

Federal Grant Applications

The following are Applications for Federal Assistance received by the State Clearinghouse **October 1 - 15, 2011**. 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

OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED 10/03/2011	Applicant Identifier
<input type="checkbox"/> Construction	<input type="checkbox"/> Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
	<input type="checkbox"/> Non-Construction		

5. APPLICANT INFORMATION

Legal Name: Bethany Services dba Bakersfield Homeless Center	Organizational Unit: Department:
Organizational DUNS: 781523824	Division:
Address: Street: 1600 E. Truxtun Ave.	Name and telephone number of person to be contacted on matters involving this application (give area code): Prefix: First Name: Louis
City: Bakersfield	Middle Name
County: Kern	Last Name Gill
State: Zip Code 93305	Suffix:
Country: USA	Email: lbgl11@bakhc.com

RECEIVED
 OCT - 3 2011
 STATE CLEARING HOUSE

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
 95-2858936

Phone Number (give area code) 661-322-9199	Fax Number (give area code) 881-322-9203
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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)
 Not for Profit
 Other (specify)

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
 14-235

TITLE (Name of Program):
Supportive Housing Program (SHP)

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
 Transitional Services Project

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.):
 County of Kern and Bakersfield, CA

13. PROPOSED PROJECT
 Start Date: Ending Date:

14. CONGRESSIONAL DISTRICTS OF:
 a. Applicant 20 & 22 b. Project 20 & 22

15. ESTIMATED FUNDING:

a. Federal	\$	269,408
b. Applicant	\$	64,146
c. State	\$	
d. Local	\$	
e. Other	\$	
f. Program Income	\$	
g. TOTAL	\$	333,554

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: 10/03/2011
 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 Louis	Middle Name
Last Name Gill	Suffix	
b. Title Executive Director	c. Telephone Number (give area code) 661-322-9199	
d. Signature of Authorized Representative	e. Date Signed 10/03/2011	

APPLICATION FOR FEDERAL ASSISTANCE

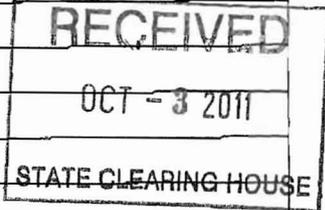
OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Pre-application <input checked="" type="checkbox"/> Construction <input type="checkbox"/> Non-Construction	2. DATE SUBMITTED 10/03/2011	Applicant Identifier
		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: Bethany Services dba Bakersfield Homeless Center	Organizational Unit: Department:
Organizational DUNS: 781523824	Division:
Address: Street: 1600 E. Truxtun Ave.	Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: First Name: Louis
City: Bakersfield	Middle Name
County: Kern	Last Name Gill
State: CA Zip Code 93305	Suffix:
Country: USA	Email: lbjill@bakhc.com



6. EMPLOYER IDENTIFICATION NUMBER (EIN):
95-2858936

Phone Number (give area code) 661-322-9199	Fax Number (give area code) 661-322-9203
---	---

8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> 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) <input type="checkbox"/> Not for Profit Other (specify)
---	---

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 14-235	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Housing Access Unit
TITLE (Name of Program): Supportive Housing Program (SHP)	
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): County of Kern and Bakersfield, CA	

13. PROPOSED PROJECT Start Date: Ending Date:	14. CONGRESSIONAL DISTRICTS OF: a. Applicant 20 & 22 b. Project 20 & 22
---	---

15. ESTIMATED FUNDING:	16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal \$ 178,881.00	a. Yes. <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:
b. Applicant \$ 42,115.00	b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372
c. State \$.00	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
d. Local \$.00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
e. Other \$.00	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No
f. Program Income \$.00	
g. TOTAL \$ 218,996.00	

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 Louis	Middle Name
Last Name Gill	Suffix	
b. Title Executive Director	c. Telephone Number (give area code) 661-322-9199	
d. Signature of Authorized Representative	e. Date Signed 10/03/2011	

APPLICATION FOR FEDERAL ASSISTANCE

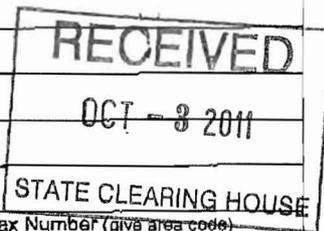
OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED 10/03/2011	Applicant Identifier
<input type="checkbox"/> Construction	Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
	<input checked="" type="checkbox"/> Non-Construction		

5. APPLICANT INFORMATION

Legal Name: Bethany Services dba Bakersfield Homeless Center	Organizational Unit: Department:
Organizational DUNS: 781523824	Division:
Address: Street: 1600 E. Truxtun Ave.	Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: First Name: Louis
City: Bakersfield	Middle Name
County: Kern	Last Name Gill
State: CA Zip Code 93305	Suffix:
Country: USA	Email: lbjill@bakhc.com



6. EMPLOYER IDENTIFICATION NUMBER (EIN):
95-2858938

Phone Number (give area code): 661-322-9199
Fax Number (give area code): 661-322-9203

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)
 Not for Profit
 Other (specify)

9. NAME OF FEDERAL AGENCY:
Federal Mediation and Conciliation Service

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
14-235

TITLE (Name of Program):
Supportive Housing Program (SHP)-Supportive Services Only (SSO)

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Casa Nueva II Placement and Supportive Services Project

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.):
County of Kern and Bakersfield, CA

13. PROPOSED PROJECT
Start Date: Ending Date:

14. CONGRESSIONAL DISTRICTS OF:
a. Applicant b. Project

15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS? a. Yes. <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 10/03/2011 b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372 <input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
a. Federal	\$ 97,000.00	
b. Applicant	\$ 23,180.00	
c. State	\$.00	
d. Local	\$.00	
e. Other	\$.00	
f. Program Income	\$.00	
g. TOTAL	\$ 120,180.00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? <input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> 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.

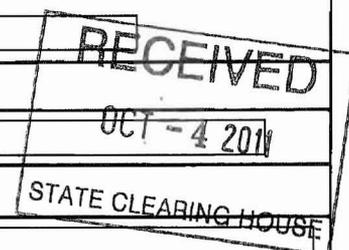
a. Authorized Representative

Prefix	First Name Louis	Middle Name
Last Name Gill	Suffix	
b. Title Executive Director	c. Telephone Number (give area code) 661-322-9199	
d. Signature of Authorized Representative	e. Date Signed 10/03/2011	

OMB Number: 4040-0004

Expiration Date: 03/31/2012

Application for Federal Assistance SF-424		
* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication	<input checked="" type="checkbox"/> New	
<input checked="" type="checkbox"/> Application	<input type="checkbox"/> Continuation	* Other (Specify):
<input type="checkbox"/> Changed/Corrected Application	<input type="checkbox"/> Revision	
* 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:	University of California/ Lawrence Berkeley Nat'l Laboratory	
* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:	
942951741	0785767380000	
d. Address:		
* Street1:	1 Cyclotron Road	
Street2:		
* City:	Berkeley	
County/Parish:	Alameda County	
* State:	CA: California	
Province:		
* Country:	USA: UNITED STATES	
* Zip / Postal Code:	94720-8121	
e. Organizational Unit:		
Department Name:	Division Name:	
Atmospheric Sciences	Environ. Energy Technologies	
f. Name and contact information of person to be contacted on matters involving this application:		
Prefix:	* First Name:	
Dr.	Marc	
Middle Name:		
* Last Name:	Fischer	
Suffix:		
Title:	Principal Investigator/Staff Scientist	
Organizational Affiliation:		
Lawrence Berkeley National Laboratory		
* Telephone Number:	Fax Number:	
(510) 486-5539	(510) 486-5928	
* Email:	MLFischer@lbl.gov	



Application for Federal Assistance SF-424

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

X: Other (specify)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

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

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.):

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

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant

b. Program/Project

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

17. Proposed Project:

* a. Start Date:

* b. End Date:

18. Estimated Funding (\$):

* a. Federal	<input type="text" value="510,000.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="510,000.00"/>

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

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

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

- Yes
- No

If "Yes", provide explanation and attach

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

** I AGREE

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

Authorized Representative:

Prefix: * First Name:

Middle Name:

* Last Name:

Suffix:

* Title:

* Telephone Number: Fax Number:

* Email:

* Signature of Authorized Representative: * Date Signed:

**APPLICATION FOR
FEDERAL ASSISTANCE**

Version 7/03

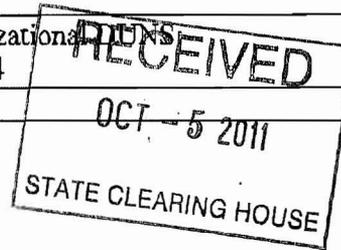
1. TYPE OF SUBMISSION: Application <input checked="" type="checkbox"/> Construction <input type="checkbox"/> Non-Construction		Pre-application <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction	2. DATE SUBMITTED	Applicant Identifier N/A
			3. DATE RECEIVED BY STATE	State Application Identifier SAI-Exempt
			4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier 06-01713
5. APPLICANT INFORMATION				
Legal Name: California - Department of Parks and Recreation			Organizational Unit: Department: California Department of Parks and Recreation	
Organizational DUNS: 172070807			Division: Office of Grants and Local Services	
Address: Street: PO Box 942896			Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Ms. First Name: Patti	
City: Sacramento			Middle Name	
County: Sacramento			Last Name Keating	
State: California		Zip Code 94296-0001	Suffix:	
Country: USA			Email: pkeating@parks.ca.gov	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 68-0303606			Phone Number (give area code) (916) 651-8597	Fax Number (give area code) (916) 653-6511
8. TYPE OF APPLICATION: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> 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)	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE (Name of Program): Land & Water Conservation Fund 15-916			9. NAME OF FEDERAL AGENCY: U.S. Department of Interior, National Park Service	
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): 06-68252			11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Crystal Springs Regional Trail South of Dam County of San Mateo	
13. PROPOSED PROJECT Start Date: Ending Date: 06/30/2014			14. CONGRESSIONAL DISTRICTS OF: a. Applicant 03 b. Project 12	
15. ESTIMATED FUNDING:			16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$	279,218.00	a. Yes. <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 10/04/2011	
b. Applicant	\$		b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372	
c. State	\$	60,483.00	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
d. Local	\$	864,049.00		
e. Other	\$			
f. Program Income	\$		17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
g. TOTAL	\$	1,203,750.00	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> 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 Patti		Middle Name
Last Name Keating			Suffix	
b. Title Chief, Office of Grants and Local Services			c. Telephone Number (give area code) (916) 651-8597	
d. Signature of Authorized Representative			e. Date Signed	

RECEIVED
OCT - 4 2011
STATE CLEARING HOUSE

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	
*3. Date Received:		4. Application Identifier:	
5a. Federal Entity Identifier:		*5b. Federal Award Identifier: CA 0406B9D001003	
State Use Only:			
6. Date Received by State:		7. State Application Identifier:	
8. APPLICANT INFORMATION:			
* a. Legal Name: New Economics for Women			
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-3969029		*c. Organization ID: 197689474	
d. Address:			
*Street1: 303 South Loma Drive			
Street 2:			
*City: Los Angeles			
County: Los Angeles			
*State: CA			
Province:			
Country: United States of America		*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: Ms.		First Name: Maggie	
Middle Name:			
*Last Name: Cervantes			
Suffix:			
Title: Executive Director			
Organizational Affiliation:			
*Telephone Number: (213) 483-2060 x 304		Fax Number: (213)483-7848	
*Email: mcervantes@neworg.us			



Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: - Select One -

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*Other (specify):

*10. Name of Federal Agency:

U.S. Department of Housing and Urban Development (HUD)

11. Catalog of Federal Domestic Assistance Number:

14.225

CFDA Title:

Supportive Housing Program

*12. Funding Opportunity Number: FR-5500-N-34

*Title: Continuum of Care Homeless Assistance Program

13. Competition Identification Number: CoC-01

Title:

2011 Super NOFA Continuum of Care

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

Transitional Housing for Single Teen Mothers and Children

*15. Descriptive Title of Applicant's Project:

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant 34

*b. Program/Project: 34

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

17. Proposed Project:

*a. Start Date: Feb 2012

*b. End Date: Jan 2013

18. Estimated Funding (\$):

*a. Federal \$155,254.00

*b. Applicant

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$155,254.00

19. Is Application Subject to Review By State Under Executive Order 12372 Process?** a. This application was made available to the State under the Executive Order 12372 Process for review on b. Program is subject to E.O. 12372 but has not been selected by the State for review. c. Program is not covered by E.O. 1237220. 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: Maggie

