAL AGENCY: Federal Aviation Administration
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 20-106. TITLE (Name of Program): Airport Improvement Program	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Watsonville Municipal Airport, Watsonville, Santa Cruz County, CA. Reconstruct Taxiway C (50' x 1,350') and General Aviation Apron Phase 1 (5,850 sq. yd.)
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): City of Watsonville, California	
13. PROPOSED PROJECT: Start Date: 2010 / Ending Date: 2010	14. CONGRESSIONAL DISTRICTS OF: a. Applicant 17 / b. Project 17

15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal	$ 1,288,200	a. Yes. ☒ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: July 20, 2010
b. Applicant	$ 67,800	
c. State	$ 0	
d. Local	$	b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372
e. Other	$	☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
f. Program Income	$	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
g. TOTAL	$ 1,356,000	☐ Yes If "Yes" attach an explanation. ☒ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative: Prefix Mr.	First Name Donald	Middle Name E.
Last Name French		Suffix
b. Title Airport Manager		c. Telephone Number (give area code) (831) 728-6075
d. Signature of Authorized Representative		e. Date Signed 7-20-10

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

1. TYPE OF SUBMISSION: Application ☐ Construction ☐ Non-Construction	Pre-application ☐ Construction ☐ Non-Construction	2. DATE SUBMITTED July 19, 2010
		3. DATE RECEIVED BY STATE
		4. DATE RECEIVED BY FEDERAL AGENCY
		Applicant Identifier
		State Application Identifier
		Federal Identifier

5. APPLICANT INFORMATION

Legal Name: City of Watsonville

Organizational Unit: Department: Airports

Division:

Organizational DUNS:

Address: 100 Aviation Way

Name and telephone number of person to be contacted on matters involving this application (give area code)

City: Watsonville

County: Santa Cruz

State: CA

Zip Code: 95076

Country: USA

Prefix: Mr. First Name: Donald

Middle Name: E.

Last Name: French

Suffix:

Email: dfrench@ci.watsonville.ca.us

Phone Number (give area code): (831) 728-6075

Fax Number (give area code): (831) 763-4058

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6. EMPLOYER IDENTIFICATION NUMBER (EIN): 9 5 - 6 0 0 0 4 5 1

7. TYPE OF APPLICANT: (See back of form for Application Types)

C. Municipal

Other (specify)

8. TYPE OF APPLICATION: ☒ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)

Other (specify)

9. NAME OF FEDERAL AGENCY: Federal Aviation Administration

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 2 0 - 1 0 6

TITLE (Name of Program): Airport Improvement Program

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Watsonville Municipal Airport, Watsonville, Santa Cruz County, CA Pavement Evaluation Study and Pavement Management Plan

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): City of Watsonville, California

13. PROPOSED PROJECT

Start Date: 2010

Ending Date: 2010

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant: 17

b. Project: 17

15. ESTIMATED FUNDING:

a. Federal	$ 52,250
b. Applicant	$ 2,750
c. State	$ 0
d. Local	$
e. Other	$
f. Program Income	$
g. TOTAL	$ 55,000

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. Yes. ☒ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON

DATE: July 20, 2010

b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes" attach an explanation. ☒ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix: Mr. First Name: Donald Middle Name: E.

Last Name: French Suffix:

b. Title: Airport Manager c. Telephone Number (give area code): (831) 728-6075

d. Signature of Authorized Representative: e. Date Signed: 07-20-2010

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*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:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Community Alliance with Family Farmers

*b. Employer/Taxpayer Identification Number (EIN/TIN): 942914745

*c. Organizational DUNS: 364179267

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JUL 20 2010
STATE CLEARING HOUSE

d. Address:

*Street 1: PO Box 363
Street 2:
*City: Davis
County:
*State: CA
Province:
*Country: USA
*Zip / Postal Code 95617

e. Organizational Unit:

Department Name:

Division Name:

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

Prefix:
*First Name: Dave
Middle Name:
*Last Name: Runsten
Suffix:

Title:

Organizational Affiliation:

*Telephone Number: 530-756-8518

Fax Number:

*Email: dave@caff.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 1 *b. Program/Project: 1,6

17. Proposed Project:

*a. Start Date: 7/1/10 *b. End Date: 6/30/10

18. Estimated Funding ($):

*a. Federal	70,000
*b. Applicant	36,911
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	106,911

***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 7/19/10

☐ 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.)**

☐ Yes ☒ No

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: Diane

Middle Name:

*Last Name: Del Signore

Suffix:

*Title: Executive Director

*Telephone Number: 530-756-8518 x 17 | Fax Number:

* Email: diane@caff.org

*Signature of Authorized Representative: Diane Del Signore | *Date Signed: 7/16/10

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

2. DATE SUBMITTED 06/15/2010	Applicant Identifier	
3. DATE RECEIVED BY STATE	State Application Identifier G1098019	
4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier W-87-R-1	

1. TYPE OF SUBMISSION:

Application: ☐ Construction ☒ Non-Construction

Pre-application: ☐ Construction ☐ Non-Construction

5. APPLICANT INFORMATION

Legal Name: STATE OF CALIFORNIA

Organizational Unit:
Department: Fish and Game
Division: GRANTS MANAGEMENT BRANCH

Organizational DUNS: 808322358

Address:
Street: 1831 9TH STREET
City: SACRAMENTO
County: SACRAMENTO
State: CA Zip Code 95811
Country: USA

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Name and telephone number of person to be contacted on matters involving this application (give area code)
Prefix: Ms First Name: LISA
Middle Name
Last Name: BAYS
Suffix:
Email: lbays@dfg.ca.gov
Phone Number (give area code): (916) 445-3701
Fax Number (give area code): (916) 327-6320

6. EMPLOYER IDENTIFICATION NUMBER (EIN): 94-1697567

7. TYPE OF APPLICANT: (See back of form for Application Types)
A. State
Other (specify)

8. TYPE OF APPLICATION:
☒ New ☐ Continuation ☐ Revision
If Revision, enter appropriate letter(s) in box(es)
(See back of form for description of letters.)
Other (specify)

9. NAME OF FEDERAL AGENCY: U.S. Department of Interior, Fish and Wildlife Service

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 15-611
TITLE (Name of Program): WILDLIFE RESTORATION ACT

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
WILDLIFE HABITAT INVENTORIES & RESEARCH - WILDLIFE MANAGEMENT - NORTHERN REGION

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.):
LASSEN, MODOC, SISKIYOU & DEL NORTE COUNTIES

13. PROPOSED PROJECT
Start Date: 07/01/2010 Ending Date: 06/30/2012

14. CONGRESSIONAL DISTRICTS OF:
a. Applicant 3 b. Project 1, 2, 4

15. ESTIMATED FUNDING:

a. Federal	$	902,251.00
b. Applicant	$	
c. State	$	300,750.00
d. Local	$	
e. Other	$	
f. Program Income	$	
g. TOTAL	$	1,203,001.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Yes. ☒ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON
DATE: 06/15/2010
b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372
☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
☐ Yes If "Yes" attach an explanation. ☒ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative
Prefix: Mr. First Name: BLAINE Middle Name
Last Name: NICKENS Suffix
b. Title: CHIEF, GRANTS MANAGEMENT BRANCH
c. Telephone Number (give area code): 916-445-9300
d. Signature of Authorized Representative
e. Date Signed: June 15, 2010

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Standard Form 424 (Rev.9-2003)
Prescribed by OMB Circular A-102

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0006 Version 7/03

1. TYPE OF SUBMISSION: Application ☑ Construction ☐ Non-Construction; Pre-application ☐ Construction ☐ Non-Construction	2. DATE SUBMITTED 7/20/10	Applicant Identifier
	3. DATE RECEIVED BY STATE	State Application Identifier
	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: Hidden Valley Lake Community Services District	Organizational Unit:
	Department:
Organizational DUNS: 024132875	Division:
Address: Street: 19400 Hartmann Road	Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: First Name: Mel
City: Hidden Valley Lake	Middle Name
County: Lake	Last Name Aust
State: CA Zip Code 95467-8371	Suffix:
Country:	Email: maust@hiddenvalleylakecsd.com
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 68-0048232	Phone Number (give area code) 707-987-9201 Fax Number (give area code) 707-987-3237
8. TYPE OF APPLICATION: ☑ New ☐ Continuation ☐ Revision; If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) ☐ ☐ Other (specify)	7. TYPE OF APPLICANT: (See back of form for Application Types) G. Special District; Other (specify)
	9. NAME OF FEDERAL AGENCY: USDA Rural Development California
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 10-760; TITLE (Name of Program): Water and Waste Disposal Systems for Rural Communities	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Hidden Valley Lake Water Reclamation Plant Energy Sustainability Project
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Hidden Valley Lake	
13. PROPOSED PROJECT: Start Date: 12/15/10 Ending Date: 08/31/11	14. CONGRESSIONAL DISTRICTS OF: a. Applicant 1 b. Project 1
15. ESTIMATED FUNDING:	16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. Federal	$ 2,982,500
b. Applicant	$ .00
c. State	$ .00
d. Local	$ .00
e. Other	$ .00
f. Program Income	$ .00
g. TOTAL	$ 2,982,500

a. Yes. ☑ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 7/22/10

b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? ☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative Prefix	First Name Mel	Middle Name
Last Name Aust		Suffix
b. Title General Manager		c. Telephone Number (give area code) 707-987-9201
d. Signature of Authorized Representative		e. Date Signed 7-21-2010

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APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

		2. DATE SUBMITTED July 19, 2010	Applicant Identifier Dept. of Food and Agriculture
1. TYPE OF SUBMISSION: Application	Pre-application	**3. DATE RECEIVED BY STATE** July 17, 2010	State Application Identifier
☐ **Construction**	☐ **Construction**	**4. DATE RECEIVED BY FEDERAL AGENCY**	Federal Identifier 10-8520-1399-CA
☑ **Non-Construction**	☐ **Non-Construction**		

5. APPLICANT INFORMATION

Legal Name: State of California	**Organizational Unit:**
	Department: Food and Agriculture
Organizational DUNS: 807487665	Division: Plant Health and Pest Prevention Services
Address:	**Name and telephone number of person to be contacted on matters involving this application (give area code)**
Street: 1220 N Street, Room 315	Prefix: / First Name: Joanne
City: Sacramento	Middle Name
County: Sacramento	Last Name Shimada
State: California / Zip Code 95814	Suffix:
Country: United States	Email: jshimada@cdfa.ca.gov
6. EMPLOYER IDENTIFICATION NUMBER *(EIN)*: 68-0325104	Phone Number (give area code) (916) 654-1211 / Fax Number (give area code) (916) 654-0555

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8. TYPE OF APPLICATION: ☑ **New** ☐ **Continuation** ☐ **Revision** If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) Other (specify)	**7. TYPE OF APPLICANT:** (See back of form for Application Types) A - State Other (specify)
	9. NAME OF FEDERAL AGENCY: USDA/APHIS/PPQ
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 10-025 TITLE (Name of Program): Expanded Pest Detection System	**11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:** Expanded pest detection system in California
12. AREAS AFFECTED BY PROJECT *(Cities, Counties, States, etc.)*: State of California	
13. PROPOSED PROJECT Start Date: July 1, 2010 / Ending Date: June 30, 2011	**14. CONGRESSIONAL DISTRICTS OF:** a. Applicant California / b. Project Expanded Pest Detection System

15. ESTIMATED FUNDING:		**16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?**
a. Federal	$ 4,305,447 .00	a. Yes. ☑ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:
b. Applicant	$ .00	
c. State	$ 638,697 .00	
d. Local	$ .00	b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372
e. Other	$ .00	☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
f. Program Income	$ .00	**17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?**
g. TOTAL	$ 4,944,144 .00	☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative		
Prefix	First Name Kathy	Middle Name
Last Name Alameda		Suffix
b. Title Manager, Federal Funds Management Unit		c. Telephone Number (give area code) (916) 651-9888
d. Signature of Authorized Representative		e. Date Signed

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Standard Form 424 (Rev.9-2003)
Prescribed by OMB Circular A-102

Joanne 916 654-0555

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [ ] New
- [x] 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:

* 5b. Federal Award Identifier: 09-8100-1418-CA

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State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: University of California Regents

* b. Employer/Taxpayer Identification Number (EIN/TIN): 94-6036494

* c. Organizational DUNS: 047120084

d. Address:

* Street1: 1850 Research Park Drive, Suite 300
Street2:
* City: Davis
County: Yolo
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 95618

e. Organizational Unit:

Department Name: Sponsored Programs

Division Name: Foundation Plant Services

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

Prefix: Dr.
* First Name: Deborah
Middle Name: A.
* Last Name: Golino
Suffix: Ph.D

Title: Director, Foundation Plant Services

Organizational Affiliation: University of California, Davis

* Telephone Number: 530-754-8102
Fax Number: 530-752-2132

* Email: dagolino@ucdavis.edu

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

H: Public/State Controlled Institution of Higher Education

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Animal and Plant Health Inspection Service

11. Catalog of Federal Domestic Assistance Number:

10.025

CFDA Title:

Plant and Animal Disease, Pest Control, and Animal Care

*** 12. Funding Opportunity Number:**

USDA-GRANTS-042210-001

* Title:

National Clean Plant Network Cooperative Agreement Program Request for Applications

13. Competition Identification Number:

Title:

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

Nationwide

*** 15. Descriptive Title of Applicant's Project:**

Grapevine, Fruit Tree, and Nut Tree Clean Plant Program at Foundation Plant Services, University of California, Davis.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant: CA-001
* b. Program/Project: CA-001

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 08/01/2010
* b. End Date: 07/31/2011

18. Estimated Funding ($):

* a. Federal	2,469,018.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	2,469,018.00

*** 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.
- [x] c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

- [ ] Yes
- [x] No

Explanation

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)**

- [x] ** 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:	Kathy
Middle Name:	
* Last Name:	Nolan
Suffix:	
* Title:	Associate Director of Sponsored Programs
* Telephone Number:	530-754-7700
Fax Number:	
* Email:	knolan@ucdavis.edu
* Signature of Authorized Representative:	Completed by Grants.gov upon submission.
* Date Signed:	Completed by Grants.gov upon submission.