Middle Name:

*Last Name: Cervantes

Suffix:

*Title: Executive Director

*Telephone Number: (213) 483-2060 ext 304

Fax Number: (213) 483-7848

*Email: mcervantes@neworg.us

*Signature of Authorized Representative: *Maggie Cervantes* Date Signed: 10/5/2011

Application for Federal Assistance SF-424

Version 02

***Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

Application for Federal Assistance SF-424		
* 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	* 2. Type of Application: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	* If Revision, select appropriate letter(s): <input type="text"/> * Other (Specify): <input type="text"/>
* 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: Exploratorium	RECEIVED OCT - 5 2011 STATE CLEARING HOUSE	
* b. Employer/Taxpayer Identification Number (EIN/TIN): 94-1696494	* c. Organizational DUNS: 0746261850000	
d. Address:		
* Street1: 3601 Lyon St. Street2: * City: San Francisco County/Parish: San Francisco * State: CA: California Province: * Country: USA: UNITED STATES * Zip / Postal Code: 94123-1019		
e. Organizational Unit:		
Department Name: Teacher Institute	Division Name:	
f. Name and contact information of person to be contacted on matters involving this application:		
Prefix: Ms. Middle Name: * Last Name: Jyu Suffix:	* First Name: Julie	
Title: Staff Scientist		
Organizational Affiliation: Exploratorium Teacher Institute		
* Telephone Number: 415 561-0313	Fax Number: 415 561-0307	
* Email: jyu@exploratorium.edu		

Application for Federal Assistance SF-424

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

X: 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:**

Department of Commerce

11. Catalog of Federal Domestic Assistance Number:

11.429

CFDA Title:

Marine Sanctuary Program

*** 12. Funding Opportunity Number:**

NOAA-NOS-NMS-2012-2003071

* Title:

Fiscal Year 2012 NOAA California Bay Watershed Education and Training Program

13. Competition Identification Number:

2239757

Title:

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

Areas Affected by the Project.doc

Upload Attachment

Delete Attachment

View Attachment

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

Watershed Awareness, Knowledge and Education by Understanding Plastics (WAKE UP)

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant

b. Program/Project

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

17. Proposed Project:

* a. Start Date:

* b. End Date:

18. Estimated Funding (\$):

* a. Federal	<input type="text" value="60,000.00"/>
* b. Applicant	<input type="text" value="31,566.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="91,566.00"/>

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

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

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

Yes No

If "Yes", provide explanation and attach

21. "By signing this application, I certify (1) to the statements contained in the list of certifications" and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances" and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 28, Section 1001)

** I AGREE

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

Authorized Representative:

Prefix: * First Name:

Middle Name:

* Last Name:

Suffix:

* Title:

* Telephone Number: Fax Number:

* Email:

* Signature of Authorized Representative: * Date Signed:

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No 16-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED October 4, 2011	Applicant Identifier
<input checked="" type="checkbox"/> Construction	<input type="checkbox"/> Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
<input type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
<input type="checkbox"/> Non-Construction			

5. APPLICANT INFORMATION

Legal Name: Alliance Against Family Violence and Sexual Assault	Organizational Unit: Department:
Organizational DUNS: 825144306	Division:
Address: Street: 1921 19th Street	Name and telephone number of person to be contacted on matters involving this application (give area code):
City: Bakersfield	Prefix: Mr. First Name: Louis
County: Kern	Middle Name
State: CA	Last Name: Gill
Zip Code: 91301	Suffix:
Country: USA	Email: lbgill@bakhc.com

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6. EMPLOYER IDENTIFICATION NUMBER (EIN):
 -

8. TYPE OF APPLICATION: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)	7. TYPE OF APPLICANT: (See back of form for Application Types) <input type="checkbox"/> Not for Profit Other (specify)
Other (specify)	9. NAME OF FEDERAL AGENCY: U.S. Department of Housing and Urban Development

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
 -

TITLE (Name of Program):
Supportive Housing Program (SHP)

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.):
County of Kern and Bakersfield, CA

13. PROPOSED PROJECT Start Date: 1/2/2012 Ending Date: 12/31/14	14. CONGRESSIONAL DISTRICTS OF: a. Applicant 20 & 22 b. Project 20 & 22
--	--

15. ESTIMATED FUNDING:	16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal \$ 350,980.00	a. Yes. <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 10/4/2011
b. Applicant \$ 195,567.00	b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372
c. State \$.00	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
d. Local \$.00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
e. Other \$.00	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No
f. Program Income \$.00	
g. TOTAL \$ 546,547.00	

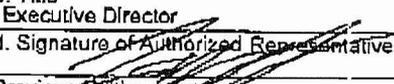
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative

Prefix: Mr.	First Name: Louis	Middle Name:
Last Name: Gill	Suffix:	

b. Title: Executive Director

c. Telephone Number (give area code): 661-322-9199

d. Signature of Authorized Representative: 

e. Date Signed: 10/3/2011



A L L I A N C E

AGAINST FAMILY VIOLENCE AND SEXUAL ASSAULT

STRENGTHENING OUR COMMUNITY ONE STEP AT A TIME

FAX

DATE SENT	10/4/2011
TIME SENT	
# of PAGES including this page	2

TO	STATE CLEARINGHOUSE	FROM	BARBARA VADNAIS
ATTN	Grants Coordination		
ORG/DEPT	Single Point of Contact	ADDRESS	1921 19 th street
CC			Bakersfield, CA 93301
PHONE	916-445-0613	PHONE	661/322-0931
FAX	916-323-3018	FAX	661/322-2916

HIPAA PRIVACY NOTICE: The information contained in this facsimile message is intended for the use of the individual named above, and privilege of confidentiality is not waived by virtue of this having been sent by facsimile. If the person actually receiving this facsimile or any other reader of this facsimile is not the named recipient, any use, dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us by telephone, and return the original message to us at the above address.

MESSAGE: Urgent For your review Reply ASAP Please comment

Re: Application is Subject to Review by State Executive Order 12372 Process

SF-424 (please Void document sent 10/3/2011)

Thank you -

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED 09-28-2011	Applicant Identifier
<input type="checkbox"/> Construction	<input type="checkbox"/> Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
	<input type="checkbox"/> Non-Construction		

5. APPLICANT INFORMATION

Legal Name: City of Glendale/Glendale Housing Authority	Organizational Unit: Department: Community Services and Parks (CSP)
Organizational DUNS: 030384325	Division: Community Development Block Grant (CDBG)/ Homeless
Address: Street: 141 N. Glendale Ave, Suite 202	Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Ms. First Name: Ivet
City: Glendale	Middle Name
County: Los Angeles	Last Name: Samvelyan
State: California Zip Code: 91206	Suffix:
Country: United States	Email: isamvelyan@ci.glendale.ca.us

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6. EMPLOYER IDENTIFICATION NUMBER (EIN):
95-8000714

Phone Number (give area code) 818-548-3720	Fax Number (give area code) 818-548-3724
---	---

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)
City Township (D)
Other (specify)

9. NAME OF FEDERAL AGENCY:
U.S. Department of Housing & Urban Development (HUD)

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
TITLE (Name of Program): Labor Management Cooperation Program
14-235
14-238

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Notice of Funding Availability for the Continuum of Care Homeless Assistance Application (NOFA).

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

13. PROPOSED PROJECT
Start Date: 2012 Ending Date: 2013

14. CONGRESSIONAL DISTRICTS OF:
a. Applicant CA-029 b. Project CA-029

15. ESTIMATED FUNDING:

a. Federal	\$	2,575,985
b. Applicant	\$	
c. State	\$	
d. Local	\$	
e. Other	\$	
f. Program Income	\$	
g. TOTAL	\$	2,575,985

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: James	Middle Name: E.
Last Name: Starbird		Suffix:
b. Title: Executive Director/ City Manager		c. Telephone Number (give area code): 818-548-4844
d. Signature of Authorized Representative: 		e. Date Signed: 10/3/11

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED October 4, 2011	Applicant Identifier
<input type="checkbox"/> Construction	<input type="checkbox"/> Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
<input type="checkbox"/> Non-Construction			

5. APPLICANT INFORMATION

Legal Name: The Association For Community Housing Solutions		Organizational Unit: Department:	
Organizational DUNS: 065816311		Division:	
Address: Street: 5151 Murphy Canyon Road, Suite #120		Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: First Name: Kimberly	
City: San Diego		Middle Name: S	
County: San Diego		Last Name: Russell-Shaw	
State: CA	Zip Code: 92123	Suffix:	
Country: US		Email: kim@tachs.org	

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6. EMPLOYER IDENTIFICATION NUMBER (EIN):

33-0602842

Phone Number (give area code) 858-277-3757	Fax Number (give area code) 858-277-3788
---	---

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)

Non-profit Organization

Other (specify)

9. NAME OF FEDERAL AGENCY:
Federal Mediation and Conciliation Service US Dept of HUD

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:

14-235

TITLE (Name of Program):
Continuum of Care - SuperNOFA Homeless Programs

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:

This funding provides for service delivery to up to 21 seriously mentally ill, homeless adults.

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

San Diego, San Diego, CA

13. PROPOSED PROJECT

Start Date:
09/01/2012

Ending Date:
08/31/2013

14. CONGRESSIONAL DISTRICTS OF:

a. Applicant
CA-053

b. Project
CA-053

15. ESTIMATED FUNDING:

a. Federal	\$	73,500 ⁰⁰
b. Applicant	\$	18,375 ⁰⁰
c. State	\$	0 ⁰⁰
d. Local	\$	0 ⁰⁰
e. Other	\$	0 ⁰⁰
f. Program Income	\$	0 ⁰⁰
g. TOTAL	\$	91,875 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: October 17, 2011

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 Kimberly	Middle Name S
Last Name Russell-Shaw	Suffix	
b. Title Exec. Consultant	c. Telephone Number (give area code)	
d. Signature of Authorized Representative 	e. Date Signed OCTOBER 17 2011	

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Authorized for Local Reproduction

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

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application		*If Revision, select appropriate letter(s):	
<input type="checkbox"/> Preapplication		<input checked="" type="checkbox"/> New			
<input checked="" type="checkbox"/> Application		<input type="checkbox"/> Continuation		* Other (Specify)	
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision			

*3. Date Received:	4. Application 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: Tuolumne River Preservation Trust	
* b. Employer/Taxpayer Identification Number (EIN/TIN): 94-2834151	*c. Organizational DUNS: 840996730

d. Address:

*Street1: 111 New Montgomery St. Suite 205	RECEIVED OCT - 6 2011 STATE CLEARING HOUSE
Street 2:	
*City: San Francisco.	
County:	
*State: California	
Province:	
Country:	*Zip/ Postal Code: 94105

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: Karyn
Middle Name:	
*Last Name: Barnes	
Suffix:	
Title: Development Director	

Organizational Affiliation:

*Telephone Number: 415-882-7252	Fax Number: 415-882-7253
*Email: karyn@tuolumne.org	

Application for Federal Assistance SF-424

Version 02

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

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*Other (specify):

*10. Name of Federal Agency:

National Ocean Service (NOS), National Oceanic and Atmospheric Administration (NOAA), Department of

11. Catalog of Federal Domestic Assistance Number:

11.429

CFDA Title:

Marine Sanctuary Program

*12. Funding Opportunity Number: **NOAA-NOS-NMS-2012-2003071**

*Title: **Fiscal Year 2012 NOAA California Bay Watershed Education and Training Program**

13. Competition Identification Number: **2239757**

Title:

San Francisco

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

San Francisco Bay

*15. Descriptive Title of Applicant's Project:

That's the Tuolumne in my Tap

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant **District 8**

*b. Program/Project: **District 8**

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

17. Proposed Project:

*a. Start Date: **8/1/2012**

*b. End Date: **7/31/2013**

18. Estimated Funding (\$):

*a. Federal **\$41,470.00**

*b. Applicant

*c. State

*d. Local

*e. Other **\$26,847.00**

*f. Program Income

*g. TOTAL **\$68,317.00**

***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 **10/4/2011**

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: **Karyn**

Middle Name:

*Last Name: **Barnes**

Suffix:

*Title: **Development Director**

*Telephone Number: **415-882-7252**

Fax Number: **415-882-7253**

*Email: **karyn@tuolumne.org**

*Signature of Authorized Representative:

Date Signed: **10/1/2011**

Application for Federal Assistance SF-424

Version 02

***Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

Application for Federal Assistance SF-424

* 1. Type of Submission:

- Preapplication
- Application
- Changed/Corrected Application

* 2. Type of Application:

- New
- Continuation
- Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

* 3. Date Received:

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 Livingston

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

9 4 6 0 0 0 3 6 0

* c. Organizational DUNS:

159904762

d. Address:

* Street1:

1416 C Street

Street2:

* City:

Livingston

County:

Merced

* State:

CA

Province:

* Country:

United States

* Zip / Postal Code:

95334



e. Organizational Unit:

Department Name:

Livingston Police Department

Division Name:

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

Prefix:

Mrs.

* First Name:

Brenda

Middle Name:

* Last Name:

Geary

Suffix:

Title:

Executive Assistant to Chief of Police

Organizational Affiliation:

Livingston Police Department

* Telephone Number:

(209) 394-5578

Fax Number:

(209) 394-1153

* Email:

bgeary@livingstonpd.org

Application for Federal Assistance SF-424**9. Type of Applicant 1: Select Applicant Type:** B. Municipal

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

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

USDA - Rural Development

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

Community Facilities Grant Program

*** 12. Funding Opportunity Number:**

* Title:

13. Competition Identification Number:

Title:

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

City of Livingston

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

Purchase of marked emergency vehicles for the police department.

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant 18th

* b. Program/Project 18th

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

17. Proposed Project:

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

18. Estimated Funding (\$):

* a. Federal	<input type="text"/>	73,741.06
* b. Applicant	<input type="text"/>	73,741.06
* c. State	<input type="text"/>	
* d. Local	<input type="text"/>	
* e. Other	<input type="text"/>	
* f. Program Income	<input type="text"/>	147,482.12
* g. TOTAL	<input type="text"/>	147,482.12

* 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: * First Name:

Middle Name:

* Last Name:

Suffix:

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

Application for Federal Assistance SF-424

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

[Empty text input area for Applicant Federal Debt Delinquency Explanation]

Application for Federal Assistance SF-424

* 1. Type of Submission: <input checked="" type="checkbox"/> Preapplication <input type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application		* 2. Type of Application: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> 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: City of Holtville		<table border="1"><tr><td style="text-align: center; vertical-align: middle;">RECEIVED</td></tr><tr><td style="text-align: center; vertical-align: middle;">OCT - 7 2011</td></tr><tr><td style="text-align: center; vertical-align: middle;">STATE CLEARING HOUSE</td></tr></table>				RECEIVED	OCT - 7 2011	STATE CLEARING HOUSE
RECEIVED								
OCT - 7 2011								
STATE CLEARING HOUSE								
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6000-721		* c. Organizational DUNS: 020507158						
d. Address:								
* Street1: 121 West Fifth Street		_____						
Street2:		_____						
* City: Holtville		_____						
County: Imperial County		_____						
* State: California		_____						
Province:		_____						
* Country:		USA: UNITED STATES						
* Zip / Postal Code: 92250		_____						
e. Organizational Unit:								
Department Name: City of Holtville			Division Name: City of Holtville					
f. Name and contact information of person to be contacted on matters involving this application:								
Prefix: Ms.		* First Name: Justina						
Middle Name:		_____						
* Last Name: Arce		_____						
Suffix:		_____						
Title: City Planner								
Organizational Affiliation: The Holt Group, Inc.								
* Telephone Number: (760) 337-3883		Fax Number: (760) 337-5997						
* Email: justina@theholtgroup.net								

Application for Federal Assistance SF-424

9. Type of Applicant 1: Select Applicant Type:

City

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

* 10. Name of Federal Agency:

USDA Rural Development

11. Catalog of Federal Domestic Assistance Number:

10.760

CFDA Title:

Water and Waste Disposal Loan and Grant Program

* 12. Funding Opportunity Number:

* Title:

13. Competition Identification Number:

Title:

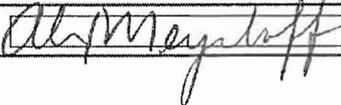
14. Areas Affected by Project (Cities, Counties, States, etc.):

City of Holtville and immediate vicinity

* 15. Descriptive Title of Applicant's Project:

Please refer to Project Summary Description Attached.

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424	
16. Congressional Districts Of:	
* a. Applicant 51st District	* b. Program/Project 51st District
Attach an additional list of Program/Project Congressional Districts if needed. <input type="text"/>	
17. Proposed Project:	
* a. Start Date: <input type="text"/>	* b. End Date: <input type="text"/>
18. Estimated Funding (\$):	
* a. Federal \$250,000 BECC; TBD USDA	
* b. Applicant 0	
* c. State TBD	
* d. Local 0	
* e. Other N/A	
* f. Program Income N/A	
* g. TOTAL \$4,700,000.00	
* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?	
<input checked="" type="checkbox"/> a. This application was made available to the State under the Executive Order 12372 Process for review on	<input type="text" value="AC to send"/>
<input type="checkbox"/> b. Program is subject to E.O. 12372 but has not been selected by the State for review.	
<input type="checkbox"/> c. Program is not covered by E.O. 12372.	
* 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.) Applicant Federal Debt Delinquency Explanation	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)	
<input checked="" type="checkbox"/> ** 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: <input type="text" value="Mr."/>	* First Name: <input type="text" value="Alexander"/>
Middle Name: <input type="text" value="P."/>	
* Last Name: <input type="text" value="Meyerhoff"/>	
Suffix: <input type="text"/>	
* Title: <input type="text" value="City Manager, AICP"/>	
* Telephone Number: <input type="text" value="(760) 356-4574"/>	Fax Number: <input type="text" value="(760) 356-1863"/>
* Email: <input type="text" value="ameyerhoff@holtville.ca.gov"/>	
* Signature of Authorized Representative: 	* Date Signed: <input type="text" value="10-6-11"/>

Application for Federal Assistance SF-424

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

[Empty text input area for delinquency explanation]

Project Summary Description

The project consists of replacing 3.2 miles of a deteriorated Sanitary Sewer Outfall Main that serves the Holtville Community. The Sanitary Outfall Main extends from the intersection of Olive Avenue and Ninth Street within the incorporated City Limits to the Holtville Wastewater Treatment Plant located in an unincorporated area of Imperial County at 1250 Kamm Road in Holtville, California and functions via gravity flow. A total of forty-three (43) manholes will be replaced along the 3.2 mile stretch.

The existing Sewer Outfall Main consists of 15-inch and 18-inch diameter gravity vitrified clay pipeline sections that extend from the intersection of Olive Avenue and Ninth Street to the Holtville Wastewater Treatment Plant (WWTP) within City and County Right-of-Way. There are currently 1,320 lineal feet of pipeline within Caltrans Right-of-Way, within Highway 115. The existing Wastewater Collection System Outfall Main Pipeline is over 80 years old and in extremely poor condition, unsalvageable and has reached the end of its life expectancy. There are frequent occurrences of manhole collapse which pose an immediate health and safety hazard to the community and motorists. The proposed Project will abandon the City's deteriorated Outfall Main Pipeline, and replace adjacent to the existing footprint, with the exception of the 1,320 lineal feet within Caltrans Right-of-Way which will require relocation outside of the Right-of-Way. Right-of-Way will need to be purchased from an estimated nine (9) private property owners.

The City's Wastewater System, as a whole is operating under a Cease & Desist Board Order by the Colorado River Water Quality Control Board (CRWQCB). The Sewer Outfall Main Pipeline Project is Phase I of a two part project that will also improve the Holtville Wastewater Treatment Plant.

There is belief that the deteriorated condition of the vitrified clay allows for infiltration by other contaminants along the 3.2 mile stretch and is a contributing factor regarding the inability of the Wastewater Treatment Plant to effectively meet the effluent discharge requirements of the CRWQCB. This project will help the City of Holtville meet compliance requirements of the CRWQCG and help eliminate imminent health and safety hazards in the community.

A new 18-inch diameter PVC outfall pipeline will replace all the existing deficient pipeline segments. It will provide a constant slope from the intersection of Olive Avenue and Ninth Street to a new manhole located immediately upstream of the existing Wastewater Treatment Plant and termination point. The project will consist of placing a gravel bedding beneath the sanitary sewer outfall pipeline for adequate support and granular sand fill in the pipe zone for a distance of 1 foot above the top of the pipe. The 5 foot diameter manholes to service this pipeline would be placed at a maximum distance of 600 feet on center. The interior of the manholes would be coated with a high quality urethane coating system similar to Zebron, Sancon or Utilithane Coating System.

This pipeline serves all households within the incorporated City limits as well as one hundred seventy-nine (179) connections outside the City limits, but within the immediate project vicinity. There are a total of 1,928 households hooked up to, and benefitting from, the City of Holtville Wastewater Collection Main Pipeline.

Additionally, two sewer laterals will be constructed along two residential blocks that have deficient and/or non-existing sewer collection services. The sewer lines are located in the alley between Ninth Street and Tenth Street for both segments: 1) between Orange Avenue and Fern Avenue 2) between Cedar Avenue and Pine Avenue. An engineering assessment has been prepared for the segments that have recurring and chronic overflows, clogging and surcharges and rehabilitation recommendation was made based on need.



CITY OF HOLTVILLE

121 WEST FIFTH STREET
HOLTVILLE, CALIFORNIA 92250-1298 • (760) 356-2912
"THE CARROT CAPITAL OF THE WORLD"

October 5, 2011

SENT VIA CERTIFIED MAIL

California State Clearinghouse
Governor's Office of Planning and Research
P.O. Box 3044
Sacramento, CA 95812

**RE: Intergovernmental Review per Executive Order 12372 for the City of Holtville
Pre-Application through the USDA Water and Waste Disposal Loan and Grant Program**

To Whom It May Concern,

The City of Holtville respectfully requests a review under Executive Order 12372. Executive Order 12372 states that Federal agencies shall provide opportunities for consultation by elected officials of those State and Local governments that would provide the non-Federal funds for, or that would be directly affected by, proposed Federal financial assistance and direct Federal development. In this vein, the USDA, a Federal agency, is requesting that the City of Holtville consult with the State Clearinghouse as it relates to the City's Pre-Application under USDA's Water and Waste Disposal Loan and Grant Program for the City's Sanitary Sewer Outfall Main Pipeline.

The City of Holtville is located in the southeastern portion of California in Imperial County. The project consists of replacing 3.2 miles of a deteriorated Sanitary Sewer Outfall Main that serves the Holtville Community. The Sanitary Outfall Main extends from the intersection of Olive Avenue and Ninth Street within the incorporated City Limits to the Holtville Wastewater Treatment Plant located in an unincorporated area of Imperial County at 1250 Kamm Road in Holtville, California. A total of forty-three (43) manholes will be replaced along the 3.2 mile stretch which functions via gravity flow.

The existing Sanitary Sewer Outfall Main is composed of 15-inch and 18-inch diameter vitrified clay pipeline sections that extend from the City Limit boundary to the Wastewater Treatment Plant (WWTP). The existing Outfall Main Pipeline is over 80 years old and in extremely poor condition, unsalvageable and has reached the end of its life expectancy. There are frequent occurrences of manhole collapse which pose an immediate health and safety hazard to the community and motorists. The proposed Project will replace the deteriorated pipeline with a new 18-inch diameter PVC line along the existing footprint, with the exception of 1,320 lineal feet within Caltrans Right-of-Way which will require relocation outside of the Right-of-Way.

Additionally, two residential sewer laterals will be constructed along two residential blocks that have deficient and/or non-existing sewer collection services. The sewer lines are located in the alley between Ninth Street and Tenth Street for both segments: 1) between Orange Avenue and Fern Avenue 2) between Cedar Avenue and Pine Avenue. Existing septic systems and/or deficient lines have recurring and chronic overflows, clogging and surcharges.

As it relates to the preparation of environmental documents, a Mitigated Negative Declaration was prepared for the replacement of the Sanitary Sewer Outfall Main Project. A Notice of Determination was filed on September 3, 2010 and the State Clearinghouse Numbers for the project is 2010061076.

In anticipation, we greatly appreciate your review. If you have any questions regarding this communication or need additional documentation, you may contact me at (760) 337-3883 or at jarce@theholtgroup.net.