Authorized for Local Reproduction

Kathleen P Nolan 6-11-10

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [ ] New
- [x] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier: Recovery Act - CCFRPP

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5a. Federal Entity Identifier:

* 5b. Federal Award Identifier: NA09NMF4630324

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: California Conservation Corps

* b. Employer/Taxpayer Identification Number (EIN/TIN): 68-0298653

* c. Organizational DUNS: 808322127

d. Address:

* Street1: 1500 Alamar Way
Street2:
* City: Fortuna
County:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 95540

e. Organizational Unit:

Department Name: Fortuna/Backcountry

Division Name: Region One - Fortuna Center

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

Prefix:
* First Name: Michelle
Middle Name:
* Last Name: Rankin
Suffix:

Title: Center Director

Organizational Affiliation:

* Telephone Number: 707-725-5106 ext 260

Fax Number:

* Email: michelle.rankin@ccc.ca.gov

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type:

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Department of Commerce

11. Catalog of Federal Domestic Assistance Number:

11.463

CFDA Title:

Habitat Conservation

*** 12. Funding Opportunity Number:**

NOAA-NMFS-HCPO-2010-2002158

* Title:

FY 2010 General Noncompetitive RFA

13. Competition Identification Number:

Title:

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

*** 15. Descriptive Title of Applicant's Project:**

Coastal California Fisheries Restoration Project Partnership - Supplemental ARRA Funding

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant: CA-001
* b. Program/Project: CA-001

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

NOAA grant attachment 1.doc | Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 08/01/2010
* b. End Date: 12/31/2011

18. Estimated Funding ($):

* a. Federal	50,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	50,000.00

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

[X] a. This application was made available to the State under the Executive Order 12372 Process for review on 07/23/2010.

[ ] 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.)**

[ ] Yes [X] No Explanation

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)**

[X] ** 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: Michelle
Middle Name:
* Last Name: Rankin
Suffix:

* Title: Center Director

* Telephone Number: 707-725-5106 ext. 260
Fax Number:

* Email: michelle.rankin@ccc.ca.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission.
* Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☒ New
- ☐ Continuation
- ☐ Revision

* If Revision, select appropriate letter(s)

*Other (Specify)

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3. Date Received: 07/20/2010

4. Applicant Identifier: 1666

5a. Federal Entity Identifier: 1666

*5b. Federal Award Identifier: 1666

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: City of Torrance - Torrance Transit System

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6000803

*c. Organizational DUNS: 136190357

d. Address:

*Street 1: 20500 Madrona Avenue
Street 2:
*City: Torrance
County: Los Angeles
*State: California
Province:
*Country: United States
*Zip / Postal Code 90503

e. Organizational Unit:

Department Name: Transit

Division Name: Administration

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

Prefix: Mr.
*First Name: Jim
Middle Name:
*Last Name: Mills
Suffix:

Title: Administration Manager

Organizational Affiliation:

*Telephone Number: 310-618-6291
Fax Number: 310-618-6229

*Email: jmills@torranceca.gov

Application for Federal Assistance SF-424 Version 02

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

C. City or Township Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

Federal Transit Administration

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

***12 Funding Opportunity Number:**

*Title:

13. Competition Identification Number:

Title:

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

City of Torrance, Los Angeles County

***15. Descriptive Title of Applicant's Project:**

Federal Fiscal Year 2011, Acquisition of Eight (8) Expansion Buses for the Operation of a new Rapid Bus Service.

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 36 (Harman) *b. Program/Project: 36 (Harman)

17. Proposed Project:

*a. Start Date: 07/01/2010 *b. End Date: 12/31/2013

18. Estimated Funding ($):

*a. Federal	$6,952,000
*b. Applicant	
*c. State	
*d. Local	
*e. Other	$948,000
*f. Program Income	
*g. TOTAL	$7,900,000

***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 07/20/2010

☐ 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.)**

☐ Yes ☒ No

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: Mr. *First Name: Jim

Middle Name:

*Last Name: Mills

Suffix:

*Title: Administration Manager

*Telephone Number: 310-618-6291 Fax Number: 310-618-6229

* Email: jmills@torranceca.gov

*Signature of Authorized Representative: *Date Signed:

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
Preapplication	X New	A
X Application	Continuation	* Other (Specify)
Changed/Corrected Application	Revision	

* 3. Date Received:	4. Applicant Identifier:
	SCRRA

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:
5802	

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State Use Only:

6. Date Received by State:	7. State Application Identifier

8. APPLICANT INFORMATION:

* a. Legal Name: Southern California Regional Rail Authority

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
9 3 4 3 5 1 6 6 3	836140475

d. Address:

* Street1: 700 South Flower Street
Street2: Suite 2600
* City: Los Angeles
County:
* State: California
Province:
* Country: USA
* Zip / Postal Code: 90017-4101

e. Organizational Unit:

Department Name:	Division Name:
Capital Planning & Prog Mgmt	

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

Prefix: Ms
* First Name: Joanna
Middle Name: Star
* Last Name: Capelle
Suffix:

Title: Grants & Development Manager

Organizational Affiliation:
Southern California Regional Rail Authority

* Telephone Number: (213) 247-8049
Fax Number: (213) 452-0421

* Email: capellej@scrra.net

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

N. Other (Specify)

Type of Applicant 2: Select Applicant Type

Type of Applicant 3: Select Applicant Type

* Other (specify)

Joint Powers Authority

*** 10. Name of Federal Agency:**

Federal Transit Administration

11. Catalog of Federal Domestic Assistance Number:

2 0 5 0 7

CFDA Title:

Federal Transit-Formula Grant

*** 12. Funding Opportunity Number:**

CA-90-Y840

* Title

Pomona North Station Platform Extension

13. Competition Identification Number:

Title

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

City of Pomona in Los Angeles County, State of California

*** 15. Descriptive Title of Applicant's Project:**

This project calls for construction of a widened, extended and improved center platform to accommodate 8-car trains

Attach supporting documents as specified in agency instructions

Add Attachments Delete Attachments View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant 22-49 * b. Program/Project 38

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

Add Attachment

17. Proposed Project:

* a. Start Date 01/15/2009 * b. End Date: 05/15/2011

18. Estimated Funding ($):

* a. Federal	271,353.00
* b. Applicant	
* c. State	
* d. Local	67,839.00
* e. Other	
* f. Program Income	
* g. TOTAL	339,192.00

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

X a. This application was made available to the State under the Executive Order 12372 Process for review on 07/23/2010

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.)**

Yes X No Explanation

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)**

X **** 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: Mr * First Name: John

Middle Name: E

* Last Name: Fenton

Suffix:

* Title: Chief Executive Officer

* Telephone Number: (213) 452-0258 Fax Number: (213) 452-0452

* Email: fentonj@scrra.net

* Signature of Authorized Representative: John E. Fenton * Date Signed: 7/22/10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application	* If Revision, select appropriate letter(s):
Preapplication	X New	A
X Application	Continuation	* Other (Specify)
Changed/Corrected Application	Revision	

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STATE CLEARING HOUSE

* 3. Date Received:	4. Applicant Identifier:
	SCRRA

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:
5802	

State Use Only:

6. Date Received by State	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Southern California Regional Rail Authority

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
9 3 4 3 5 1 6 6 3	836140475

d. Address:

* Street1: 700 South Flower Street
Street2: Suite 2600
* City: Los Angeles
County:
* State: California
Province:
* Country: USA
* Zip / Postal Code: 90017-4101

e. Organizational Unit:

Department Name:	Division Name:
Capital Planning & Prog Mgmt	

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

Prefix: Ms
* First Name: Joanna
Middle Name: Starr
* Last Name: Capelle
Suffix:

Title: Grants & Development Manager

Organizational Affiliation:
Southern California Regional Rail Authority

* Telephone Number: (213) 247-8049
Fax Number: (213) 452-0421

* Email: capellej@scrra.net

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

N. Other (Specify)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify)

Joint Powers Authority

*** 10. Name of Federal Agency:**

Federal Transit Administration

11. Catalog of Federal Domestic Assistance Number:

2 0 5 0 7

CFDA Title:

Federal Transit-Formula Grant

*** 12. Funding Opportunity Number:**

CA-90-Y777

* Title:

Pomona North Station

13. Competition Identification Number:

Title:

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

City of Pomona in Los Angeles County, State of California

*** 15. Descriptive Title of Applicant's Project:**

This project calls for construction 2 new pedestrian-rail grade crossings, relocation and safety enhancements (gates, flashers, fencing) to 1 existing highway-rail grade crossing, and realignment of the track, expanded parking with a net increase of approximately 180 new parking spaces

Attach supporting documents as specified in agency instructions.

Add Attachments Delete Attachments View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant 22-49 * b. Program/Project 38

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

Add Attachment

17. Proposed Project:

* a. Start Date 01/15/2009 * b. End Date: 05/15/2011

18. Estimated Funding ($):

* a. Federal	4,208,646.00
* b. Applicant	
* c. State	
* d. Local	1,052,162.00
* e. Other	
* f. Program Income	
* g. TOTAL	5,260,808.00

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

X a. This application was made available to the State under the Executive Order 12372 Process for review on 07/23/2010

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.)**

Yes X No Explanation

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)**

X ** 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 Mr * First Name John

Middle Name E

* Last Name Fenton

Suffix:

* Title: Chief Executive Officer

* Telephone Number: (213) 452-0258 Fax Number: (213) 452-0452

* Email: fentonj@scrra.net

* Signature of Authorized Representative: John E. Fenton * Date Signed: 7/22/10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

RECEIVED JUL 26 2010 STATE CLEARINGHOUSE

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: The Regents of the University of California

* b. Employer/Taxpayer Identification Number (EIN/TIN): 956006142W

* c. Organizational DUNS: 6277974260000

d. Address:

* Street1: 200 University Office Building
Street2:
* City: Riverside
County: Riverside
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 92521-0217

e. Organizational Unit:

Department Name: Office of Research

Division Name: Sponsored Programs Admin

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

Prefix:
* First Name: Ursula
Middle Name:
* Last Name: Prins
Suffix:

Title: Sr. Contract & Grant Officer

Organizational Affiliation: The Regents of the University of California

* Telephone Number: 951-827-4808
Fax Number: 951-827-4483

* Email: ursula.prins@ucr.edu

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

H: Public/State Controlled Institution of Higher Education

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Animal and Plant Health Inspection Service

11. Catalog of Federal Domestic Assistance Number:

10.025

CFDA Title:

Plant and Animal Disease, Pest Control, and Animal Care

*** 12. Funding Opportunity Number:**

USDA-GRANTS-042210-001

* Title:

National Clean Plant Network Cooperative Agreement Program Request for Applications

13. Competition Identification Number:

Title:

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

Worldwide

*** 15. Descriptive Title of Applicant's Project:**

This project will ensure that high quality citrus propagative material will be produced, maintained, and supplied to scientists and the industry in the USA under the standards of excellence of NCPN.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant: CA-044
* b. Program/Project: CA-044

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 08/01/2010
* b. End Date: 07/31/2011

18. Estimated Funding ($):

* a. Federal	1,511,725.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,511,725.00

*** 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.
- [x] c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

- [ ] Yes
- [x] No

Attach an explanation

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)**

- [x] ** 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: Cynthia
Middle Name:
* Last Name: Wells
Suffix:

* Title: Director, Sponsored Programs

* Telephone Number: 951-827-5535
Fax Number: 951-827-4483

* Email: cynthia.wells@ucr.edu

* Signature of Authorized Representative: Completed by Grants.gov upon submission.
* Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☐ New
- ☒ Continuation
- ☐ Revision

* If Revision, select appropriate letter(s)

*Other (Specify)

RECEIVED JUL 26 2010 STATE

3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: County of Los Angeles

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6000927

*c. Organizational DUNS: 106625903

d. Address:

*Street 1: 425 Shatto Place
Street 2:
*City: Los Angeles
County: Los Angeles
*State: CA
Province:
*Country: USA
*Zip / Postal Code 90020

e. Organizational Unit:

Department Name: Department of Children and Family Services

Division Name: Youth Development Services

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

Prefix: Ms.
*First Name: Bedrae
Middle Name:
*Last Name: Davis
Suffix:

Title: Children Services Administrator

Organizational Affiliation:
Department of Children and Family Services, Transitional Housing Program

*Telephone Number: 213-351-0239

Fax Number: 213-637-0042

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***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:**

U.S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

CFDA 14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5409-N-01

*Title:

NOFA Continuum of Care

13. Competition Identification Number:

Title:

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

Los Angeles, Los Angeles County, California

***15. Descriptive Title of Applicant's Project:**

Transitional Housing for Homeless Young People

***15. Descriptive Title of Applicant's Project:**

Transitional Housing for Homeless Young People

OMB Number: 4040-0004

Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 33 *b. Program/Project: 27,29,30

17. Proposed Project:

*a. Start Date: 07-01-11 *b. End Date: 06-30-12

18. Estimated Funding ($):

*a. Federal	$384,676
*b. Applicant	$60,184
*c. State	
*d. Local	
*e. Other	
*f. Program Income	$446,860
*g. TOTAL	

***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.)**

☐ Yes ☒ No

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:	Ms.	*First Name:	Patricia
Middle Name:	S.		
*Last Name:	Ploehn		
Suffix:			
*Title: Director			
*Telephone Number: 213-351-5600		Fax Number: 213-427-6125	
* Email: tploehn@dcfs.lacounty.gov			
*Signature of Authorized Representative:	Trish Ploehn	*Date Signed:	5-2-10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☐ New
- ☒ Continuation
- ☐ Revision

* If Revision, select appropriate letter(s)

*Other (Specify)

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STATE CLEARING HOUSE

3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: County of Los Angeles

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6000927

*c. Organizational DUNS: 106625903

d. Address:

*Street 1: 425 Shatto Place
Street 2:
*City: Los Angeles
County: Los Angeles
*State: California
Province:
*Country: USA
*Zip / Postal Code 90020

e. Organizational Unit:

Department Name: Department of Children and Family Services

Division Name: Youth Development Services

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

Prefix: Ms.
*First Name: Bedrae
Middle Name:
*Last Name: Davis
Suffix:

Title: Children Services Administrator

Organizational Affiliation: Department of Children and Family Services

*Telephone Number: 213-351-0239
Fax Number: 213-637-0042

*Email: davisb@dcfs.lacounty.gov

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***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:**

U.S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

CFDA 14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5409-N-01

*Title:

NOFA Continuum of Care

13. Competition Identification Number:

Title:

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

Los Angeles, Los Angeles County, California

***15. Descriptive Title of Applicant's Project:**

Transitional Housing for Homeless Young People

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 33 *b. Program/Project: 22,25,32,35

17. Proposed Project:

*a. Start Date: 04-01-11 *b. End Date: 03-31-12

18. Estimated Funding ($):

*a. Federal	$274,400
*b. Applicant	$65,696
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	$340,096

***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.)**

☐ Yes ☒ No

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: Ms. *First Name: Patricia

Middle Name: S.

*Last Name: Ploehn

Suffix:

*Title: Director

*Telephone Number: 213-351-5600 Fax Number: 213-427-6125

* Email: tploehn@dcfs.lacounty.gov

*Signature of Authorized Representative: Trish Ploehn *Date Signed: 5-7-10

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*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:

4. Applicant Identifier:

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STATE CLEARING HOUSE

5a. Federal Entity Identifier:

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: County of Los Angeles

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6000927

*c. Organizational DUNS: 106625903

d. Address:

*Street 1: 425 Shatto Place
Street 2:
*City: Los Angeles
County: Los Angeles
*State: CA
Province:
*Country: USA
*Zip / Postal Code 90020

e. Organizational Unit:

Department Name: Department of Children and Family Services

Division Name: Youth Development Services

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

Prefix: Ms. *First Name: Bedrae
Middle Name:
*Last Name: Davis
Suffix:

Title: Children Services Administrator

Organizational Affiliation:
Department of Children and Family Services, Transitional Housing Program

*Telephone Number: 213-351-0239 Fax Number: 213-637-0042

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***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:**

U.S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

CFDA 14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5409-N-01

*Title:

NOFA Continuum of Care

13. Competition Identification Number:

Title:

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

Los Angeles, Los Angeles County, California

***15. Descriptive Title of Applicant's Project:**

Transitional Housing for Homeless Young People

***15. Descriptive Title of Applicant's Project:**

Transitional Housing for Homeless Young People

OMB Number: 4040-0004

Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 33 *b. Program/Project: 35

17. Proposed Project:

*a. Start Date: 07-01-11 *b. End Date: 06-30-12

18. Estimated Funding ($):

*a. Federal	$197,621
*b. Applicant	$27,465
*c. State	
*d. Local	
*e. Other	
*f. Program Income	$225,086
*g. TOTAL	

***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.)**

☐ Yes ☒ No

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:	Ms.	*First Name:	Patricia
Middle Name:	S.		
*Last Name:	Ploehn		
Suffix:			
*Title: Director			
*Telephone Number: 213-351-5600		Fax Number: 213-427-6125	
* Email: tploehn@dcfs.lacounty.gov			
*Signature of Authorized Representative:		*Date Signed	

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application	* If Revision, select appropriate letter(s)
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

3. Date Received: 4. Applicant Identifier:

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JUL 26 2010
STATE CLEARING HOUSE

5a. Federal Entity Identifier: *5b. Federal Award Identifier:

State Use Only:

6. Date Received by State: 7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: County of Los Angeles

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6000927

*c. Organizational DUNS: 106625903

d. Address:

*Street 1: 425 Shatto Place
Street 2:
*City: Los Angeles
County: Los Angeles
*State: CA
Province:
*Country: USA
*Zip / Postal Code 90020

e. Organizational Unit:

Department Name: Department of Children and Family Services

Division Name: Youth Development Services

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

Prefix: Ms. *First Name: Bedrae
Middle Name:
*Last Name: Davis
Suffix:

Title: Children Services Administrator

Organizational Affiliation:
Department of Children and Family Services, Transitional Housing Program

*Telephone Number: 213-351-0239 Fax Number: 213-637-0042

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***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:**

U.S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

CFDA 14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5409-N-01

*Title:

NOFA Continuum of Care

13. Competition Identification Number:

Title:

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

Los Angeles, Los Angeles County, California

***15. Descriptive Title of Applicant's Project:**

Transitional Housing for Homeless Young People

***15. Descriptive Title of Applicant's Project:**

Transitional Housing for Homeless Young People

OMB Number: 4040-0004

Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 33 *b. Program/Project: 30,31,35

17. Proposed Project:

*a. Start Date: 07-01-11 *b. End Date: 06-30-12

18. Estimated Funding ($):

*a. Federal	$89,062
*b. Applicant	$22,354
*c. State	
*d. Local	
*e. Other	
*f. Program Income	$111,416
*g. TOTAL	

***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.)**

☐ Yes ☒ No

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:	Ms.	*First Name:	Patricia
Middle Name:	S.		
*Last Name:	Ploehn		
Suffix:			
*Title: Director			
*Telephone Number: 213-351-5600		Fax Number: 213-427-6125	
* Email: tploehn@dcfs.lacounty.gov			
*Signature of Authorized Representative:		*Date Signed:	5-7-10

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Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approval No. 0348-0043

	2. DATE SUBMITTED July 26, 2010	Applicant Identifier
1. TYPE OF SUBMISSION: Application ☐ Construction ☑ Non-Construction; Preapplication ☐ Construction ☑ Non-Construction	3. DATE RECEIVED BY STATE	State Application Identifier
	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: ANTELOPE VALLEY TRANSIT AUTHORITY	Organizational Unit: ANTELOPE VALLEY TRANSIT AUTHORITY
Address *(give city, county, State, and zip code)*: 42210 6TH STREET WEST LANCASTER, CA 93534	Name and telephone number of person to be contacted on matters involving this application *(give area code)* RANDY FLOYD 661-729-2206

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6. EMPLOYER IDENTIFICATION NUMBER *(EIN)*:

7. TYPE OF APPLICANT: *(enter appropriate letter in box)* N

A. State
B. County
C. Municipal
D. Township
E. Interstate
F. Intermunicipal
G. Special District
H. Independent School Dist.
I. State Controlled Institution of Higher Learning
J. Private University
K. Indian Tribe
L. Individual
M. Profit Organization
N. Other (Specify) Joint Powers Auth

8. TYPE OF APPLICATION:

☑ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es)

A. Increase Award B. Decrease Award C. Increase Duration
D. Decrease Duration Other*(specify)*:

9. NAME OF FEDERAL AGENCY:

US DOT & FTA

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:

2 0 5 0 7

TITLE FEDERAL TRANSIT FORMULA GRANTS

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:

Purchase: DAR expansion vehicles, hybrid local transit buses, driver relief minivans, maintenance and administrative equipment such as: new and replacement computers, digital imaging press, rotary trimmer & paper cutter, major facility equipment and large parts necessary

12. AREAS AFFECTED BY PROJECT *(Cities, Counties, States, etc.)*:

Antelope Valley portion of Northern Los Angeles

13. PROPOSED PROJECT

Start Date	Ending Date
9/1/10	9/1/12

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant 22 & 25 b. Project 22 & 25

15. ESTIMATED FUNDING:

a. Federal	$ 8,163,600.00
b. Applicant	$ 2,040,900.00
c. State	$ .00
d. Local	$ .00
e. Other	$ .00
f. Program Income	$ .00
g. TOTAL	$ 10,204,500.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:

DATE _____

b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372
☑ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes," attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Type Name of Authorized Representative RANDY FLOYD	b. Title EXECUTIVE DIRECTOR	c. Telephone Number (661) 729-2206
d. Signature of Authorized Representative		e. Date Signed 7/26/2010

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☒ New
- ☐ Continuation
- ☐ Revision

* If Revision, select appropriate letter(s)

*Other (Specify)

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JUL 26 2010
STATE CLEARING HOUSE

3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: City of Santa Monica Housing Authority

*b. Employer/Taxpayer Identification Number (EIN/TIN):
95-6000790

*c. Organizational DUNS:
149405123

d. Address:

*Street 1: 1901 Main Street
Street 2: 1st Floor, Suite A
*City: Santa Monica
County: Los Angeles
*State: California
Province:
*Country: USA
*Zip / Postal Code 90405

e. Organizational Unit:

Department Name:
Housing and Economic Development

Division Name:
Housing Authority

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

Prefix: Mrs.
*First Name: Julie
Middle Name: Piedras
*Last Name: Lansing
Suffix:

Title: Housing Authority Administrator

Organizational Affiliation:
City of Santa Monica Housing Authority

*Telephone Number: 310-458-8743
Fax Number: 310-264-7757

*Email: julie.lansing@smgov.net

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**
U. S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

***12 Funding Opportunity Number:**

FR-5409-N-01

*Title:

13. Competition Identification Number:

Title:

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

City of Santa Monica

***15. Descriptive Title of Applicant's Project:**

New Project Application under 2010 SuperNOFA through Los Angeles Continuum of Care

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 30 *b. Program/Project: 30

17. Proposed Project:

*a. Start Date: *b. End Date:

18. Estimated Funding ($):

*a. Federal _____
*b. Applicant _____
*c. State _____
*d. Local _____
*e. Other _____
*f. Program Income _____
*g. TOTAL _____

***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.)**

☐ Yes ☒ No

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: Mr. *First Name: Rod
Middle Name: _____
*Last Name: Gould
Suffix: _____

*Title: City Manager

*Telephone Number: 310-458-8743 | Fax Number: 310-264-7757

* Email: rod.gould@smgov.net

*Signature of Authorized Representative: | *Date Signed:

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☐ New	
☑ Application	☑ Continuation	* Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:
94-2219349	

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
94-2219349	0729402320000

d. Address:

* Street1: 18646 Oxnard Street
Street2:
* City: Tarzana
County:
* State: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 91356

e. Organizational Unit:

Department Name:	Division Name:

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

Prefix: Mr. * First Name: Albert
Middle Name:
* Last Name: Senella
Suffix:

Title: President and Chief Operating Officer

Organizational Affiliation:

* Telephone Number: (818) 654-3815 Fax Number: (818) 936-0133

* Email: asenella@tarzanalc.org

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STATE CLEARING HOUSE

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

M: Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

*** 12. Funding Opportunity Number:**

FR-5409-N-01

* Title:

Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

*** 15. Descriptive Title of Applicant's Project:**

Transitional Housing Program

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant: 27
* b. Program/Project: Ca-027

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 07/01/10
* b. End Date: 06/30/11

18. Estimated Funding ($):

* a. Federal	$188,491
* b. Applicant	$37,733
* c. State	$0
* d. Local	$0
* e. Other	$0
* f. Program Income	$0
* g. TOTAL	$226,224

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

- [x] a. This application was made available to the State under the Executive Order 12372 Process for review on 10/27/09
- [ ] 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.)**

- [ ] Yes
- [x] No

Explanation

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)**

- [x] **** 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: Mr. * First Name: Albert

Middle Name:

* Last Name: Senella

Suffix:

* Title: President and Chief Operating Officer

* Telephone Number: (818) 654-3815 Fax Number: (818) 996-3051

* Email: asenella@tarzanatc.org

* Signature of Authorized Representative: Date Signed: 7/27/10

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Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission:	*2. Type of Application	* If Revision, select appropriate letter(s)
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

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STATE CLEARING HOUSE

3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier: CA0461B9D000801

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: SHIELDS For Families

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4336420

*c. Organizational DUNS: 136274870

d. Address:

*Street 1: 11601 S. Western Avenue
Street 2:
*City: Los Angeles
County: Los Angeles
*State: California
Province:
*Country: USA
*Zip / Postal Code 90047

e. Organizational Unit:

Department Name:

Division Name:

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

Prefix:
*First Name: Kathryn
Middle Name:
*Last Name: Icenhower
Suffix: Ph.D.