Sincerely,


Justina G. Arce,
City Planner

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approval No. 0348-0043

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction <input checked="" type="checkbox"/> Preapplication <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction		2. DATE SUBMITTED September 8, 2011	Applicant Identifier
3. DATE RECEIVED BY STATE		State Application Identifier	
4. DATE RECEIVED BY FEDERAL AGENCY		Federal Identifier	

5. APPLICANT INFORMATION

Legal Name: University of California, Davis
 Address (give city, county, state, and zip code):
 1 Shields Avenue
 Davis, Yolo County, California: 95616

Organizational Unit: Interdisciplinary Center for Inductively Coupled Mass Spectrometry

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

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
 94 - 6036494

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

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)

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:
 U.S. Department of Interior, Fish and Wildlife Service

RECEIVED
 OCT 10 2011
 STATE CLEARING HOUSE

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
 15 - 608
 TITLE: Fish and Wildlife Management Assistance

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
 Rio Grande silvery minnow trans-generational tagging technique development

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.):
 State of California, State of New Mexico

13. PROPOSED PROJECT		14. CONGRESSIONAL DISTRICTS OF:	
Start Date 10/1/2011	Ending Date 12/31/2012	a. Applicant CA-01	b. Project CA-01, NM-01
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 10,000.00	a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: DATE 10/10/2011	
b. Applicant	\$	b. NO. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E.O. 12372 <input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
c. State	\$	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
d. Local	\$	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," attach an explanation.	
e. Other	\$		
f. Program Income	\$		
g. TOTAL	\$ 10,000.00		

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 Kathleen P. Nolan, J.D. JMF	b. Title Associate Director, Sponsored Programs	c. Telephone Number 530-754-7700
d. Signature of Authorized Representative <i>Kathleen P. Nolan</i>		e. Date Signed 10-6-11

APPLICATION FOR FEDERAL ASSISTANCE

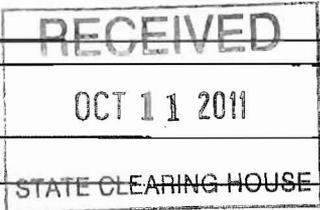
OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED 10/11/2011	Applicant Identifier
<input type="checkbox"/> Construction	<input type="checkbox"/> Construction	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input checked="" type="checkbox"/> Non-Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier CA8368

5. APPLICANT INFORMATION

Legal Name: Friendship Shelter, Inc.	Organizational Unit: Department:
Organizational DUNS: 863815375	Division:
Address: Street: PO Box 4252	Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: First Name: Dawn
City: Laguna Beach	Middle Name
County: Orange	Last Name Price
State: CA	Suffix:
Zip Code 92652	Email: 0



6. EMPLOYER IDENTIFICATION NUMBER (EIN):
33-0219404

Phone Number (give area code): (949) 494-6928
Fax Number (give area code): (949) 497-4324

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)
 Not for Profit Organization
 Other (specify)

9. NAME OF FEDERAL AGENCY:
HUD

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
14-235

TITLE (Name of Program):
Labor Management Cooperation Program

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Project READY

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.):
Orange County, CA

13. PROPOSED PROJECT
Start Date: 11/01/2012 Ending Date: 10/31/2013

14. CONGRESSIONAL DISTRICTS OF:
a. Applicant CA-048 b. Project CA-044

15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 68,136 ⁰⁰	a. Yes. <input checked="" type="checkbox"/>	THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 10/11/2011
b. Applicant	\$ ⁰⁰	b. No. <input type="checkbox"/>	PROGRAM IS NOT COVERED BY E. O. 12372
c. State	\$ ⁰⁰	<input type="checkbox"/>	OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
d. Local	\$ ⁰⁰	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
e. Other	\$ ⁰⁰	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No	
f. Program Income	\$ ⁰⁰		
g. TOTAL	\$ 68,136 ⁰⁰		

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 Dawn	Middle Name
Last Name Price	Suffix	
b. Title Executive Director	c. Telephone Number (give area code) (949) 494-6928	
d. Signature of Authorized Representative <i>Dawn Price</i>	e. Date Signed 10/11/2011	

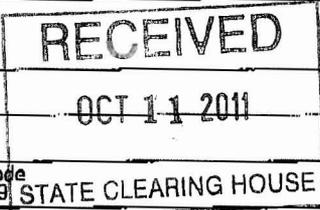
APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 2076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction	Pre-application <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction	2. DATE SUBMITTED 10/11/2011	Applicant Identifier CA0579B9D021003
		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION Legal Name: Human Options, Inc.		Organizational Unit: Department: Business Office	
Organizational DUNS: 808923306		Division:	
Address: Street: P.O. Box 53745		Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Ms. First Name: Irene	
City: Irvine		Middle Name	
County: Orange		Last Name Rausch	
State: CA	Zip Code 92819	Suffix:	
Country: United States of America		Email: irausch@humanoptions.org	



6. EMPLOYER IDENTIFICATION NUMBER (EIN): 95-3667817	Phone Number (give area code) (949) 737-5242 x 212	Fax Number (give area code) (949) 737-5244
8. TYPE OF APPLICATION: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)	7. TYPE OF APPLICANT: (See back of form for Application Types) <input type="checkbox"/> Not for Profit Organization Other (specify)	

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 14-235 TITLE (Name of Program): Supportive Housing Program - SSO	9. NAME OF FEDERAL AGENCY: Department of Housing and Urban Development
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Orange County, CA	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Second Step/Clients Assistance

13. PROPOSED PROJECT Start Date: 08/01/2012 Ending Date: 07/31/2013	14. CONGRESSIONAL DISTRICTS OF: a. Applicant CA-048 b. Project CA-046																					
15. ESTIMATED FUNDING: <table border="1"> <tr><td>a. Federal</td><td>\$</td><td>30,793.00</td></tr> <tr><td>b. Applicant</td><td>\$</td><td>7,332.00</td></tr> <tr><td>c. State</td><td>\$</td><td></td></tr> <tr><td>d. Local</td><td>\$</td><td></td></tr> <tr><td>e. Other</td><td>\$</td><td></td></tr> <tr><td>f. Program Income</td><td>\$</td><td></td></tr> <tr><td>g. TOTAL</td><td>\$</td><td>38,125.00</td></tr> </table>	a. Federal	\$	30,793.00	b. Applicant	\$	7,332.00	c. State	\$		d. Local	\$		e. Other	\$		f. Program Income	\$		g. TOTAL	\$	38,125.00	16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS? a. Yes. <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 10/11/2011 b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372 <input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
a. Federal	\$	30,793.00																				
b. Applicant	\$	7,332.00																				
c. State	\$																					
d. Local	\$																					
e. Other	\$																					
f. Program Income	\$																					
g. TOTAL	\$	38,125.00																				
17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? <input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No																						

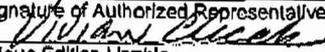
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

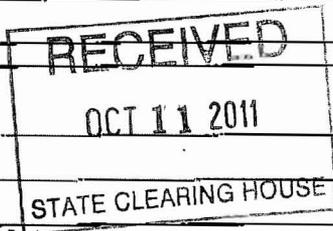
a. Authorized Representative		
Prefix Ms. First Name Vivian	Middle Name	
Last Name Clecak	Suffix LCSW	
b. Title Chief Executive Officer	c. Telephone Number (give area code) (949) 737-5242 x 222	
d. Signature of Authorized Representative <i>Vivian Clecak</i>	e. Date Signed 10/11/11	

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		2. DATE SUBMITTED 10/11/2011	Applicant Identifier CA0580B9D021003																					
Pre-application <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction	3. DATE RECEIVED BY STATE		State Application Identifier																					
5. APPLICANT INFORMATION Legal Name: Human Options, Inc.		4. DATE RECEIVED BY FEDERAL AGENCY Federal Identifier																						
Organizational DUNS: 806923308		Organizational Unit: Department: Business Office Division:																						
Address: Street: P.O. Box 53745		Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Ms. First Name: Irene																						
City: Irvine		Middle Name																						
County: Orange		Last Name Rausch																						
State: CA		Suffix:																						
Country: United States of America		Email: irausch@humanoptions.org																						
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 95-3867817		Phone Number (give area code) (949) 737-5242 x 212	Fax Number (give area code) (949) 737-5244																					
8. TYPE OF APPLICATION: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> 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)																						
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 14-235 TITLE (Name of Program): Supportive Housing Program - TH		9. NAME OF FEDERAL AGENCY: Department of Housing and Urban Development																						
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Orange County, CA		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Second Step/Operations																						
13. PROPOSED PROJECT Start Date: 07/01/2012 Ending Date: 06/30/2013		14. CONGRESSIONAL DISTRICTS OF: a. Applicant CA-048 b. Project CA-048																						
15. ESTIMATED FUNDING: <table border="1"> <tr> <td>a. Federal</td> <td>\$</td> <td>111,122.00</td> </tr> <tr> <td>b. Applicant</td> <td>\$</td> <td>31,252.00</td> </tr> <tr> <td>c. State</td> <td>\$</td> <td>.00</td> </tr> <tr> <td>d. Local</td> <td>\$</td> <td>.00</td> </tr> <tr> <td>e. Other</td> <td>\$</td> <td>.00</td> </tr> <tr> <td>f. Program Income</td> <td>\$</td> <td>.00</td> </tr> <tr> <td>g. TOTAL</td> <td>\$</td> <td>142,374.00</td> </tr> </table>		a. Federal	\$	111,122.00	b. Applicant	\$	31,252.00	c. State	\$.00	d. Local	\$.00	e. Other	\$.00	f. Program Income	\$.00	g. TOTAL	\$	142,374.00	16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS? a. Yes. <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 10/11/2011 b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372 <input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
a. Federal	\$	111,122.00																						
b. Applicant	\$	31,252.00																						
c. State	\$.00																						
d. Local	\$.00																						
e. Other	\$.00																						
f. Program Income	\$.00																						
g. TOTAL	\$	142,374.00																						
17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? <input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> 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 Vivian Middle Name																								
Last Name Clocak Suffix LCSW		c. Telephone Number (give area code) (949) 737-5242 x 222																						
b. Title Chief Executive Officer		e. Date Signed 10/11/11																						
d. Signature of Authorized Representative 																								



OMB Number: 4040-0004
Expiration Date: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	
*3. Date Received:		4. Application Identifier:	
5a. Federal Entity Identifier: CA0505B9D001003		*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:			
*Street1: 7843 Lankershim Blvd. Street 2: *City: North Hollywood County: *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: Middle Name:		First Name: Christine	
*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: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit Type of Applicant 2: Select Applicant Type: - Select One - Type of Applicant 3: Select Applicant Type: - Select One - *Other (specify):
*10. Name of Federal Agency:
11. Catalog of Federal Domestic Assistance Number: CFDA Title: 14-2345
*12. Funding Opportunity Number: FR-5500-N-34 *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, is a renewal project that provides 135 beds of transitional housing combined with supportive services to homeless individuals with multiple diagnoses. Supportive services offered include intensive case management, life skills counseling, on-site medical and mental health services, employment assessment, training, money management, etc.
Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant

28

*b. Program/Project:

28

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

17. Proposed Project:

*a. Start Date: 10/01/11

*b. End Date: 09/30/2012

18. Estimated Funding (\$):

*a. Federal

\$355,664.00

*b. Applicant

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL

\$355,664.00

*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 10/12/2011
- 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-Gamer

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: 10/12/11

OMB Number: 4040-0004
Expiration Date: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	
*3. Date Received:		4. Application Identifier:	
5a. Federal Entity Identifier: CA0490B9D001003		*5b. Federal Award Identifier:	
STATE CLEARING HOUSE			
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:			
*Street1: 7843 Lankershim Blvd.			
Street 2:			
*City: North Hollywood			
County:			
*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: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*Other (specify):

*10. Name of Federal Agency:

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

14-2345

*12. Funding Opportunity Number: FR-5500-N-34

*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, tenant education, parenting skills, money management, etc.