Title: Executive Director

Organizational Affiliation:

*Telephone Number: 323-242-5000 x 1268

Fax Number: 323-242-5011

*Email: kicenhower@shieldsforfamilies.org

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STATE CLEARING HOUSE

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

HUD

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

2010 SuperNOFA Continuum of Care

***12 Funding Opportunity Number:**

FR5409-N-01

*Title:

13. Competition Identification Number:

Title:

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

Los Angeles, California

***15. Descriptive Title of Applicant's Project:**

Transitional Housing Program for dually diagnosed substance abusing women and children

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: CA-037 *b. Program/Project: CA-037

17. Proposed Project:

*a. Start Date: 12/2010 *b. End Date: 11/2011

18. Estimated Funding ($):

*a. Federal	90935
*b. Applicant	
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	90935

***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 06/15/2010

☐ 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.)**

☐ Yes ☒ No

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: Kathryn

Middle Name:

*Last Name: Icenhower

Suffix: Ph.D.

*Title: Executive Director

*Telephone Number: 323-242-5000 x 1268 Fax Number: 323-242-5011

* Email: kicenhower@shieldsforfamilies.org

*Signature of Authorized Representative: Kathryn Icenhower, PhD *Date Signed: 7/27/10

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*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:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier:

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STATE CLEARING HOUSE

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Su Casa ~ Ending Domestic Violence

*b. Employer/Taxpayer Identification Number (EIN/TIN): 953495175

*c. Organizational DUNS: 101805575

d. Address:

*Street 1: 3840 Woodruff Avenue - Ste. 203
Street 2:
*City: Long Beach
County: Los Angeles
*State: CA
Province:
*Country: U.S.
*Zip / Postal Code 90808

e. Organizational Unit:

Department Name:

Division Name:

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

Prefix: Ms.
*First Name: Vicki
Middle Name: L.
*Last Name: Doolittle
Suffix:

Title: Executive Director

Organizational Affiliation:

*Telephone Number: 562-421-6537
Fax Number: 562 421-8117

*Email: vicki@sucasadv.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**
M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**
Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

***12 Funding Opportunity Number:**
FR5341-N-01

***Title:**
Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

***15. Descriptive Title of Applicant's Project:**
Su Casa Supportive Housing Program

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: CA-039 *b. Program/Project: CA-039

17. Proposed Project:

*a. Start Date: January 1, 2012 *b. End Date: December 31, 2012

18. Estimated Funding ($):

*a. Federal	$52,463
*b. Applicant	$14,376
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	$66,839

***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 7/27/2010

☐ 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.)**

☐ Yes ☒ No

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: Ms. *First Name: Vicki

Middle Name: L.

*Last Name: Doolittle

Suffix:

*Title: Executive Director

*Telephone Number: 562-421-6537 Fax Number: 562-421-8117

* Email: vicki@sucasadv.org

*Signature of Authorized Representative: Vicki Doolittle *Date Signed: 7/27/2010

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*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:

4. Applicant Identifier:

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5a. Federal Entity Identifier:

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Testimonial Community Love Center

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4376926

*c. Organizational DUNS: 87-4689391

d. Address:

*Street 1: 5721 South Western Avenue
Street 2:
*City: Los Angeles
County: Los Angeles
*State: California
Province:
*Country: USA
*Zip / Postal Code 90062

e. Organizational Unit:

Department Name: Supportive Housing Program

Division Name: TCLC Transitional Housing Program

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

Prefix: Ms. *First Name: Cynthia
Middle Name:
*Last Name: Carter
Suffix:

Title: Program Director

Organizational Affiliation: Testimonial Community Love Center

*Telephone Number: 323 291-6753 Fax Number: 323 292-1512

*Email: cindytclc@aol.com

RECEIVED JUL 27 2010 STATE CLEARING HOUSE

Application for Federal Assistance SF-424 Version 02

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

M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

U.S. Dept. Of Housing & Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5409-N-01

*Title:

Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

COC-01

Title:

2010 SuperNofa Continuum of Care

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

Los Angeles City/County

***15. Descriptive Title of Applicant's Project:**

TCLC Transitional Housing Program

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 33rd Cong.District *b. Program/Project: 33rd Congressional District

17. Proposed Project:

*a. Start Date: 5/1/2011 *b. End Date: 4/30/12

18. Estimated Funding ($):

*a. Federal	136,888
*b. Applicant	
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	136,888

***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 7/26/10

☐ 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.)**

☐ Yes ☒ No

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: Ms. *First Name: Cynthia

Middle Name: Delphene

*Last Name: Carter

Suffix:

*Title: Program Director

*Telephone Number: 323 291-6753 Fax Number: 323 292-1512

* Email: cindytclc@aol.com

*Signature of Authorized Representative: Cynthia Carter *Date Signed: 7/26/10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
[X] Preapplication	[ ] New	
[ ] Application	[X] Continuation	* Other (Specify)
[ ] Changed/Corrected Application	[ ] Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:

RECEIVED
JUL 28 2010
STATE CLEARING HOUSE

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Southern California Alcohol and Drug Programs, Inc.

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
237228780	060378189

d. Address:

* Street1: 11500 Paramount Blvd.
Street2:
* City: Downey
County:
* State: CA
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 90241

e. Organizational Unit:

Department Name:	Division Name:

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

Prefix: Ms. * First Name: Lynne
Middle Name:
* Last Name: Appel
Suffix: M.S.

Title: Executive Director

Organizational Affiliation:
Southern California Alcohol and Drug Programs, Inc.

* Telephone Number: 562-923-4545 x2226 Fax Number: 562-862-0918

* Email: lrappel@earthlink.net

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JUL 28 2010
STATE CLEARINGHOUSE

Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

M. Nonprofit with 501 (C)(3) IRS Status (Other than Institution of Higher Education)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

NGMS Agency

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

*** 12. Funding Opportunity Number:**

FR-5409-N-01

* Title:

Conntinum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

Los Angeles

*** 15. Descriptive Title of Applicant's Project:**

Angel Step Too is a transitional housing program targeting battered, substance addicted women and their children. The program offers needs assessment, case management and service linkage, substance abuse counseling and education, domestic violence counseling and education, life skills training, and vocational/educational services. Angel Step Too works to place our transitional housing participants into stable housing following program completion.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant: CA-034
* b. Program/Project: CA-034

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date:
* b. End Date:

18. Estimated Funding ($):

* a. Federal	355,943
* b. Applicant	
* c. State	
* d. Local	
* e. Other	
* f. Program Income	
* g. TOTAL	355,943

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

[X] a. This application was made available to the State under the Executive Order 12372 Process for review on 7-28-2010.

[ ] 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.)**

[X] Yes [ ] No Explanation

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)**

[X] ** 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: Ms. * First Name: Lynne

Middle Name:

* Last Name: Appel

Suffix: M.S.

* Title: Executive Director

* Telephone Number: 562-923-4545 x2226 Fax Number: 562-862-0918

* Email: lrappel@earthlink.net

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

APPLICATION FOR FEDERAL ASSISTANCE

2. DATE SUBMITTED	July 20, 2010
Applicant Identifier	KREI
3. DATE RECEIVED BY STATE	
State Application Identifier	
4. DATE RECEIVED BY FEDERAL AGENCY	
Federal Identifier	

1. TYPE OF SUBMISSION:

Application
- ☒ Construction
- ☐ Non-Construction

Preapplication
- ☐ Construction
- ☐ Non-Construction

5. APPLICANT INFORMATION

Legal Name: City of Redlands - Redlands Municipal Airport

Organizational DUNS: 094712205

Address:
Street: 35 Cajon Street, Suite 222

City: Redlands

County: San Bernardino

State: CA Zip Code: 92373-1505

Country : US

Organizational Unit:
Department: Quality of Life Department
Division: Airport

Name and telephone number of person to be contacted on matters involving this application (give area code)

Prefix: First Name: Danielle
Middle Name: Suzanne
Last Name: Garcia
Suffix:
Email: dgarcia@cityofredlands.org
Phone number (give area code): 909-753-5800
FAX number (give area code): 909-798-7697

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6. EMPLOYER IDENTIFICATION NUMBER (EIN): 9 5 - 6 0 0 0 7 6 6

7. TYPE OF APPLICANT: (See back of form for Application Types) C

Other (specify)

8. TYPE OF APPLICATION:

☒ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es): (See back of form for description of letters)

Other (specify)

9. NAME OF FEDERAL AGENCY
Federal Aviation Administration

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER
2 0 - 1 0 6
TITLE: Airport Improvement Program

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Extension of West Ramp Taxiway Improvements, Storm Drain and Pavement Rehabilitation

12. AREAS AFFECTED BY PROJECT (cities, counties, states, etc.):
Redlands, San Bernardino County, California

13. PROPOSED PROJECT

Start Date	Ending Date
September 30, 2010	December 30, 2010

14. CONGRESSIONAL DISTRICTS OF

a. Applicant	b. Project
CA-041	CA-041

15. ESTIMATED FUNDING

a. Federal	$	150000 .00
b. Applicant	$	9000 .00
c. State	$	.00
d. Local	$	.00
e. Other	$	.00
f. Program income	$	.00
g. TOTAL	$	.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS

a. Yes. ☒ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON

DATE: 07/21/2010

b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes" attach an explanation ☐ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix Ms.	First Name Pat	Middle Name
Last Name Gilbreath		Suffix
b. Title Mayor, City of Redlands		c. Telephone number (give area code) 909-798-7533
d. Signature of Authorized Representative Pat Gilbreath		e. Date Signed July 20, 2010

Previous Editions Not Usable
Authorized for Local Reproduction

Standard Form 424 (Rev.9-2003)
Prescribed by OMB Circular A-102

ATTEST:

City Clerk

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [ ] New
- [x] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

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JUL 28 2010
STATE CLEARING HOUSE

* 3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: 1736 Family Crisis Center

* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-3989251

* c. Organizational DUNS: 61-821-6519

d. Address:

* Street1: 2116 Arlington Avenue, #200
Street2:
* City: Los Angeles
County: Los Angeles
* State: CA
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 90018

e. Organizational Unit:

Department Name: N/A

Division Name: N/A

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

Prefix: Ms.
* First Name: Carol
Middle Name: A.
* Last Name: Adelkoff
Suffix:

Title: CEO and Executive Director

Organizational Affiliation:
1736 Family Crisis Center

* Telephone Number: (323) 737-3900
Fax Number: (323) 737-3993

* Email: carol.adelkoff@gmail.com

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

Private nonprofit with 501(c)(3)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

U.S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Program (SHP)

*** 12. Funding Opportunity Number:**

FR-5220-N-01

* Title:

Continuum of Care Homeless Assistance Program

13. Competition Identification Number:

N/A

Title:

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

Los Angeles County, California

*** 15. Descriptive Title of Applicant's Project:**

Two Domestic Violence Shelters and Comprehensive Supportive Services

Attach supporting documents as specified in agency instructions.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant CA-033, CA-036, CA-037 * b. Program/Project 33

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

17. Proposed Project:

* a. Start Date: 07/01/11 * b. End Date: 06/30/12

18. Estimated Funding ($):

* a. Federal 521,823
* b. Applicant 139,137
* c. State
* d. Local
* e. Other
* f. Program Income
* g. TOTAL 660,960

*** 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 07/28/10.

☐ 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.)**

☐ Yes ☑ No

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: Ms. * First Name: Carol

Middle Name: A.

* Last Name: Adelkoff

Suffix:

* Title: CEO and Executive Director

* Telephone Number: (323) 737-3900 Fax Number: (323) 737-3993

* Email: carol.adelkoff@gmail.com

* Signature of Authorized Representative: Carol A. Adelkoff * Date Signed: July 28, 2010

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application	* If Revision, select appropriate letter(s)
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

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3. Date Received: 4. Applicant Identifier:
Completed by grants.gov upon submission

5a. Federal Entity Identifier: *5b. Federal Award Identifier:

State Use Only:

6. Date Received by State: 7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: St. Joseph Center

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-3874381

*c. Organizational DUNS: 169308566

d. Address:

*Street 1: 204 Hampton Drive
Street 2:
*City: Venice
County:
*State: California
Province:
*Country:
*Zip / Postal Code 90291-8633

e. Organizational Unit:

Department Name: Division Name:

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

Prefix: *First Name: Nick
Middle Name:
*Last Name: Maiorino
Suffix:

Title: Deputy Director for Contracts

Organizational Affiliation:
St. Joseph Center

*Telephone Number: (310) 396-6468 x330 Fax Number: (310) 392-8402

*Email: nmaiorino@stjosephctr.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**
M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**
U.S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:
14.235

CFDA Title:

***12 Funding Opportunity Number:**
FR-5409-N-01

*Title:
MBL-SF424Family-All forms

13. Competition Identification Number:

Title:
2010 SuperNOFA Continuum of Care- CFDA 14.235

14. Areas Affected by Project (Cities, Counties, States, etc.):
Los Angeles City and County

***15. Descriptive Title of Applicant's Project:**
St. Joseph Center Homeless Senior Outrach Program

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 36 *b. Program/Project: 36

17. Proposed Project:

*a. Start Date: 07/01/11 *b. End Date: 6/30/12

18. Estimated Funding ($):

*a. Federal	47,247
*b. Applicant	11,249
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	58,496

***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 7/28/10

☐ 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.)**

☐ Yes ☒ No

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: Va Lecia

Middle Name:

*Last Name: Adams

Suffix: Ph.D.

*Title: Executive Director

*Telephone Number: (310) 396-6468 x304 Fax Number: (310) 392-8402

* Email: vadams@stjosephctr.org

*Signature of Authorized Representative: Va Lecia Adams, Ph.D. *Date Signed: 7/28/10

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☒ New
- ☐ Continuation
- ☐ Revision

* If Revision, select appropriate letter(s)

*Other (Specify)

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JUL 28 2010
STATE CLEARING HOUSE

3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: The Salvation Army, a California corporation

*b. Employer/Taxpayer Identification Number (EIN/TIN): 94-1156347

*c. Organizational DUNS: 074629460

d. Address:

*Street 1: 900 West James M. Wood Boulevard
Street 2:
*City: Los Angeles
County: Los Angeles
*State: CA
Province:
*Country: USA
*Zip / Postal Code 90015

e. Organizational Unit:

Department Name:

Division Name: Southern California

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

Prefix: Mr.
*First Name: Steve
Middle Name:
*Last Name: Lytle
Suffix:

Title: Funding Consultant

Organizational Affiliation:

*Telephone Number: (213) 553-3253
Fax Number: (213) 607-7253

*Email: Steve.Lytle@usw.salvationarmy.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5415-N-01

*Title:

Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

Cities of Bell, Los Angeles, and Santa Fe Springs; County of Los Angeles, State of California

***15. Descriptive Title of Applicant's Project:**

The Salvation Army Southern California Division Supportive Housing Programs.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 34 *b. Program/Project: 30, 31, 33, 34, and 39

17. Proposed Project:

*a. Start Date: 05/01/2011 *b. End Date: 12/31/2012

18. Estimated Funding ($):

*a. Federal	2,462,629
*b. Applicant	
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	2,462,629

***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 July 27, 2010

☐ 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.)**

☐ Yes ☒ No

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: Lt. Colonel *First Name: Victor

Middle Name: A.

*Last Name: Leslie

Suffix:

*Title: Divisional Commander

*Telephone Number: (213) 553-3253 Fax Number: (213) 607-7253

* Email: Victor.Leslie@usw.salvationarmy.org

*Signature of Authorized Representative: *Date Signed: July 27, 2010

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

		2. DATE SUBMITTED ~~6.13.10~~ 7-12-10	Applicant Identifier
1. TYPE OF SUBMISSION: Application	Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
☑ Construction	☑ Construction	4. DATE RECEIVED BY FEDERAL AGENCY ~~Sept-9-2009~~ 7-12-10	Federal Identifier 550664639
☐ Non-Construction	☐ Non-Construction		

5. APPLICANT INFORMATION

Legal Name: Corcoran District Hospital	Organizational Unit:
Organizational DUNS: 020021366	Department:
Address:	Division:
Street: 1310 Hanna Avenue	Name and telephone number of person to be contacted on matters involving this application (give area code)
City: Corcoran	Prefix: Ms. / First Name: Cynthia
County: Kings	Middle Name: Bruno
State: CA / Zip Code: 93212	Last Name: Wynkoop
Country:	Suffix:
	Email: cbwynkoop@gibruno.com
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 9 4 - 6 0 0 3 7 3 0	Phone Number (give area code): 559.454.7744 / Fax Number (give area code): 559.454.7748

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8. TYPE OF APPLICATION:

☑ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) ☐ ☐

Other (specify)

7. TYPE OF APPLICANT: (See back of form for Application Types)

G - Public Hospital District

Other (specify)

9. NAME OF FEDERAL AGENCY: USDA

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 1 0 - 7 6 6

TITLE (Name of Program): Community Facilities

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:

Corcoran Community Outpatient Center

12. AREAS AFFECTED BY PROJECT *(Cities, Counties, States, etc.)*:

13. PROPOSED PROJECT

Start Date: Mar-10 / Ending Date: April-11

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant 20th / b. Project 20th

15. ESTIMATED FUNDING:

a. Federal	$ 12,000,000 .00
b. Applicant	$ 3,403,778 .00
c. State	$ .00
d. Local	$ .00
e. Other	$ .00
f. Program Income	$ .00
g. TOTAL	$ 15,403,778 .00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. Yes. ☐ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON

DATE:

b. No. ☑ PROGRAM IS NOT COVERED BY E. O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix: Mr.	First Name: Jonathan	Middle Name
Last Name: Brenn		Suffix
b. Title: Chief Executive Officer		c. Telephone Number (give area code): 559.992.5051
d. Signature of Authorized Representative		e. Date Signed

Previous Edition Usable
Authorized for Local Reproduction

Standard Form 424 (Rev.9-2003)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	* Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	09-436

RECEIVED
JUL 29 2010
HOUSE

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:
	66.034

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Dominican University of California

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
94-1156525	074664855

d. Address:

* Street1:	50 Acacia Avenue
Street2:	
* City:	San Rafael
County:	
* State:	CA: California
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	94901

e. Organizational Unit:

Department Name:	Division Name:
Business	

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

Prefix:		* First Name:	Carol
Middle Name:			
* Last Name:	Patterson		
Suffix:			

Title: Director, Corp, Fnd & Govnt Relations

Organizational Affiliation:
Dominican Unviersity of California

* Telephone Number:	415-257-0116	Fax Number:	415-257-0162

* Email: carol.patterson@dominican.edu

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type:

O: Private Institution of Higher Education

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Environmental Protection Agency

11. Catalog of Federal Domestic Assistance Number:

66.034

CFDA Title:

Surveys, Studies, Research, Investigations, Demonstrations, and Special Purpose Activities Relating to the Clean Air Act

*** 12. Funding Opportunity Number:**

EPA-OAR-CCD-10-09

* Title:

Facilitating Tribal Climate Change Adaptation Planning and Communicating Climate Change Impacts

13. Competition Identification Number:

Title:

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

EFC 9 - all (California, Nevada, Arizona,Hawaii); and EFC 6 - all (New Mexico, Texas, Oklahoma, Arkansas, Louisiana and 66 tribal nations) and EFC 8 all(Colorado, Montana, North Dakota, South Dakota, Utah Wyoming and 27 sovereign tribal nations)

*** 15. Descriptive Title of Applicant's Project:**

Facilitating Tribal Climate Change Adaptation Planning and Communicating Climate Change Impacts

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant: ca-all
* b. Program/Project: nm-all

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 11/01/2010
* b. End Date: 10/31/2011

18. Estimated Funding ($):

* a. Federal	159,200.00
* b. Applicant	11,628.00
* c. State	
* d. Local	
* e. Other	
* f. Program Income	
* g. TOTAL	170,828.00

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

- [x] a. This application was made available to the State under the Executive Order 12372 Process for review on 07/29/2010.
- [ ] 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.)**

- [ ] Yes
- [x] No

Explanation

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)**

- [x] ** 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: Cecilia
Middle Name:
* Last Name: Minalga
Suffix:

* Title: Chief Financial Officer

* Telephone Number: 415-485-3297
Fax Number: 415-482-1865

* Email: cecilia.minalga@dominican.edu

* Signature of Authorized Representative: Completed by Grants.gov upon submission.
* Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☐ New	
☑ Application	☑ Continuation	* Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

RECEIVED JUL 28 2010 STATE CLEARINGHOUSE

* 3. Date Received:	4. Applicant Identifier:

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: City of Santa Monica

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
95-6000790	074152596

d. Address:

* Street1: 1685 Main Street, Room 212
Street2:
* City: Santa Monica
County:
* State: CA
Province:
* Country: USA
* Zip / Postal Code: 90401

e. Organizational Unit:

Department Name:	Division Name:
Community and Cultural Services	Human Services

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

Prefix:
* First Name: Margaret
Middle Name:
* Last Name: Willis
Suffix:

Title: Sr. Administrative Analyst

Organizational Affiliation:

* Telephone Number: 310-458-8701x5239	Fax Number: 310-458-3380

* Email: margaret.willis@smgov.net

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

City or Township Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*** Other (specify):**

*** 10. Name of Federal Agency:**

U.S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Program

*** 12. Funding Opportunity Number:**

FR-5409-N-01

*** Title:**

2010 Continuum of Care Homeless Assistance Program

13. Competition Identification Number:

Title:

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

City of Santa Monica, County of Los Angeles

*** 15. Descriptive Title of Applicant's Project:**

Serial Inebriate Program

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant: 30 * b. Program/Project: 30

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 4/1/11 * b. End Date: 3/31/12

18. Estimated Funding ($):

* a. Federal	491,791
* b. Applicant	8,328
* c. State	
* d. Local	
* e. Other	
* f. Program Income	
* g. TOTAL	500,119

*** 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 7/29/10.

☐ 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.)**

☐ Yes ☑ No Explanation

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: Rod

Middle Name:

* Last Name: Gould

Suffix:

* Title: City Manager

* Telephone Number: 310-458-8301 Fax Number: 310-917-6640

* Email: rod.gould@smgov.net

* Signature of Authorized Representative: * Date Signed: 7.28.10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*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:

4. Applicant Identifier:

RECEIVED JUL 29 2010

5a. Federal Entity Identifier:
CA0505B9D000801

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: L.A Family Housing

*b. Employer/Taxpayer Identification Number (EIN/TIN):
95-3920560

*c. Organizational DUNS:
617533708

d. Address:

*Street 1: 7843 Lankershim Blvd.
Street 2:
*City: North Hollywood
County: Los Angeles
*State: CA
Province:
*Country: United States of America
*Zip / Postal Code 91605

e. Organizational Unit:

Department Name:
N/A

Division Name:
N/A

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

Prefix:
*First Name: Christine
Middle Name:
*Last Name: Ferguson
Suffix:

Title: Vice President of Programs

Organizational Affiliation:
N/A

*Telephone Number: (818) 255-2711
Fax Number: (818) 255-2770

*Email: cferguson@lafh.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**
M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**
Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14-235

CFDA Title:
Transitional Housing and Supportive Services Program

***12 Funding Opportunity Number:**
FR-5409-N-01

*Title:
Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

North Hollywood, Los Angeles County, CA

***15. Descriptive Title of Applicant's Project:**

The Transitional Housing and Supportive Services Project (THP) is a renewal project that provides 135 beds of transitional housing combined with supportive services to homeless individuals with multiple diagnoses. Supportive services offered at THP include intensive case management, life skills counseling, on-site medical and mental health services, employment assessment, training and placement, money management, tenant education, benefits assistance, substance abuse treatment and follow-up self-sufficiency case management. THP remains the only transitional housing program for single individuals in the San Fernando Valley (SPA 2).

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 28 *b. Program/Project: 28

17. Proposed Project:

*a. Start Date: 10/01/2010 *b. End Date: 9/30/2011

18. Estimated Funding ($):

*a. Federal	355,664
*b. Applicant	
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	355,664

***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 7/28/2010

☐ 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.)**

☐ Yes ☒ No

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: Stephanie

Middle Name:

*Last Name: Klasky-Garner

Suffix:

*Title: President and CEO

*Telephone Number: (818) 982-4091 Fax Number: (818) 255-2770

* Email: stephanie@lafh.org

*Signature of Authorized Representative: Stephanie Klasky *Date Signed: 7/28/10

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☐ New
- ☒ Continuation
- ☐ Revision

* If Revision, select appropriate letter(s)

*Other (Specify)

RECEIVED JUL 29 2010

3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:
CA0490B9D000801

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: LA Family Housing

*b. Employer/Taxpayer Identification Number (EIN/TIN):
95-3920560

*c. Organizational DUNS:
617533708

d. Address:

*Street 1: 7843 Lankershim Blvd.
Street 2:
*City: North Hollywood
County: Los Angeles
*State: CA
Province:
*Country: United States of America
*Zip / Postal Code 91605

e. Organizational Unit:

Department Name:
N/A

Division Name:
N/A

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

Prefix:
*First Name: Christine
Middle Name:
*Last Name: Ferguson
Suffix:

Title: Vice President of Programs

Organizational Affiliation:
N/A

*Telephone Number: (818) 255-2711
Fax Number: (818) 255-2770

*Email: cferguson@lafh.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**
M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**
Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14-235

CFDA Title:
Sydney M. Irmas Transitional Living Center

***12 Funding Opportunity Number:**
FR-5409-N-01

*Title:
Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

North Hollywood, Los Angeles County, CA

***15. Descriptive Title of Applicant's Project:**

The Transitional Living Center (TLC) is a renewal project that provides 30 units of transitional housing and supportive services to a minimum of 120 homeless families with general needs per year. Supportive services offered at TLC include intensive case management, on-site medical and mental health services, employment assessment, training and placement, money management, tenant education, parenting skills, on-site licensed pre-school, children's enrichment activities, and follow-up self-sufficiency case management. TLC remains the only transitional housing program in the San Fernando Valley (SPA 2) that accepts all of the subpopulations of homeless families with children.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 28 *b. Program/Project: 28

17. Proposed Project:

*a. Start Date: 01/01/11 *b. End Date: 12/31/2011

18. Estimated Funding ($):

*a. Federal	363,659
*b. Applicant	
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	363,659

***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 7/28/2010

☐ 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.)**

☐ Yes ☒ No

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: Stephanie

Middle Name:

*Last Name: Klasky-Garner

Suffix:

*Title: President and CEO

*Telephone Number: (818) 982-4091 Fax Number: (818) 255-2770

* Email: stephanie@lafh.org

*Signature of Authorized Representative: *Date Signed: 7/28/10

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

2. DATE SUBMITTED	Applicant Identifier	
3. DATE RECEIVED BY STATE	State Application Identifier	
4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier	

1. TYPE OF SUBMISSION:

Application	Pre-application
☐ Construction	☐ Construction
☑ Non-Construction	☐ Non-Construction

5. APPLICANT INFORMATION

Legal Name: The Nature Conservancy	Organizational Unit: Department: Central Valley & Mountains
Organizational DUNS: 072656630	Division: Lassen Foothills Project
Address: Street: 201 Mission Street, 4th Floor	Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: First Name: Andrea
City: San Francisco	Middle Name
County: San Francisco	Last Name: Craig
State: CA / Zip Code: 94105	Suffix:
Country: USA	Email: acraig@tnc.org
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 53-0242652	Phone Number (give area code): (530) 527-4261 / Fax Number (give area code): (530) 527-0384

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8. TYPE OF APPLICATION:

☑ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)

Other (specify)

7. TYPE OF APPLICANT: (See back of form for Application Types)

O. Not For Profit Organization

Other (specify)

9. NAME OF FEDERAL AGENCY: Fish & Wildlife Service, Department of the Interior

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 15-631

TITLE (Name of Program):

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Clark Unit Restoration

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Northern California

13. PROPOSED PROJECT

Start Date:	Ending Date:
September 1, 2010	June 24, 2013

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant	b. Project
8	2

15. ESTIMATED FUNDING:

a. Federal	$ 50,000.00
b. Applicant	$ 50,000.00
c. State	$ .00
d. Local	$ .00
e. Other	$ .00
f. Program Income	$ .00
g. TOTAL	$ 100,000.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. Yes. ☑ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON

DATE: 6/28/10

b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix	First Name: Wendie	Middle Name
Last Name: Duron		Suffix
b. Title: Grants Specialist		c. Telephone Number (give area code): (530) 897-6370 ext. 202
d. Signature of Authorized Representative: Wendie Duron		e. Date Signed: 6/28/10

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

1. TYPE OF SUBMISSION: Application ☐ Construction ☑ Non-Construction	Pre-application ☐ Construction ☐ Non-Construction	2. DATE SUBMITTED	Applicant Identifier
		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: The Nature Conservancy	Organizational Unit:
Organizational DUNS: 072656630	Department: Central Valley & Mountains
Address:	Division: Lassen Foothills Project
Street: 201 Mission Street, 4th Floor	Name and telephone number of person to be contacted on matters involving this application (give area code)
City: San Francisco	Prefix: First Name: Andrea
County: San Francisco	Middle Name
State: CA / Zip Code: 94105	Last Name: Craig
Country: USA	Suffix:
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 5 3 - 0 2 4 2 6 5 2	Email: acraig@tnc.org
	Phone Number (give area code): (530) 527-4261 / Fax Number (give area code): (530) 527-0384

8. TYPE OF APPLICATION: ☑ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) ☐ ☐

Other (specify)

7. TYPE OF APPLICANT: (See back of form for Application Types)

O. Not For Profit Organization

Other (specify)

9. NAME OF FEDERAL AGENCY: Fish & Wildlife Service, Department of the Interior

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 1 5 - 6 3 1

TITLE (Name of Program):

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Childs Meadow Fencing

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Northern California

13. PROPOSED PROJECT

Start Date:	Ending Date:
September 14, 2010	September 13, 2015

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant	b. Project
8	2

15. ESTIMATED FUNDING:

a. Federal	$ 25,000 .00
b. Applicant	$ 25,000 .00
c. State	$ .00
d. Local	$ .00
e. Other	$ .00
f. Program Income	$ .00
g. TOTAL	$ 50,000 .00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. Yes. ☑ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON

DATE: 6/28/10

b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative		
Prefix	First Name: Wendie	Middle Name
Last Name: Duron		Suffix
b. Title: Grants Specialist		c. Telephone Number (give area code): (530) 897-6370 ext. 202
d. Signature of Authorized Representative: Wendie Duron		e. Date Signed: 6/28/10

Previous Edition Usable
Authorized for Local Reproduction

Standard Form 424 (Rev.9-2003)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application	* If Revision, select appropriate letter(s)
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

3. Date Received: 4. Applicant Identifier:

RECEIVED JUL 29 2010 STATE CLEARING HOUSE

5a. Federal Entity Identifier: *5b. Federal Award Identifier:

State Use Only:

6. Date Received by State: 7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: United Friends of the Children

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-3665186

*c. Organizational DUNS: 146784884

d. Address:

*Street 1: 1055 Wilshire Blvd., Suite 1955
Street 2:
*City: Los Angeles
County: Los Angeles
*State: CA
Province:
*Country: United States
*Zip / Postal Code 90017

e. Organizational Unit:

Department Name: Division Name:

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

Prefix: *First Name: Polly
Middle Name: C.
*Last Name: Williams
Suffix:

Title: President

Organizational Affiliation:

*Telephone Number: 213-580-1850 Fax Number: 213-580-1820

*Email: Polly@unitedfriends.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**
M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**
U.S Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:
14.235

CFDA Title:
Supportive Housing Program

***12 Funding Opportunity Number:**
FR 5415-N-01

*Title:
Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

***15. Descriptive Title of Applicant's Project:**
Pathways to Independence, a transitional housing program for homeless emancipated foster youth.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 34 *b. Program/Project: 39

17. Proposed Project:

*a. Start Date: 10-01-11 *b. End Date: 9-30-12

18. Estimated Funding ($):

*a. Federal	295,657
*b. Applicant	206,400
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	502,057

***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 7-27-10

☐ 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.)**

☐ Yes ☒ No

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: Polly

Middle Name: C.

*Last Name: Williams

Suffix:

*Title: President

*Telephone Number: 213-580-1850 Fax Number: 213-580-1820

* Email: Polly@unitedfriends.org

*Signature of Authorized Representative: Polly Williams *Date Signed: 7/27/10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☒ New
- ☐ Continuation
- ☐ Revision

* If Revision, select appropriate letter(s)

*Other (Specify) _____

RECEIVED
JUL 29 2010
STATE CLEARING HOUSE

3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier: CA0521B9D000802

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Rainbow Services, Ltd.

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-3855705

*c. Organizational DUNS: 825412182

d. Address:

*Street 1: 453 W. 7th Street

Street 2:

*City: San Pedro

County: Los Angeles

*State: CA

Province:

*Country: USA

*Zip / Postal Code 90731

e. Organizational Unit:

Department Name:

Division Name:

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

Prefix: Mr. *First Name: B.

Middle Name: Bennett

*Last Name: Schirmer

Suffix:

Title: Executive Director

Organizational Affiliation:

*Telephone Number: 310-548-5450 Fax Number: 310-548-0611

*Email: bschirmer@rainbowservicesdv.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5409-N-01

*Title:

Continuum of Care Housing Assistance Competition

13. Competition Identification Number:

Title:

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

Los Angeles County, CA

***15. Descriptive Title of Applicant's Project:**

Rainbow Services Transitional Housing

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 36 *b. Program/Project: 36

17. Proposed Project:

*a. Start Date: 12/01/2011 *b. End Date: 11/30/2012

18. Estimated Funding ($):

*a. Federal	255,012
*b. Applicant	65,600
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	320,612

***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 07/29/10

☐ 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.)**

☐ Yes ☒ No

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: Mr. *First Name: B.

Middle Name: Bennett

*Last Name: Schirmer

Suffix:

*Title: Executive Director

*Telephone Number: 310-548-5450 Fax Number: 310-548-0611

* Email: bschirmer@rainbowservicesdv.org

*Signature of Authorized Representative: *Date Signed: 07/29/10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	* Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	

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JUL 29 2010
STATE CLEARING HOUSE

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: City of Angeles - CRA

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
95-6347218	010701167

d. Address:

* Street1: 3055 Wilshire Blvd, Suite 1120
Street2:
* City: Los Angeles
County:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 90010

e. Organizational Unit:

Department Name:	Division Name:

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

Prefix: Mr. * First Name: Michelle
Middle Name:
* Last Name: Banks-Ordone
Suffix:

Title: Project Manager

Organizational Affiliation:

* Telephone Number: 213.977.2616 Fax Number: 213.384.7371

* Email: mbanks-ordone@cra.lacity.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

C: City or Township Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Economic Development Administration

11. Catalog of Federal Domestic Assistance Number:

11.300

CFDA Title:

Investments for Public Works and Economic Development Facilities

*** 12. Funding Opportunity Number:**

EDA06222009EDAP

* Title:

Economic Development Assistance Programs

13. Competition Identification Number:

01

Title:

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

City of Los Angeles, County of Los Angeles

*** 15. Descriptive Title of Applicant's Project:**

MidCity Public Improvements Project

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant: CA-028 * b. Program/Project: CA-028

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 10/01/2010 * b. End Date: 01/31/2012

18. Estimated Funding ($):

* a. Federal	2,000,000.00
* b. Applicant	2,000,000.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	4,000,000.00

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

- [x] a. This application was made available to the State under the Executive Order 12372 Process for review on 07/30/2010.
- [ ] 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.)**

- [ ] Yes
- [x] No

Explanation

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)**

- [x] ** 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: Ms. * First Name: Cathleen

Middle Name:

* Last Name: Essel

Suffix:

* Title: Chief Executive Officer

* Telephone Number: 213.977.1859 Fax Number: 213.617.8053

* Email: cessel@cra.lacity.org

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

9 10 03:10p p.6

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application	* If Revision, select appropriate letter(s)
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

3. Date Received: 4. Applicant Identifier:

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STATE CLEARING HOUSE

5a. Federal Entity Identifier:

*5b. Federal Award Identifier: CA0436B9D000802

State Use Only:

6. Date Received by State: 7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: City of Pomona

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6000764

*c. Organizational DUNS: 07-412-7481

d. Address:

*Street 1: 505 S. Garey Avenue
Street 2:
*City: Pomona
County: Los Angeles
*State: CA
Province:
*Country: USA
*Zip / Postal Code 91766

e. Organizational Unit:

Department Name: Community Development Department

Division Name: Housing

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

Prefix: Ms. *First Name: Jan
Middle Name:
*Last Name: Cicco
Suffix:

Title: Homeless Services Coordinator

Organizational Affiliation: Employee

*Telephone Number: 909-620-2571 Fax Number: 909-620-4567

*Email: jan_cicco@ci.pomona.ca.us

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

C. City or Township Government

Type of Applicant 2: Select Applicant Type:

M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Protram

***12 Funding Opportunity Number:**

FR-5409-N-01

*Title:

2010 Opportunity to Register

13. Competition Identification Number:

Title:

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

City

***15. Descriptive Title of Applicant's Project:**

Pomona Transitional Living Center provides housing and supportive services to 10 homeless men annually

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 38 *b. Program/Project: CA-038

17. Proposed Project:

*a. Start Date: 4-1-11 *b. End Date: 3-31-12

18. Estimated Funding ($):

*a. Federal	162154
*b. Applicant	
*c. State	
*d. Local	
*e. Other	41505
*f. Program Income	
*g. TOTAL	203659

***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.)**

☐ Yes ☒ No

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: Ms *First Name: Linda

Middle Name:

*Last Name: Lowry

Suffix:

*Title: City Manager

*Telephone Number: 909-620-3773 Fax Number: 909-620-3707

* Email: linda_lowry@ci.pomona.ca.us

*Signature of Authorized Representative: Linda C Lowry *Date Signed: July 29, 2010

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application	* If Revision, select appropriate letter(s)
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

3. Date Received: 4. Applicant Identifier:

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JUL 30 2010
STATE CLEARING HOUSE

5a. Federal Entity Identifier: *5b. Federal Award Identifier:

State Use Only:

6. Date Received by State: 7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: HARBOR INTERFAITH SERVICES, INC.

*b. Employer/Taxpayer Identification Number (EIN/TIN): 330-03-1099

*c. Organizational DUNS: 618378053

d. Address:

*Street 1: 670 W. Ninth Street
Street 2:
*City: San Pedro (postal address/neighborhood within the City of Los Angeles
County: Los Angeles
*State: California
Province:
*Country: USA
*Zip / Postal Code 90731

e. Organizational Unit:

Department Name: Residential Programs - Transitional Housing

Division Name: "You Can Have It A.L.L."

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

Prefix: Ms. *First Name: Tahia
Middle Name:
*Last Name: Hayslet
Suffix:

Title: Executive Director

Organizational Affiliation: Private/independent nonprofit

*Telephone Number: (310) 831-0003 Fax Number: (310) 831-0791

*Email: exec.dir@harborinterfaith.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

U.S. Department of Housing and Urban Development (HUD)

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5341-N-01

*Title:

SUPER NOFA, Direct Grantee Renewal, Los Angeles Continuum of Care Homeless Assistance

13. Competition Identification Number:

Title:

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

Primarily the Harbor District within the City of Los Angeles; also, some outlying independent municipalities surrounding it– all located in the County of Los Angeles.