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

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

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

17. Proposed Project:

*a. Start Date: 01/01/2012

*b. End Date: 12/31/2012

18. Estimated Funding (\$):

*a. Federal	\$363,659.00
*b. Applicant	
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	\$363,659.00

*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 10/12/2011
- 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-Gamer

Suffix:

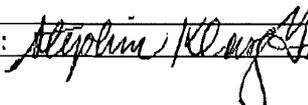
*Title: President and CEO

*Telephone Number: (818) 982-4091

Fax Number: (818) 255-2770

*Email: stephanie@lafh.org

*Signature of Authorized Representative:



Date Signed:

10/12/11

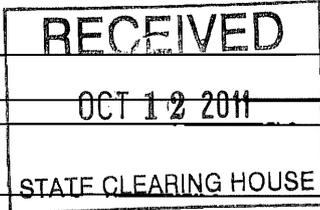
**APPLICATION FOR
FEDERAL ASSISTANCE**

OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED October 12, 2011	Applicant Identifier
<input type="checkbox"/> Construction	<input type="checkbox"/> Construction	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input checked="" type="checkbox"/> Non-Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION		Organizational Unit:	
Legal Name: Orange Coast Interfaith Shelter		Department: N/A	
Organizational DUNS: 807722731		Division: N/A	
Address: Street: 1963 Wallace Avenue		Name and telephone number of person to be contacted on matters involving this application (give area code)	
City: Costa Mesa		Prefix: Ms.	First Name: Laura
County: Orange County		Middle Name	
State: California		Last Name Miller	
Zip Code: 92627	Suffix:		
Country: USA		Email: Lmiller@ocinterfaithshelter.org	



6. EMPLOYER IDENTIFICATION NUMBER (EIN): 95-3813254		Phone Number (give area code) (949) 631-7213 Extension 132		Fax Number (give area code) (949) 631-7648	
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> 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. Other (specify)			
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE (Name of Program): Labor Management Cooperation Program		9. NAME OF FEDERAL AGENCY: U.S. Department of Housing and Urban Development			

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Orange County, California		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Transitional Housing Program for homeless families with children. We provide supportive services: Case Management to address goals/objectives towards self-sufficiency, Mental Health Therapy to address barriers that may be causing homelessness in families, Subsidized Childcare, Parenting Classes and transportation assistance.			
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13. PROPOSED PROJECT		14. CONGRESSIONAL DISTRICTS OF:			
Start Date:	Ending Date:	a. Applicant 46		b. Project 42	

15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?			
a. Federal	\$ 283,129.00	b. Yes. <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:			
b. Applicant	\$ 55,453.00	b. No. <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372			
c. State	\$ 0.00	<input checked="" type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW			
d. Local	\$ 0.00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?			
e. Other	\$ 0.00	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No			
f. Program Income	\$ 0.00				
g. TOTAL	\$ 333,582.00				

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: Laura	Middle Name
Last Name: Miller		Suffix
b. Title Executive Director		c. Telephone Number (give area code) (949) 631-7213 ext. 132
d. Signature of Authorized Representative		e. Date Signed October 12, 2011

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction	Pre-application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction	2. DATE SUBMITTED 10/11/11	Applicant Identifier CA0585B9D021003
		3. DATE RECEIVED BY STATE	State Application Identifier N/A
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier CA0585B9D021003

RECEIVED
 OCT 12 2011
 STATE CLEARING HOUSE

5. APPLICANT INFORMATION

Legal Name: The Eli Home, Inc.	Organizational Unit: Department: N/A
Organizational DUNS: 008391463	Division: N/A
Address: Street: 1175 N. East St.	Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: First Name: Middle Name: Sonja
City: Anaheim	Last Name: Grewal
County: Orange	Suffix:
State: CA Zip Code 92805	Email: sonjag@elihome.org
Country: United States	Phone Number (give area code): 3 (714) 300-0600 ext. 227
	Fax Number (give area code): (714) 300-0665

6. EMPLOYER IDENTIFICATION NUMBER (EIN):

33-0189254

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)

Not for profit organization
 Other (specify)
501 (c) (3)

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:

14-235

TITLE (Name of Program):
Shelter Housing Partnership

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Continuum of Care Homeless Assistance Competition

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.):
Anaheim, Orange, Santa Ana, Tustin and surrounding Orange County, CA cities.

13. PROPOSED PROJECT

Start Date: 8/1/2012 Ending Date: 7/31/2013

14. CONGRESSIONAL DISTRICTS OF:
a. Applicant CA-040 and CA-047 b. Project CA-040, 042, 44, 046, 047, 048

15. ESTIMATED FUNDING:

a. Federal	\$	524,275 ⁰⁰
b. Applicant	\$	133,970 ⁰⁰
c. State	\$	⁰⁰
d. Local	\$	⁰⁰
e. Other	\$	⁰⁰
f. Program Income	\$	⁰⁰
g. TOTAL	\$	658,246 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: 10/11/2011

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 Mrs.	First Name Lorri	Middle Name
Last Name Galloway		Suffix
b. Title Executive Director		c. Telephone Number (give area code) (714) 300-0600
d. Signature of Authorized Representative <i>Lorri Galloway</i>		e. Date Signed 10/11/2011

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		2. DATE SUBMITTED 10/12/11	Applicant Identifier
Pre-application <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

6. APPLICANT INFORMATION		Organizational Unit:	
Legal Name: American Family Housing		Department: Not Applicable	
Organizational DUNS: 188406474		Division: Not Applicable	
Address: Street: 15161 Jackson Street		Name and telephone number of person to be contacted on matters involving this application (give area code)	
City: Midway City		Prefix: Mr.	First Name: Scott
County: Orange		Middle Name: Montgomery	
State: CA		Last Name: Mather	
Zip Code: 92655		Suffix:	
Country: United States		Email: sctmather@yahoo.com	

RECEIVED
 OCT 12 2011
 STATE CLEARING HOUSE

6. EMPLOYER IDENTIFICATION NUMBER (EIN): 33-0071782		Phone Number (give area code) (714) 897-3221 ext 126	Fax Number (give area code) (714) 893-8858
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> 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. Other (specify)	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE (Name of Program): Supportive Housing Program		9. NAME OF FEDERAL AGENCY: Housing and Urban Development	

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Orange County, California		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: American Family Housing Permanent Housing Collaborative is a permanent housing program with supportive services to assist formerly homeless families with children in maintaining their housing stability.	
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13. PROPOSED PROJECT Start Date: 1/1/2013 Ending Date: 12/31/2013		14. CONGRESSIONAL DISTRICTS OF: a. Applicant 48th b. Project 46th, 47th	
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15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 315,478 ⁰⁰	a. Yes. <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:	
b. Applicant	\$ 60,875 ⁰⁰	b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372	
c. State	\$ ⁰⁰	<input checked="" type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
d. Local	\$ ⁰⁰	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
e. Other	\$ ⁰⁰	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No	
f. Program Income	\$ ⁰⁰		
g. TOTAL	\$ 376,353 ⁰⁰		

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		c. Telephone Number (give area code) (714) 897-3221 ext 109	
Prefix: Mr.	First Name: Robert	e. Date Signed: October 11, 2011	
Last Name: Murphy			
b. Title: General Manager			
d. Signature of Authorized Representative: <i>Robert Murphy</i>			

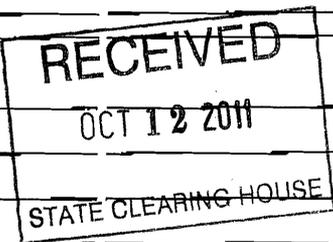
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APPLICATION FOR FEDERAL ASSISTANCE

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		2. DATE SUBMITTED 10/12/11	Applicant Identifier
Pre-application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: American Family Housing	Organizational Unit: Department: Not Applicable
Organizational DUNS: 188406474	Division: Not Applicable
Address: Street: 15181 Jackson Street	Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Mr. First Name: Scott
City: Midway City	
County: Orange	Middle Name: Montgomery
State: CA	Last Name: Mather
Zip Code: 92655	Suffix:
Country: United States	Email: smather@afhusa.org



6. EMPLOYER IDENTIFICATION NUMBER (EIN): 33-0071782	Phone Number (give area code) (714) 897-3221 ext 115	Fax Number (give area code) (714) 893-8858
---	---	---

8. TYPE OF APPLICATION: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> 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. Other (specify)
---	--

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 14-235 TITLE (Name of Program): Supportive Housing Program	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: American Family Housing Haven is a transitional housing program assisting and supporting chronic homeless individuals transition into more permanent housing.
--	---

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Orange County, California	9. NAME OF FEDERAL AGENCY: Housing and Urban Development
---	--

13. PROPOSED PROJECT Start Date: 11/1/2012 Ending Date: 10/31/2013	14. CONGRESSIONAL DISTRICTS OF: a. Applicant 48th b. Project 40th
---	--

15. ESTIMATED FUNDING:	16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal \$ 419,882 ⁰⁰	a. Yes <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:
b. Applicant \$ 68,555 ⁰⁰	b. No <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372
c. State \$ ⁰⁰	<input checked="" type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
d. Local \$ ⁰⁰	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
e. Other \$ ⁰⁰	<input type="checkbox"/> Yes if "Yes" attach an explanation. <input checked="" type="checkbox"/> No
f. Program Income \$ ⁰⁰	
g. TOTAL \$ 488,217 ⁰⁰	

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 Robert	Middle Name
Last Name Murphy		Suffix
b. Title General Manager		c. Telephone Number (give area code) (714) 897-3221 ext 109
d. Signature of Authorized Representative 		e. Date Signed October 11, 2011

APPLICATION FOR FEDERAL ASSISTANCE

CMB Approved No. 3076-0096

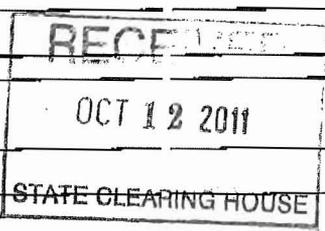
Version 7/02

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		2. DATE SUBMITTED 10/12/11	Applicant Identifier		
3. DATE RECEIVED BY STATE		State Application Identifier			
4. DATE RECEIVED BY FEDERAL AGENCY		Federal Identifier			
5. APPLICANT INFORMATION Legal Name: The John Henry Foundation		Organizational Unit: Department:			
Organizational DUNS: 02638327a		Division:			
Address: Street: 409 North Susan Street		RECEIVED OCT 12 2011 STATE CLEARING HOUSE			
City: Santa Ana				Name and telephone number of person to be contacted on matters involving this application (give area code): Prefix: First Name: Scott	
County: Orange				Middle Name: Montgomery	
State: California		Last Name: Mather			
Zip Code: 92703		Suffix:			
Country: United States		Email: scimather@yahoo.com			
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 93-0399548		Phone Number (give area code): 714 642-2680			
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> 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) 0 Other (specify)			
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 14-235		9. NAME OF FEDERAL AGENCY: Housing and Urban Renewal			
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Santa Ana Orange County United States		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: The John Henry Foundation Sattered Site Permanent Housing Project			
13. PROPOSED PROJECT Start Date: 5/01/2012 Ending Date: 4/30/2013		14. CONGRESSIONAL DISTRICTS OF: a. Applicant CA-048 CA-047 b. Project CA-048 CA-047			
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?			
a. Federal	\$ 146,369	a. Yes. <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:			
b. Applicant	\$ 35,000	b. No. <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372			
c. State	\$	<input checked="" type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW			
d. Local	\$	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?			
e. Other	\$	<input type="checkbox"/> Yes if "Yes" attach an explanation. <input checked="" type="checkbox"/> No			
f. Program Income	\$	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.			
g. TOTAL	\$ 181,369	a. Authorized Representative Prefix: First Name: Terrence Middle Name: Last Name: Kennedy Suffix:			
b. Title Chair, Board of Trustees		c. Telephone Number (give area code): 714 584-8906			
d. Signature of Authorized Representative		e. Date Signed: October 11, 2011			

APPLICATION FOR FEDERAL ASSISTANCE

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED 10/12/11	Applicant Identifier
<input type="checkbox"/> Construction	<input type="checkbox"/> Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
	<input type="checkbox"/> Non-Construction		

6. APPLICANT INFORMATION		Organizational Unit:	
Legal Name: American Family Housing		Department: Not Applicable	
Organizational DUNS: 188408474		Division: Not Applicable	
Address:		Name and telephone number of person to be contacted on matters involving this application (give area code)	
Street: 15161 Jackson Street		Prefix: Mr.	First Name: Scott
City: Midway City		Middle Name: Montgomery	
County: Orange		Last Name: Mather	
State: CA	Zip Code: 92655	Suffix:	
Country: United States		Email: scmather@yahoo.com	



6. EMPLOYER IDENTIFICATION NUMBER (EIN): 33-0071782		Phone Number (give area code) (714) 897-3221 ext 126	Fax Number (give area code) (714) 893-6858
---	--	---	---

8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> 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. Other (specify)
---	--

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 14-235 TITLE (Name of Program): Supportive Housing Program	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: American Family Housing Collaborative is a transitional housing program with supportive services to assist homeless families with children and unaccompanied adults to become self-sufficient.
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Orange County, California	9. NAME OF FEDERAL AGENCY: Housing and Urban Development

13. PROPOSED PROJECT Start Date: 1/1/2013 Ending Date: 12/31/2013	14. CONGRESSIONAL DISTRICTS OF: a. Applicant 48th b. Project 40th, 46th, 48th
--	--

16. ESTIMATED FUNDING:	16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal \$ 286,276.00	a. Yes. <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:
b. Applicant \$ 52,963.00	b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372
c. State \$.00	<input checked="" type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
d. Local \$.00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
e. Other \$.00	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No
f. Program Income \$.00	
g. TOTAL \$ 339,239.00	

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		b. Telephone Number (give area code) (714) 897-3221 ext 109	
Prefix: Mr.	First Name: Robert	Middle Name:	
Last Name: Murphy		Suffix:	
b. Title General Manager		c. Date Signed October 11, 2011	
d. Signature of Authorized Representative <i>[Signature]</i>			

OMB Number: 4040-0004
Expiration Date: 04/31/2012

Application for Federal Assistance SF-424		Version 02
*1. Type of Submission		*2. Type of Application
<input type="checkbox"/> Preapplication	<input type="checkbox"/> New	*If Revision, select appropriate letter(s):
<input checked="" type="checkbox"/> Application	<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application	<input type="checkbox"/> Revision	
*3. Date Received:	4. Application Identifier: CA16B700126	RECEIVED OCT 12 2011
5a. Federal Entity Identifier: CA7231	*5b. Federal Award Identifier: CA0385B9D001003	STATE CLEARING HOUSE
State Use Only:		
6. Date Received by State:	7. State Application Identifier:	
8. APPLICANT INFORMATION:		
* a. Legal Name: Jewish Family Service of Los Angeles		
* b. Employer/Taxpayer Identification Number (EIN/TIN): 951691013	*c. Organizational DUNS: 11379076	
d. Address:		
*Street 1: 3580 Wilshire Blvd. #700		
Street 2:		
*City: Los Angeles		
County: Los Angeles		
*State: CA		
Province:		
Country: USA		*Zip/ Postal Code: 90010
e. Organizational Unit:		
Department Name: Shelter Services		Division Name: Gramercy Place Shelter
f. Name and contact information of person to be contacted on matters involving this application:		
Prefix:	First Name: Paul	
Middle Name: S.		
*Last Name: Castro		
Suffix:		
Title: Chief Executive Officer		
Organizational Affiliation:		
*Telephone Number: 323-761-8800		Fax Number: 323-761-8801
*Email: pscastro@jfsla.org		

OMB Number: 4040-0004
Expiration Date: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*Other (specify):

*10. Name of Federal Agency:

Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.235

CFDA Title:

Continuum of Care Homeless Assistance Competition

*12. Funding Opportunity Number: FR-5500-N-34

*Title: Continuum of Care Homeless Assistance Competition

13. Competition Identification Number: CoC-01

Title:

2011 SuperNOFA Continuum of Care Homeless Assistance Competition

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

Los Angeles County

*15. Descriptive Title of Applicant's Project:

Gramercy Place Shelter - transitional shelter and services for homeless families

Attach supporting documents as specified in agency instructions.

OMB Number: 4040-0004
Expiration Date: 04/31/2012

Application for Federal Assistance SF-424		Version 02
16. Congressional Districts Of:		
*a. Applicant 33	*b. Program/Project: CA-4, CA-10, CA-24, CA-48	
Attach an additional list of Program/Project Congressional Districts if needed.		
17. Proposed Project:		
*a. Start Date: 7/1/2012	*b. End Date: 6/30/2013	
18. Estimated Funding (\$):		
*a. Federal	\$394,495.00	
*b. Applicant	\$150,000.00	
*c. State	\$50,000.00	
*d. Local	\$83,000.00	
*e. Other	\$0.00	
*f. Program Income	\$0.00	
*g. TOTAL	\$677,495.00	
*19. Is Application Subject to Review By State Under Executive Order 12372 Process?		
<input checked="" type="checkbox"/> a. This application was made available to the State under the Executive Order 12372 Process for review on 10/11/2011 <input type="checkbox"/> b. Program is subject to E.O. 12372 but has not been selected by the State for review. <input type="checkbox"/> c. Program is not covered by E.O. 12372		
*20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)		
<input checked="" type="checkbox"/> **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: Paul	
Middle Name: S.		
*Last Name: Castro		
Suffix:		
*Title: Chief Executive Officer		
*Telephone Number: 323-761-8800	Fax Number: 323-761-8801	
*Email: pscastro@jfla.org		
*Signature of Authorized Representative: <i>Jane For-Delaney</i> <i>for Paul S. Castro</i>		Date Signed: <i>10/12/2011</i>

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approval No. 0348-0043

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		2. DATE SUBMITTED October 13, 2011	Applicant Identifier
Preapplication <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction		3. DATE RECEIVED BY STATE	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: Los Angeles County Dept. of Public Works	Organizational Unit: Transit Operations
--	---

Address (give city, county, State, and zip code): 900 S. Fremont Avenue Alhambra, CA 91803	Name and telephone number of person to be contacted on matters involving this application (give area code): Renato P. Reyes (626) 458-3932
--	--

6. EMPLOYER IDENTIFICATION NUMBER (EIN): 95 - 6000927	7. TYPE OF APPLICANT: (enter appropriate letter in box) B
---	--

8. TYPE OF APPLICATION: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) <input type="checkbox"/> <input type="checkbox"/> A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration Other (specify): _____	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) _____
--	---

9. NAME OF FEDERAL AGENCY: Federal Transportation Administration
--

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 20 - 507 TITLE: _____	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Purchase of 2 CNG-powered Transit Style Buses for use in the unincorporated Los Angeles County area of South Whittier, California.
---	--

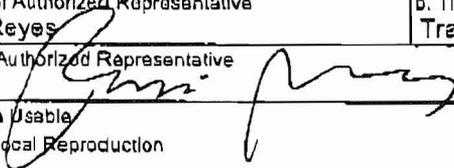
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Los Angeles County
--

13. PROPOSED PROJECT	14. CONGRESSIONAL DISTRICTS OF:
-----------------------------	--

Start Date: 6/13/11 Ending Date: 8/30/13	a. Applicant: L. A. County Dept. of Public Works	b. Project: Purchase of 2 CNG-powered Transit Style Buses
---	--	---

15. ESTIMATED FUNDING:		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 10/13/11 b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372 <input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
a. Federal	\$ 569,000 ⁰⁰	
b. Applicant	\$ 256,000 ⁰⁰	
c. State	\$ ⁰⁰	
d. Local	\$ ⁰⁰	
e. Other	\$ ⁰⁰	
f. Program Income	\$ ⁰⁰	
g. TOTAL		17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? <input type="checkbox"/> Yes If "Yes," attach an explanation. <input checked="" type="checkbox"/> 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 Renato P. Reyes	b. Title Transit Program Specialist	c. Telephone Number (626) 458-3932
d. Signature of Authorized Representative 		e. Date Signed 10-13-2011

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0006

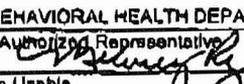
Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED October 28, 2011		Applicant Identifier	
<input type="checkbox"/> Construction		<input type="checkbox"/> Construction		3. DATE RECEIVED BY STATE	
<input checked="" type="checkbox"/> Non-Construction		<input type="checkbox"/> Non-Construction		State Application Identifier	
5. APPLICANT INFORMATION		4. DATE RECEIVED BY FEDERAL AGENCY		Federal Identifier	
Legal Name: VENTURA COUNTY		RECEIVED OCT 13 2011		Organizational Unit: Department: BEHAVIORAL HEALTH	
Organizational DUNS: 068891122				Division: MENTAL HEALTH	
Address: Street: 1911 Williams Dr.		STATE CLEARING HOUSE		Name and telephone number of person to be contacted on matters involving this application (give area code)	
City: OXNARD				Prefix: Ms.	
County: VENTURA				First Name: CAROLYN	
State: CA		Zip Code 93036		Middle Name	
Country: USA				Last Name BRIGGS	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 95-6000944		6. EMPLOYER IDENTIFICATION NUMBER (EIN):		Email: Carolyn.Briggs@ventura.org	
7. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)		7. TYPE OF APPLICANT: (See back of form for Application Types) COUNTY Other (specify)		Phone Number (give area code) (805) 981-3300	
Other (specify)				Fax Number (give area code) (805) 981-2112	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE (Name of Program): Labor Management Cooperation Program		10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 14-238		9. NAME OF FEDERAL AGENCY: DEPT. OF HOUSING AND URBAN DEVELOPMENT (HUD)	
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): CITY OF OXNARD		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Shelter Plus Care will provide the necessary services to chronically homeless severely mentally ill persons to achieve stability in housing; maintain participation in mental health and medical treatment; decrease recidivism to jail and inpatient hospitals; and improve their quality of life.			
13. PROPOSED PROJECT Start Date: October 1, 2012		13. PROPOSED PROJECT Ending Date: September 30, 2013		14. CONGRESSIONAL DISTRICTS OF: a. Applicant 24th District	
15. ESTIMATED FUNDING:		15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal S+C TRA \$ 214,608		a. Federal S+C TRA \$ 214,608		a. Yes. <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON	
b. Applicant \$		b. Applicant \$		DATE:	
c. State \$		c. State \$		b. No. <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372	
d. Local \$		d. Local \$		<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
e. Other \$		e. Other \$		17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
f. Program Income \$		f. Program Income \$		<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No	
g. TOTAL \$ 214,608		g. TOTAL \$ 214,608			
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		a. Authorized Representative		b. Title DIRECTOR, BEHAVIORAL HEALTH DEPARTMENT	
Prefix Ms.		First Name MELONEY		Middle Name	
Last Name ROY, LCSW				Suffix	
c. Telephone Number (give area code) (805) 981-2214		c. Telephone Number (give area code) (805) 981-2214		d. Signature of Authorized Representative	
e. Date Signed 10.12.11		e. Date Signed 10.12.11			

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		2. DATE SUBMITTED October 28, 2011	Applicant Identifier
<input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction	3. DATE RECEIVED BY STATE	State Application Identifier
5. APPLICANT INFORMATION		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
Legal Name: VENTURA COUNTY		Organizational Unit: Department: BEHAVIORAL HEALTH	
Organizational DUNS: 066891122		Division: MENTAL HEALTH	
Address: Street: 1911 Williams Dr.		Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Ms. First Name: CAROLYN	
City: OXNARD		Middle Name	
County: VENTURA		Last Name BRIGGS	
State: CA	Zip Code 93038	Suffix:	
Country: USA		Email: Carolyn.Briggs@ventura.org	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 95-8000944		Phone Number (give area code) (805) 981-3300	Fax Number (give area code) (805) 981-2112
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)		7. TYPE OF APPLICANT: (See back of form for Application Types) COUNTY Other (specify)	
Other (specify)		9. NAME OF FEDERAL AGENCY: DEPT. OF HOUSING AND URBAN DEVELOPMENT (HUD)	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 14-238 TITLE (Name of Program): Labor Management Cooperation Program		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Shelter Plus Care will provide the necessary services to chronically homeless severely mentally ill persons to achieve stability in housing; maintain participation in mental health and medical treatment; decrease recidivism to jail and inpatient hospitals; and improve their quality of life.	
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): CITIES OF THOUSAND OAKS & SIMI VALLEY		14. CONGRESSIONAL DISTRICTS OF: a. Applicant 24th District	
13. PROPOSED PROJECT Start Date: September 4, 2012		b. Project	
Ending Date: September 3, 2013		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS? a. Yes. <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: b. No. <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372 <input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
16. ESTIMATED FUNDING:		17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? <input type="checkbox"/> Yes if "Yes" attach an explanation. <input checked="" type="checkbox"/> No	
a. Federal S+C TRA	\$ 43,200.00		
b. Applicant	\$.00		
c. State	\$.00		
d. Local	\$.00		
e. Other	\$.00		
f. Program Income	\$.00		
g. TOTAL	\$ 43,200.00		
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 MELONEY	Middle Name	
Last Name ROY, LCSW		Suffix	
b. Title DIRECTOR, BEHAVIORAL HEALTH DEPARTMENT		c. Telephone Number (give area code) (805) 981-2214	
d. Signature of Authorized Representative 		e. Date Signed 10.12.11	