***15. Descriptive Title of Applicant's Project:**

"You Can Have It A.L.L. (Accelerated Learning and Living)" is a transitional housing program that primarily serves female-headed families for periods of 12-18 months. Permanent housing and job placement both are achieved through ongoing case management, intensive education/training, and abundant supportive services.

OMB Number: 4040 0001
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 36th (Harman) *b. Program/Project: 36th (Harman)

17. Proposed Project:

*a. Start Date: One year *b. End Date:

18. Estimated Funding ($):

*a. Federal		127,673
*b. Applicant		31,983
*c. State		
*d. Local		
*e. Other		
*f. Program Income		
*g. TOTAL		159,656

***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 July 30, 2010

☐ 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.)**

☐ Yes ☒ No

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: Ms *First Name: Tahia

Middle Name:

*Last Name: Hayslet

Suffix:

*Title: Executive Director

*Telephone Number: (310) 831-0603 Fax Number: (310) 831-0791

* Email: exec.dir@harbor.interfaith.org

*Signature of Authorized Representative: Tahia Hayslet *Date Signed: July 30, 2010

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*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:

4. Applicant Identifier:

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JUL 20 2010
STATE CLEARING HOUSE

5a. Federal Entity Identifier:
CA0530B9D000802

*5b. Federal Award Identifier:
CA 03-600-017

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: California Council for Veterans Affairs, Inc.

*b. Employer/Taxpayer Identification Number (EIN/TIN):
95-2861434

*c. Organizational DUNS:
158141015

d. Address:

*Street 1: 2501 West Florence Avenue

Street 2:

*City: Los Angeles

County: Los Angeles

*State: California

Province:

*Country: USA

*Zip / Postal Code 90043

e. Organizational Unit:

Department Name:
Women and Children First

Division Name:

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

Prefix: Ms.

*First Name: Margaret

Middle Name:

*Last Name: Bush Ware

Suffix:

Title: Executive Director

Organizational Affiliation:

*Telephone Number: 323-299-9273

Fax Number: 323-299-0350

*Email: mbushware@hotmail.com

Application for Federal Assistance SF-424 Version 02

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

M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

U. S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5409-N-01

*Title:

Continuum of Care Homeless Assistance Program

13. Competition Identification Number:

COC-01

Title:

2010 SuperNofa Continuum of Care

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

Los Angeles, California

***15. Descriptive Title of Applicant's Project:**

Transitional housing and supportive services, with an emphasis on homeless female veterans and their minor children.

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 33rd *b. Program/Project: 33rd

17. Proposed Project:

*a. Start Date: April 1, 2011 *b. End Date: March 31, 2012

18. Estimated Funding ($):

*a. Federal	136,216
*b. Applicant	40,000
*c. State	
*d. Local	
*e. Other	95,315
*f. Program Income	
*g. TOTAL	271,531

***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 07/30/2010

☐ 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.)**

☐ Yes ☒ No

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: Ms. *First Name: Margaret

Middle Name:

*Last Name: Bush Ware

Suffix:

*Title: Executive Director

*Telephone Number: 323-299-9273 Fax Number: 323-299-0350

* Email: mbushware@hotmail.com

*Signature of Authorized Representative: *Date Signed: 30 July 2010

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☐ New
- ☐ Continuation
- ☒ Revision

* If Revision, select appropriate letter(s)
A. Increase Award C. Increase Duration
*Other (Specify)

3. Date Received:
4. Applicant Identifier:

RECEIVED JUL 30 2010 STATE CLEARING HOUSE

5a. Federal Entity Identifier: N/A
*5b. Federal Award Identifier: CA0384B9D000802

State Use Only:

6. Date Received by State:
7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Gramercy Housing Group

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4396861
*c. Organizational DUNS: 874617103

d. Address:

*Street 1: 1824 4th Street
Street 2:
*City: Los Angeles
County: Los Angeles
*State: CA
Province:
*Country: USA
*Zip / Postal Code 90019

e. Organizational Unit:

Department Name:
Division Name:

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

Prefix: Mrs.
*First Name: Joey
Middle Name:
*Last Name: Solomon
Suffix:

Title: Executive Director

Organizational Affiliation:

*Telephone Number: (323) 737-7351
Fax Number: (323) 737-1790

*Email: joey@gramercyhousinggroup.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**
M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

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:
14.235

CFDA Title:
Supportive Housing Program

***12 Funding Opportunity Number:**
FR-5341-N-01

*Title:
Continuum of Care Homeless Assistance Program (CoC)

13. Competition Identification Number:
CoC-01

Title:

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

***15. Descriptive Title of Applicant's Project:**
Supportive Housing Program: Gramercy Court Transitional Housing Program

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 33 *b. Program/Project: 33

17. Proposed Project:

*a. Start Date: 7/1/10 *b. End Date: 6/30/11

18. Estimated Funding ($):

*a. Federal	210,960
*b. Applicant	66,972
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	

***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 7/30/10

☐ 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.)**

☐ Yes ☒ No

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: Ms. *First Name: Joey

Middle Name:

*Last Name: Solomon

Suffix:

*Title: Executive Director

*Telephone Number: (323) 737-7351 Fax Number: (323) 737-1790

* Email: joey@gramercyhousinggroup.org

*Signature of Authorized Representative: Joey Solomon *Date Signed: 7/30/10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application	* If Revision, select appropriate letter(s)
☐ Preapplication	☐ New	
☒ Application	☒ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

3. Date Received: 4. Applicant Identifier:

RECEIVED
JUL 29 2010
STATE CLEARING HOUSE

5a. Federal Entity Identifier:

*5b. Federal Award Identifier: CA0470B9D000801

State Use Only:

6. Date Received by State: 7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Stop Homelessness in the Rio Hondo Area, Inc.

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4084509

*c. Organizational DUNS: 603919127

d. Address:

*Street 1: 12300 Fourth Street, Bldg. 213
Street 2:
*City: Norwalk
County:
*State: CA
Province:
*Country: U.S.A.
*Zip / Postal Code 90650

e. Organizational Unit:

Department Name: Division Name:

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

Prefix: Mr. *First Name: David
Middle Name:
*Last Name: Littlehales
Suffix:

Title: Executive Director

Organizational Affiliation:

*Telephone Number: (562) 863-8805 ext.222 Fax Number: (562) 863-4529

*Email: dlittlehales@riohondohome.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**
M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**
Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

***12 Funding Opportunity Number:**
FR-5341-N-01

*Title:
Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

***15. Descriptive Title of Applicant's Project:**

Stop Homelessness in the Rio Hondo Area, Inc. is a non-profit organization that provides transitional housing for homeless families with dependent children.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: CA-038 *b. Program/Project: CA-038

17. Proposed Project:

*a. Start Date: 06/01/10 *b. End Date: 05/31/11

18. Estimated Funding ($):

*a. Federal	$165,207
*b. Applicant	$63,479
*c. State	0
*d. Local	$570,973
*e. Other	$553,218
*f. Program Income	0
*g. TOTAL	$1,352,877

***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.)**

☐ Yes ☒ No

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: Mr. *First Name: David

Middle Name:

*Last Name: Littlehales

Suffix:

*Title: Executive Director

*Telephone Number: (562) 863-8805 ext.222 Fax Number: (562) 863-4529

* Email: dlittlehales@riohondohome.org

*Signature of Authorized Representative: *Date Signed: 7/29/10

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [ ] New
- [x] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

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JUL 30 2010
STATE CLEARING HOUSE

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier: 610043135

* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Alliance for Housing and Healing (formerly Serra Ancillary Care Corporation)

* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4147364

* c. Organizational DUNS: 610043135

d. Address:

* Street1: 825 Colorado Blvd.
Street2: Suite 100
* City: Los Angeles
County: Los Angeles
* State: California
Province:
* Country: USA USA: UNITED STATES
* Zip / Postal Code: 90041

e. Organizational Unit:

Department Name: The Serra Project

Division Name: CHOISS SPA 8

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

Prefix: Ms.
* First Name: Susan
Middle Name:
* Last Name: McGinnis
Suffix:

Title: Director of Operations

Organizational Affiliation:

* Telephone Number: 323 344-4898
Fax Number: 323 254-2956

* Email: smcginnis@alliancehh.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

M. Nonprofit with 501(c)(3) IRS status (other than Institution of Higher Learning)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

NGMS Agency US Department of Housing and Urban Development (HUD)

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Program

*** 12. Funding Opportunity Number:**

MBL-SF424FAMILY-ALLFORMS FR-5409-N-01

* Title:

MBL-SF424Family-AllForms

Continuum of Care Homeless Assistance Program

13. Competition Identification Number:

CoC-01

Title:

2010 SuperNOFA Continuum of Care

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

City of Los Angeles, SPA 8

*** 15. Descriptive Title of Applicant's Project:**

Housing and supportive services at 18 rental units throughout Service Provider Area 8 in Los Angeles city.

Attach supporting documents as specified in agency instructions.

Add Attachments Delete Attachments View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant: CA-031 * b. Program/Project: CA-035

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

CA-036, CA-037 Add Attachment Delete Attachment View Attachment

17. Proposed Project:

* a. Start Date: 1/1/12 * b. End Date: 12/31/12

18. Estimated Funding ($):

* a. Federal	326,848
* b. Applicant	27,792
* c. State	
* d. Local	
* e. Other	
* f. Program Income	
* g. TOTAL	354,640

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

[X] a. This application was made available to the State under the Executive Order 12372 Process for review on 7/30/10.

[ ] 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.)**

[ ] Yes [X] No Explanation

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)**

[X] ** 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: Mr. * First Name: Terry

Middle Name:

* Last Name: Goddard

Suffix:

* Title: Executive Director

* Telephone Number: 323 344-4899 Fax Number: 323 254-2956

* Email: tgoddard@alliancehh.org

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application	* If Revision, select appropriate letter(s)
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

3. Date Received: 4. Applicant Identifier:

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5a. Federal Entity Identifier:

*5b. Federal Award Identifier: CFDA 14-235

State Use Only:

6. Date Received by State: 7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Venice Community Housing Corporation

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4200761

*c. Organizational DUNS: 883805509

d. Address:

*Street 1: 720 Rose Avenue
Street 2:
*City: Venice
County: Los Angeles
*State: CA
Province:
*Country: United States
*Zip / Postal Code 90291

e. Organizational Unit:

Department Name: N/A

Division Name: N/A

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

Prefix: Ms. *First Name: Priscilla
Middle Name: Ellen
*Last Name: Smith
Suffix:

Title: Controller

Organizational Affiliation:

*Telephone Number: 310-399-4100 x105 Fax Number: 310-399-1130

*Email: priscilla@vchcorp.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**
Housing & Urban Development

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:
14-235

***12 Funding Opportunity Number:**

*Title:

13. Competition Identification Number:

Title:

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

***15. Descriptive Title of Applicant's Project:**

Transitional Living Center for Homeless women and their children.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: CA-036 *b. Program/Project: CA-036

17. Proposed Project:

*a. Start Date: 01/01/2011 *b. End Date: 12/31/2011

18. Estimated Funding ($):

*a. Federal	81,170
*b. Applicant	60,000
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	141,170

***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 07/30/2010

☒ 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.)**

☐ Yes ☒ No

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: Ms *First Name: Priscilla

Middle Name: Ellen

*Last Name: Smith

Suffix:

*Title: Controller

*Telephone Number: 310-399-4100 x105 Fax Number: 310-399-1130

* Email: priscilla@vchcorp.org

*Signature of Authorized Representative: Priscilla E. Smith *Date Signed: 07/30/2010

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [ ] New
- [x] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

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* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier: 610043135

* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Alliance for Housing and Healing (formerly Serra Ancillary Care Corporation)

* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4147364

* c. Organizational DUNS: 610043135

d. Address:

* Street1: 825 Colorado Blvd.
Street2: Suite 100
* City: Los Angeles
County: Los Angeles
* State: California
Province:
* Country: USA — USA: UNITED STATES
* Zip / Postal Code: 90041

e. Organizational Unit:

Department Name: The Serra Project

Division Name: CHOISS SPA 2

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

Prefix: Ms.
* First Name: Susan
Middle Name:
* Last Name: McGinnis
Suffix:

Title: Director of Operations

Organizational Affiliation:

* Telephone Number: 323 344-4898
Fax Number: 323 254-2956

* Email: smcginnis@alliancehh.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

M. Nonprofit with 501(c)(3) IRS status (other than Institution of Higher Learning)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

NGMS Agency US Department of Housing and Urban Development (HUD)

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Supportive Housing Program

*** 12. Funding Opportunity Number:**

MBL-SF424FAMILY-ALLFORMS FR-5409-N-01

* Title:

MBL-SF424Family-AllForms

Continuum of Care Homeless Assistance Program

13. Competition Identification Number:

CoC-01

Title:

2010 SuperNOFA Continuum of Care

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

City of Los Angeles, SPA 2

*** 15. Descriptive Title of Applicant's Project:**

Housing and supportive services at 18 rental units throughout Service Provider Area 2 in Los Angeles.

Attach supporting documents as specified in agency instructions.

Add Attachments Delete Attachments View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant: CA-031 * b. Program/Project: CA-027

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

CA-028, CA-029 Add Attachment Delete Attachment View Attachment

17. Proposed Project:

* a. Start Date: 12/1/11 * b. End Date: 11/30/12

18. Estimated Funding ($):

* a. Federal	303,173
* b. Applicant	22,954
* c. State	
* d. Local	
* e. Other	
* f. Program Income	
* g. TOTAL	326,127

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

[X] a. This application was made available to the State under the Executive Order 12372 Process for review on 7/30/10.