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 30-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED 10/13/2011	Applicant Identifier
<input type="checkbox"/> Construction	<input type="checkbox"/> Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier
	<input type="checkbox"/> Non-Construction		CA0583B8D011003
5. APPLICANT INFORMATION			
Legal Name: Regional Task Force on the Homeless, Inc.		Organizational Unit: Department: HMIS	
Organizational DUNS: 927230565		Division:	
Address: Street: 4689 Murphy Canyon Road		Name and telephone number of person to be contacted on matters involving this application (give area code): Prefix: Peter First Name: Peter	
City: San Diego		Middle Name	
County: San Diego		Last Name Callstrom	
State: CA	Zip Code 92123	Suffix:	
Country:		Email: Peter.Callstrom@rtfhsd.org	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 11-3729099		Phone Number (give area code) (858) 292-1392	Fax Number (give area code) (858) 292-7989
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision (If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)		7. TYPE OF APPLICANT: (See back of form for Application Types) O - Not for Profit Organization Other (specify)	
Other (specify)		9. NAME OF FEDERAL AGENCY: Department of Housing and Urban Development (HUD)	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 14-235		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: HMIS San Diego	
TITLE (Name of Program): Supporting Housing Program (SHP)			
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): City of San Diego			
13. PROPOSED PROJECT Start Date: 11/01/2012 Ending Date: 10/31/2013		14. CONGRESSIONAL DISTRICTS OF: a. Applicant CA-049,050,051,052,053 b. Project CA-059	
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 108,915 ⁰⁰	a. Yes. <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 10/17/2011	
b. Applicant	\$ ⁰⁰	b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372	
c. State	\$ ⁰⁰	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
d. Local	\$ 27,500 ⁰⁰		
e. Other	\$ ⁰⁰		
f. Program Income	\$ ⁰⁰	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
g. TOTAL	\$ 136,415 ⁰⁰	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> 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 Peter	Middle Name	
Last Name Callstrom	Suffix		
b. Title Executive Director	c. Telephone Number (give area code) (858) 292-1392		
d. Signature of Authorized Representative	e. Date Signed 10/13/11		

RECEIVED
 OCT 13 2011
 STATE CLEARING HOUSE
 STATE CLEARING HOUSE

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 30.r-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED 10/13/2011	Applicant Identifier
<input type="checkbox"/> Construction	<input type="checkbox"/> Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier CA0702B8D101003
<input type="checkbox"/> Non-Construction	<input type="checkbox"/> Pre-application		
5. APPLICANT INFORMATION			
Legal Name: Regional Task Force on the Homeless, Inc.		Organizational Unit: Department: HMIS	
Organizational DUNS: 927230565		Division:	
Address: Street: 4699 Murphy Canyon Road		Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Peter First Name: Peter	
City: San Diego		Middle Name	
County: San Diego		Last Name Callstrom	
State: CA	Zip Code 92123	Suffix:	
Country:		Email: Peter.Callstrom@rtfhsd.org	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 11-3729093		Phone Number (give area code) (858) 292-1392	Fax Number (give area code) (858) 292-7969
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)		7. TYPE OF APPLICANT: (See back of form for Application Types) <input type="checkbox"/> Not for Profit Organization Other (specify)	
Other (specify)		9. NAME OF FEDERAL AGENCY: Department of Housing and Urban Development (HUD)	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE (Name of Program): Supporting Housing Program (SHP)		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: HMIS San Diego Co. Expansion	
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): County of San Diego			
13. PROPOSED PROJECT Start Date: 11/01/2012 Ending Date: 10/31/2013		14. CONGRESSIONAL DISTRICTS OF: a. Applicant CA-049,050,051,052,053 b. Project CA-049,050,051,052,053	
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 222,007 ⁰⁰	a. Yes <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 10/17/2011	
b. Applicant	\$ ⁰⁰	b. No <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372	
c. State	\$ ⁰⁰	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
d. Local	\$ 69,082 ⁰⁰		
e. Other	\$ ⁰⁰		
f. Program Income	\$ ⁰⁰	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
g. TOTAL	\$ 291,089 ⁰⁰	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> 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 Peter	Middle Name	
Last Name Callstrom	Suffix		
b. Title Executive Director	c. Telephone Number (give area code) (858) 292-1392		
d. Signature of Authorized Representative	e. Date Signed 10/13/11		

RECEIVED
RECEIVED
OCT 13 2011
STATE CLEARING HOUSE
STATE CLEARING HOUSE

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3070-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED 10/13/2011	Applicant Identifier
<input type="checkbox"/> Construction	<input type="checkbox"/> Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier CA0701B9D101003
<input type="checkbox"/> Non-Construction	<input type="checkbox"/> Pre-application		
5. APPLICANT INFORMATION			
Legal Name: Regional Task Force on the Homeless, Inc.		Organizational Unit: Department: HMIS	
Organizational DUNS: 927290565		Division:	
Address: Street: 4699 Murphy Canyon Road		Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Peter First Name: Peter	
City: San Diego		Middle Name	
County: San Diego		Last Name Callstrom	
State: CA	Zip Code 92123	Suffix:	
Country:		Email: Peter.Callstrom@rtfhed.org	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 11-3723093		Phone Number (give area code) (658) 292-1392	Fax Number (give area code) (658) 292-7989
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) Other (specify) <input type="checkbox"/> <input type="checkbox"/>		7. TYPE OF APPLICANT: (See back of form for Application Types) <input type="checkbox"/> O - Not for Profit Organization Other (specify)	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE (Name of Program): Supporting Housing Program (SHP)		9. NAME OF FEDERAL AGENCY: Department of Housing and Urban Development (HUD)	
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): County of San Diego		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: HMIS San Diego Co.	
13. PROPOSED PROJECT Start Date: 11/01/2012 Ending Date: 10/31/2013		14. CONGRESSIONAL DISTRICTS OF: a. Applicant CA-049,050,051,052,053 b. Project CA-049,050,051,052,053	
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 89,796 ⁰⁰	a. Yes. <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE: 10/17/2011	
b. Applicant	\$ ⁰⁰	b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372	
c. State	\$ ⁰⁰	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
d. Local	\$ 24,928 ⁰⁰	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
e. Other	\$ ⁰⁰	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No	
f. Program Income	\$ ⁰⁰		
g. TOTAL	\$ 114,726 ⁰⁰		
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 Peter	Middle Name	
Last Name Callstrom			Suffix
b. Title Executive Director		c. Telephone Number (give area code) (658) 292-1392	
d. Signature of Authorized Representative		e. Date Signed 10/13/11	

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	Not applicable
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	Not applicable
*3. Date Received: N/A		4. Application 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: Family Supportive Housing, Inc.	
* b. Employer/Taxpayer Identification Number (EIN/TIN): 77-0106237	*c. Organizational DUNS: 194923066

d. Address:

*Street1: 1590 Las Plumas Avenue	
Street 2:	
*City: San Jose	
County: Santa Clara	
*State: CA	
Province:	
Country: USA	*Zip/ Postal Code: 95133

e. Organizational Unit:

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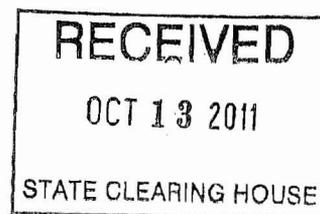
f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Ms.	First Name: Patricia (Trish)
Middle Name: Anne	
*Last Name: Crowder	
Suffix:	
Title: Transitional Housing for Families # 1	

Organizational Affiliation:

*Telephone Number: 408-926-8885	Fax Number: 408-254-2056
---------------------------------	--------------------------

*Email: trish.crowder@familysupportivehousing.org



Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: N. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5341-N-01.

*Title: Continuum of Care (CoC) Homeless Assistance Programs.

13. Competition Identification Number:

Title:

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

San Jose, California

*15. Descriptive Title of Applicant's Project:

Transitional Housing for Families # 1

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of: 16th

*a. Applicant 16 th

*b. Program/Project: 16th

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

17. Proposed Project: Transitional Housing for Families

*a. Start Date: 8/1/2012

*b. End Date: 7/31/2012

18. Estimated Funding (\$):

*a. Federal \$201,927.00

*b. Applicant \$18,658.00

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$220,585.00

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

a. This application was made available to the State under the Executive Order 12372 Process for review on

b. Program is subject to E.O. 12372 but has not been selected by the State for review.

c. Program is not covered by E.O. 12372

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

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: Anne

*Last Name: Crowder

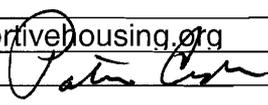
Suffix:

*Title: Executive Director

*Telephone Number: 408-926-8885

Fax Number: 408-254-2056

*Email: trish.crowder@familysupportivehousing.org

*Signature of Authorized Representative: 

Date Signed: 10/04/2011

Application for Federal Assistance SF-424

Version 02

<p>*1. Type of Submission</p> <p><input type="checkbox"/> Preapplication</p> <p><input checked="" type="checkbox"/> Application</p> <p><input type="checkbox"/> Changed/Corrected Application</p>	<p>*2. Type of Application</p> <p><input type="checkbox"/> New</p> <p><input checked="" type="checkbox"/> Continuation</p> <p><input type="checkbox"/> Revision</p>	<p>*If Revision, select appropriate letter(s):</p> <p>Not applicable</p> <p>* Other (Specify)</p> <p>Not applicable</p>
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<p>*3. Date Received: N/A</p>	<p>4. Application Identifier:</p>
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<p>5a. Federal Entity Identifier:</p>	<p>*5b. Federal Award Identifier:</p>
---------------------------------------	---------------------------------------

State Use Only:

<p>6. Date Received by State:</p>	<p>7. State Application Identifier:</p>
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8. APPLICANT INFORMATION:

* a. Legal Name: Family Supportive Housing, Inc.

<p>* b. Employer/Taxpayer Identification Number (EIN/TIN): 77-0106237</p>	<p>*c. Organizational DUNS:</p>
---	---------------------------------

d. Address:

*Street1: 1590 Las Plumas Avenue
 Street 2:
 *City: San Jose
 County: Santa Clara
 *State: CA
 Province:
 Country: USA *Zip/ Postal Code: 95133

e. Organizational Unit:

<p>Department Name:</p>	<p>Division Name:</p>
-------------------------	-----------------------

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

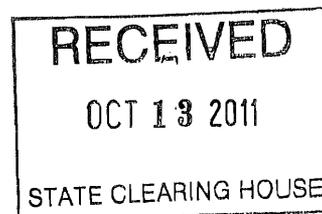
Prefix: Ms. First Name: Patricia (Trish)
 Middle Name: Anne
 *Last Name: Crowder
 Suffix:

Title: Transitional housing for Families # 2

Organizational Affiliation:

*Telephone Number: 408-926-8885 Fax Number: 408-254-2056

*Email: trish.crowder@familysupportivehousing.org



Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: N. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5341-N-01.

*Title:

Continuum of Care (CoC) Homeless Assistance Programs.

13. Competition Identification Number:

Title:

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

San Jose, California

*15. Descriptive Title of Applicant's Project:

Transitional Housing for Families # 2

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of: 16th

*a. Applicant 16th

*b. Program/Project: 16th

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

17. Proposed Project: Transitional Housing for Families # 2

*a. Start Date: 8/1/2012

*b. End Date: 7/31/2012

18. Estimated Funding (\$):

*a. Federal	\$211,231.00
*b. Applicant	\$18,658.00
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	\$229,889.00

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

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

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

- 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: Anne

*Last Name: Crowder

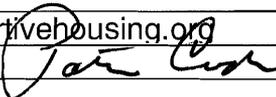
Suffix:

*Title: Executive Director

*Telephone Number: 408-926-8885

Fax Number: 408-254-2056

*Email: trish.crowder@familysupportivehousing.org

*Signature of Authorized Representative: 

Date Signed: 10/04/2011

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	*2. Type of Application <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision	*If Revision, select appropriate letter(s): Not applicable * Other (Specify) Not applicable
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*3. Date Received: N/A	4. Application Identifier:
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5a. Federal Entity Identifier:	*5b. Federal Award Identifier:
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State Use Only:

6. Date Received by State:	7. State Application Identifier:
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8. APPLICANT INFORMATION:

* a. Legal Name: Family Supportive Housing, Inc.