[ ] 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.)**

[ ] Yes [X] No Explanation

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)**

[X] ** 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: Mr. * First Name: Terry

Middle Name:

* Last Name: Goddard

Suffix:

* Title: Executive Director

* Telephone Number: 323 344-4899 Fax Number: 323 254-2956

* Email: tgoddard@alliancehh.org

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☐ New
- ☐ Continuation
- ☒ Revision

* If Revision, select appropriate letter(s)
A. Increase Award C. Increase Duration
*Other (Specify)

3. Date Received:
4. Applicant Identifier:

5a. Federal Entity Identifier:
*5b. Federal Award Identifier: CA0429B9D000802

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JUL 30 2010
STATE CLEARING HOUSE

State Use Only:

6. Date Received by State:
7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: PATH (People Assisting the Homeless)

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-3950196
*c. Organizational DUNS: 847856390

d. Address:

*Street 1: 340 North Madison Avenue
Street 2:
*City: Los Angeles
County: Los Angeles
*State: CA
Province:
*Country: USA
*Zip / Postal Code 90004

e. Organizational Unit:

Department Name: PATH Westside Center
Division Name: PATH Finders

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

Prefix: Mrs.
*First Name: Tricia
Middle Name: Leigh
*Last Name: Ciampa
Suffix:

Title: Managing Director

Organizational Affiliation:

*Telephone Number: (323) 644-2257
Fax Number: (323) 644-2288

*Email: pciampa@epath.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

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:

14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5341-N-01

*Title:

Continuum of Care Homeless Assistance Program (CoC)

13. Competition Identification Number:

CoC-01

Title:

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

Los Angeles County

***15. Descriptive Title of Applicant's Project:**

PATHFinders Job Center/PATH Westside Center

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 30 *b. Program/Project: 30,31

17. Proposed Project:

*a. Start Date: 9/1/11 *b. End Date: 8/30/12

18. Estimated Funding ($):

*a. Federal	100,275
*b. Applicant	23,875
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	124,150

***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 7/30/10

☐ 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.)**

☐ Yes ☒ No

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: Mr. *First Name: Joel

Middle Name: John

*Last Name: Roberts

Suffix:

*Title: Chief Executive Officer

*Telephone Number: (323) 644-2209 Fax Number: (323) 644-2288

* Email: joelr@epath.org

*Signature of Authorized Representative: *Date Signed: 7/30/10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☐ New
- ☐ Continuation
- ☒ Revision

* If Revision, select appropriate letter(s)
A. Increase Award C. Increase Duration
*Other (Specify)

3. Date Received:
4. Applicant Identifier:

5a. Federal Entity Identifier:
*5b. Federal Award Identifier: CA0432B9D000802

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STATE CLEARING HOUSE

State Use Only:

6. Date Received by State:
7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: PATH (People Assisting the Homeless)

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-3950196
*c. Organizational DUNS: 847856390

d. Address:

*Street 1: 340 North Madison Avenue
Street 2:
*City: Los Angeles
County: Los Angeles
*State: CA
Province:
*Country: USA
*Zip / Postal Code 90004

e. Organizational Unit:

Department Name: Regional Homeless Center
Division Name: PATH Ways Transitional Housing

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

Prefix: Mrs.
*First Name: Tricia
Middle Name: Leigh
*Last Name: Ciampa
Suffix:

Title: Managing Director

Organizational Affiliation:

*Telephone Number: (323) 644-2257
Fax Number: (323) 644-2288

*Email: pciampa@epath.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

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

M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

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:

14.235

CFDA Title:

Supportive Housing Program

***12 Funding Opportunity Number:**

FR-5341-N-01

*Title:

Continuum of Care Homeless Assistance Program (CoC)

13. Competition Identification Number:

CoC-01

Title:

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

Los Angeles County

***15. Descriptive Title of Applicant's Project:**

Supportive Housing Program - PATH Ways Transitional Housing Program

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 30 *b. Program/Project: 30,31

17. Proposed Project:

*a. Start Date: 3/1/11 *b. End Date: 2/28/12

18. Estimated Funding ($):

*a. Federal	199,201
*b. Applicant	
*c. State	
*d. Local	
*e. Other	$66,401
*f. Program Income	
*g. TOTAL	$265,602

***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 Ordar 12372 Process for review on 7/30/10

☐ 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 Dabt? (If "Yes", provide explanation.)**

☐ Yes ☒ No

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: Mr. *First Name: Joel

Middle Name: John

*Last Name: Roberts

Suffix:

*Title: Chief Executive Officer

*Telephone Number: (323) 644-2209 Fax Number: (323) 644-2288

* Email: joelr@epath.org

*Signature of Authorized Representative: *Date Signed: 7/30/10

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☐ New
- ☐ Continuation
- ☒ Revision

* If Revision, select appropriate letter(s)
A. Increase Award C. Increase Duration
*Other (Specify)

3. Date Received:
4. Applicant Identifier:

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STATE CLEARING HOUSE

5a. Federal Entity Identifier:
*5b. Federal Award Identifier: CA0455B9D00802

State Use Only:

6. Date Received by State:
7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: PATH (People Assisting the Homeless)

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-3950196
*c. Organizational DUNS: 847856390

d. Address:

*Street 1: 340 North Madison Avenue
Street 2:
*City: Los Angeles
County: Los Angeles
*State: CA
Province:
*Country: USA
*Zip / Postal Code 90004

e. Organizational Unit:

Department Name: PATH
Division Name: Street Outreach

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

Prefix: Mrs.
*First Name: Tricia
Middle Name: Leigh
*Last Name: Ciampa
Suffix:

Title: Managing Director

Organizational Affiliation:

*Telephone Number: (323) 644-2257
Fax Number: (323) 644-2288

*Email: pciampa@epath.org

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**
M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

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:
14.235

CFDA Title:
Supportive Housing Program

***12 Funding Opportunity Number:**
FR-5341-N-01

*Title:
Continuum of Care Homeless Assistance Program (CoC)

13. Competition Identification Number:
CoC-01

Title:

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

***15. Descriptive Title of Applicant's Project:**
Regional Street Outreach

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 30 *b. Program/Project: 30,31

17. Proposed Project:

*a. Start Date: 7/1/11 *b. End Date: 6/30/12

18. Estimated Funding ($):

*a. Federal	114,529
*b. Applicant	27,274
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	141,803

***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 7/30/10

☐ 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.)**

☐ Yes ☒ No

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: Mr. *First Name: Joel

Middle Name: John

*Last Name: Roberts

Suffix:

*Title: Chief Executive Officer

*Telephone Number: (323) 644-2209 Fax Number: (323) 644-2288

* Email: joelr@epath.org

*Signature of Authorized Representative: *Date Signed: 7/30/10

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Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

2. DATE SUBMITTED July 28, 2010	Applicant Identifier	
3. DATE RECEIVED BY STATE	State Application Identifier	
4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier	

1. TYPE OF SUBMISSION:

Application	Pre-application
☐ Construction	☑ Construction
☐ Non-Construction	☐ Non-Construction

5. APPLICANT INFORMATION

Legal Name: Merced College

Organizational DUNS: 074667072

Address:

Street: 3600 M Street

City: Merced

County: Merced County

State: CA

Zip Code: 95348

Country: United States of America

Organizational Unit:

Department:

Division:

Name and telephone number of person to be contacted on matters involving this application (give area code)

Prefix: Dr.

First Name: Benjamin

Middle Name

Last Name: Duran

Suffix:

Email: duran.b@mccd.edu

Phone Number (give area code): (209) 384-6100

Fax Number (give area code): (209) 384-6043

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JUL 30 2010
STATE CLEARING HOUSE

6. EMPLOYER IDENTIFICATION NUMBER *(EIN)*: 77-0362218

8. TYPE OF APPLICATION:

☑ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)

Other (specify)

7. TYPE OF APPLICANT: (See back of form for Application Types)

I. State Controlled Institution of Higher Learning

Other (specify)

9. NAME OF FEDERAL AGENCY: Economic Development Administration

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 11-300

TITLE (Name of Program): Public Works

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:

"Creation of the Innovation Place Network"

12. AREAS AFFECTED BY PROJECT *(Cities, Counties, States, etc.)*:

Cities of Los Banos and Merced, Merced County

13. PROPOSED PROJECT

Start Date: March 2011

Ending Date: February 2012

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant: 18th District

b. Project: 18th District

15. ESTIMATED FUNDING:

a. Federal	$ 1,200,001.00
b. Applicant	$ .00
c. State	$ .00
d. Local	$ 1,445,210.00
e. Other	$ .00
f. Program Income	$ 172,500.00
g. TOTAL	$ 2,645,211.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. Yes. ☑ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON

DATE: July 29, 2010

b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix: Dr.

First Name: Benjamin

Middle Name

Last Name: Duran

Suffix

b. Title: President

c. Telephone Number (give area code): (209) 384-6100

d. Signature of Authorized Representative

e. Date Signed: 7/27/10

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Prescribed by OMB Circular A-102

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JUL 30 2010
STATE C

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:
- [x] Preapplication
- [ ] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

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JUL 30 2010
STATE CLEARING HOUSE

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: County of Santa Cruz

* b. Employer/Taxpayer Identification Number (EIN/TIN): 946000534

* c. Organizational DUNS: 069117208

d. Address:

* Street1: 701 Ocean Street, Room 520
Street2:
* City: Santa Cruz
County:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 95060

e. Organizational Unit:

Department Name: County Administrative Office

Division Name:

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

Prefix: Ms.
* First Name: Susan
Middle Name:
* Last Name: Pearlman
Suffix:

Title: Principal Administrative Analyst

Organizational Affiliation: County of Santa Cruz

* Telephone Number: 831 454-3412
Fax Number: 831 454-3420

* Email: susan.pearlman@co.santa-cruz.ca.us

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

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:**

Economic Development Administration

11. Catalog of Federal Domestic Assistance Number:

11.300

CFDA Title:

Grants for Public Works and Economic Development Facilities

*** 12. Funding Opportunity Number:**

EDA10012008EDAP

* Title:

Economic Development Assistance Programs

13. Competition Identification Number:

01

Title:

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

Unincorporated Santa Cruz County and the cities of Santa Cruz, Capitola and Scotts Valley

*** 15. Descriptive Title of Applicant's Project:**

This project will fund the renovation of a 19,000 square foot County-owned building to allow small business incubation and entrepreneurial growth, restore 40 jobs and enhance economic vitality.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

* a. Applicant: 14&17
* b. Program/Project: 17

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

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 01/31/2011
* b. End Date: 01/01/2013

18. Estimated Funding ($):

* a. Federal	1,280,000.00
* b. Applicant	320,000.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,600,000.00

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

[X] a. This application was made available to the State under the Executive Order 12372 Process for review on 07/26/2010.

[ ] 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.)**

[ ] Yes [X] No Explanation

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)**

[X] ** 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: Ms. * First Name: Susan

Middle Name: A.

* Last Name: Mauriello

Suffix: JD

* Title: County Administrative Officer

* Telephone Number: 831 454-3400 Fax Number: 831 454-3420

* Email: cao001@co.santa-cruz.ca.us

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:
- ☐ Preapplication
- ☒ Application
- ☐ Changed/Corrected Application

*2. Type of Application
- ☐ New
- ☒ Continuation
- ☐ Revision

* If Revision, select appropriate letter(s)

*Other (Specify) _____

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STATE CLEARING HOUSE

3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier: CA0516B9D000803

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Ocean Park Community Center

*b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6143865

*c. Organizational DUNS: 08-433-7922

d. Address:

*Street 1: 1453 16th Street
Street 2:
*City: Santa Monica
County: Los Angeles
*State: California
Province:
*Country: USA
*Zip / Postal Code 90404

e. Organizational Unit:

Department Name:

Division Name:

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

Prefix: Ms.
*First Name: Christina Miller
Middle Name:
*Last Name: Miller
Suffix:

Title: Associate Director

Organizational Affiliation:

*Telephone Number: (310) 264.6646
Fax Number: (310) 264.6647

*Email: chmiller@opcc.net

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

***9. Type of Applicant 1: Select Applicant Type:**
M.Nonprofit w/501C3 IRS Status(Oth Than Higher Edu

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**
Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:
14-235

CFDA Title:
Supportive Housing Program

***12 Funding Opportunity Number:**

*Title:
FY2010 SuperNOFA

13. Competition Identification Number:

Title:

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

Santa Monica, Los Angeles

***15. Descriptive Title of Applicant's Project:**

Turning Point Transitional Housing

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant: 30 *b. Program/Project: 30

17. Proposed Project:

*a. Start Date: 7/1/2011 *b. End Date: 6/30/2012

18. Estimated Funding ($):

*a. Federal	305,938
*b. Applicant	
*c. State	87,672
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	393,610

***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.)**

☐ Yes ☒ No

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: Mr. *First Name: John

Middle Name:

*Last Name: Maceri

Suffix:

*Title: Executive Director

*Telephone Number: (310) 264.6646 Fax Number: (310) 264.6647

* Email: jmaceri@opcc.net

*Signature of Authorized Representative: *Date Signed: 7/29/2010

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Prescribed by OMB Circular A-102