* b. Employer/Taxpayer Identification Number (EIN/TIN): 77-0106237	*c. Organizational DUNS:
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d. Address:

*Street1: 1590 Las Plumas Avenue
Street 2:
*City: San Jose
County: Santa Clara
*State: CA
Province:
Country: USA *Zip/ Postal Code: 95133

e. Organizational Unit:

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

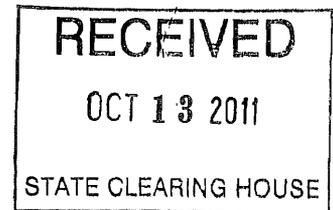
Prefix: Ms. First Name: Patricia (Trish)
Middle Name: Anne
*Last Name: Crowder
Suffix:

Title: Transitional housing for Families

Organizational Affiliation:

*Telephone Number: 408-926-8885 Fax Number: 408-254-2056

*Email: trish.crowder@familysupportivehousing.org



Application for Federal Assistance SF-424

Version 02

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

Type of Applicant 2: Select Applicant Type:
- Select One -

Type of Applicant 3: Select Applicant Type:
- Select One -

*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-5341-N-01.**

*Title:
Continuum of Care (CoC) Homeless Assistance Programs.

13. Competition Identification Number:

Title:

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

San Jose, California

*15. Descriptive Title of Applicant's Project:

Transitional Housing for Families

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of: 16th

*a. Applicant 16 th

*b. Program/Project: 16th

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

17. Proposed Project: Transitional Housing for Families # 4

*a. Start Date: 8/1/2012

*b. End Date: 7/31/2012

18. Estimated Funding (\$):

*a. Federal	\$46,036.00
*b. Applicant	\$4,074.00
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	\$50,110.00

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

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

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

- 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: Anne

*Last Name: Crowder

Suffix:

*Title: Executive Director

*Telephone Number: 408-926-8885

Fax Number: 408-254-2056

*Email: trish.crowder@familysupportivehousing.org

*Signature of Authorized Representative: *Patricia Crowder*

Date Signed: October 4, 2011

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	*2. Type of Application <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision	*If Revision, select appropriate letter(s): Not applicable * Other (Specify) Not applicable
--	--	--

*3. Date Received: N/A	4. Application 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: Family Supportive Housing, Inc.

* b. Employer/Taxpayer Identification Number (EIN/TIN): 77-0106237	*c. Organizational DUNS:
---	--------------------------

d. Address:

*Street1: 1590 Las Plumas Avenue
Street 2:
*City: San Jose
County: Santa Clara
*State: CA
Province:
Country: USA *Zip/ Postal Code: 95133

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: Patricia (Trish)
Middle Name: Anne
*Last Name: Crowder
Suffix:

Title: Transitional Housing for Families # 3

Organizational Affiliation:

*Telephone Number: 408-926-8885 Fax Number: 408-254-2056

*Email: trish.crowder@familysupportivehousing.org



Application for Federal Assistance SF-424

Version 02

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

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5341-N-01.**

*Title: **Continuum of Care (CoC) Homeless Assistance Programs.**

13. Competition Identification Number:

Title:

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

San Jose, California

*15. Descriptive Title of Applicant's Project:

Transitional Housing for Families # 3

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of: 16th
 *a. Applicant 16 th *b. Program/Project: 16th

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

17. Proposed Project: Transitional Housing for Families # 3
 *a. Start Date: 8/1/2012 *b. End Date: 7/31/2012

18. Estimated Funding (\$):

*a. Federal	\$97,368.00
*b. Applicant	\$8,856.00
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	\$106,224.00

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

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

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

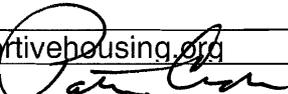
21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept 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: Anne
 *Last Name: Crowder
 Suffix:
 *Title: Executive Director

*Telephone Number: 408-926-8885 Fax Number: 408-254-2056
 *Email: trish.crowder@familysupportivehousing.org
 *Signature of Authorized Representative:  Date Signed: October 4, 2011

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED	Applicant Identifier
<input checked="" type="checkbox"/> Construction	<input type="checkbox"/> Pre-application	3. DATE RECEIVED BY STATE 10/13/2011	State Application Identifier
<input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Construction	4. DATE RECEIVED BY FEDERAL AGENCY 10/13/2011	Federal Identifier
<input type="checkbox"/> Non-Construction	<input type="checkbox"/> Pre-application		
5. APPLICANT INFORMATION			
Legal Name: Crisis House, Inc.		Organizational Unit: Department: n/a	
Organizational DUNS: 602940407		Division: n/a	
Address: Street: 1034 N. Magnolia Avenue		Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: First Name: Ron	
City: El Cajon		Middle Name L	
County: San Diego CA		Last Name Miller	
State: California		Suffix:	
Zip Code 92020		Email: AD@crishouse.com	
Country: United States		Phone Number (give area code) 619-444-1194 X316	
		Fax Number (give area code) 619-444-1422	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 33-0217339		7. TYPE OF APPLICANT: (See back of form for Application Types) Not For Profit Other (specify)	
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> 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: Department of Housing & Urban Development (HUD)	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE (Name of Program): Labor Management Cooperation Program		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: SHP Crisis House Disabilities Transitional Housing Project	
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): El Cajon, CA			
13. PROPOSED PROJECT Start Date: 01/01/2012 Ending Date: 12/31/2012		14. CONGRESSIONAL DISTRICTS OF: a. Applicant CA-052 b. Project CA-052	
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 445,011	a. Yes <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON	
b. Applicant	\$ 125,025	DATE:	
c. State	\$	b. No <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372	
d. Local	\$	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
e. Other	\$	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
f. Program Income	\$	<input type="checkbox"/> Yes if "Yes" attach an explanation. <input checked="" type="checkbox"/> No	
g. TOTAL	\$ 570,036		
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 Ron	Middle Name L	
Last Name Miller	Suffix		
b. Title Assistant Director	c. Telephone Number (give area code) 619-444-1194 x316		
d. Signature of Authorized Representative	e. Date Signed 10-13-2011		

RECEIVED
OCT 13 2011
STATE CLEARING HOUSE

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0006

Version 7/03

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		2. DATE SUBMITTED	Applicant Identifier
Pre-application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction		3. DATE RECEIVED BY STATE 10/13/2011	State Application Identifier
		4. DATE RECEIVED BY FEDERAL AGENCY 10/13/2011	Federal Identifier
5. APPLICANT INFORMATION			
Legal Name: Crisis House, Inc		RECEIVED OCT 13 2011	Organizational Unit:
Organizational DUNS: 602840407			Department: n/a
Address: Street: 1034 N. Magnolia Ave.		Name and telephone number of person to be contacted on matters involving this application (give area code)	
City: El Cajon		Prefix:	First Name: Ron
County: San Diego		Middle Name:	L
State: CA		Last Name:	Miller
Zip Code 92020		Suffix:	
Country: United States		Email: AD@crisishouse.com	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 93-0217339		Phone Number (give area code) 619-444-1184 x316	Fax Number (give area code) 619-444-1422
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) Other (specify) <input type="checkbox"/>		7. TYPE OF APPLICANT: (See back of form for Application Types) Not for Profit Other (specify)	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: TITLE (Name of Program): Labor Management Cooperation Program		8. NAME OF FEDERAL AGENCY:	
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): El Cajon, CA		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: SHP Crisis House Domestic Violence Transitional Housing Project	
13. PROPOSED PROJECT Start Date: Ending Date:		14. CONGRESSIONAL DISTRICTS OF: a. Applicant CA-052 b. Project CA-052	
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 189,081 ⁰⁰	a. Yes. <input checked="" type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON	
b. Applicant	\$ 32,503 ⁰⁰	DATE:	
c. State	\$ ⁰⁰	b. No. <input type="checkbox"/> PROGRAM IS NOT COVERED BY E. O. 12372	
d. Local	\$ ⁰⁰	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
e. Other	\$ ⁰⁰	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?	
f. Program Income	\$ ⁰⁰	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input type="checkbox"/> No	
g. TOTAL	\$ 221,584 ⁰⁰		
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 Ron	Middle Name L	
Last Name Miller		Suffix	
b. Title Assistant Director		c. Telephone Number (give area code) 619-444-1184 x316	
d. Signature of Authorized Representative <i>Ron Miller</i>		e. Date Signed 10-13-2011	

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: 04/31/2012

Application for Federal Assistance SF-424		Version 02
*1. Type of Submission <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application		*2. Type of Application <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision
*If Revision, select appropriate letter(s): * Other (Specify)		
*3. Date Received:		4. Application Identifier:
5a. Federal Entity Identifier: 14.235		*5b. Federal Award Identifier: CA0530B9D001003 <div style="border: 1px solid black; padding: 5px; display: inline-block;"> RECEIVED OCT 13 2011 </div>
State Use Only:		STATE CLEARING HOUSE
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 W. 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: Non profit human service organization		
*Telephone Number: 323-299-9273		Fax Number: 323-299-0350
*Email: mbushware@hotmail.com		

OMB Number: 4040-0004
Expiration Date: 04/31/2012

Application for Federal Assistance SF-424

Version 02

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

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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:

SHP

*12. Funding Opportunity Number: **FR-5500-N-34**

*Title:

Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

City of Los Angeles, County of Los Angeles, State of California

*15. Descriptive Title of Applicant's Project:

The California Council for Veterans Affairs, Inc. has provided transitional shelter and supportive services to homeless female veterans with minor children for more than 38 years. Our gender specific program provides educational guidance, housing referrals, parenting skills training, case management for homeless families. All services are provided free of charge.

Attach supporting documents as specified in agency instructions.

OMB Number: 4040-0004
Expiration Date: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

16. Congressional Districts Of: 33rd Congressional District

*a. Applicant: California Council for Veterans Affairs *b. Program/Project: Women and Children First

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

17. Proposed Project:

*a. Start Date: FY2012

*b. End Date: FY2015

18. Estimated Funding (\$):

*a. Federal \$230,210.00

*b. Applicant

*c. State

*d. Local

*e. Other \$40,000.00

*f. Program Income

*g. TOTAL \$270,210.00

***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 14 October 2011
- 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

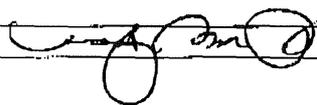
Suffix:

*Title: Executive Director

*Telephone Number: 323-299-9273

Fax Number: 323-299-0350

*Email: mbushware@hotmail.com

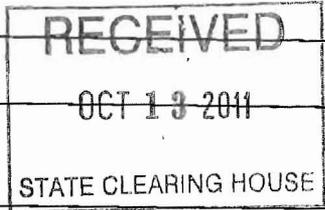
*Signature of Authorized Representative: 

Date Signed: 13 Oct 2011

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application		*If Revision, select appropriate letter(s):	
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New			
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation		* Other (Specify)	
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision			



*3. Date Received:	4. Application Identifier: CA7130
--------------------	--------------------------------------

5a. Federal Entity Identifier:	*5b. Federal Award Identifier: CA0520B9D001003
--------------------------------	---

State Use Only:

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

8. APPLICANT INFORMATION:

* a. Legal Name: United States Veterans Initiative

* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4382752	*c. Organizational DUNS: 829704761
---	---------------------------------------

d. Address:

*Street1: 733 South Hindry Avenue
 Street 2:
 *City: Inglewood
 County: Los Angeles
 *State: California
 Province:
 Country: United States of America *Zip/ Postal Code: 90301

e. Organizational Unit:

Department Name: United States Veterans Initiative	Division Name:
---	----------------

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

Prefix: Ms. First Name: Nicole
 Middle Name:
 *Last Name: Ward
 Suffix:

Title: Regional Operations Coordinator

Organizational Affiliation:

*Telephone Number: 310-348-7600 ext. 3105 Fax Number: 310-645-2605
 *Email: nward@usvetsinc.org

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5500-N-34

*Title: Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

Inglewood, Los Angeles County, California

*15. Descriptive Title of Applicant's Project:

Veterans in Progress Program

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant **35**

*b. Program/Project: **35**

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

17. Proposed Project:

*a. Start Date: **8/1/2012**

*b. End Date: **7/31/2013**

18. Estimated Funding (\$):

*a. Federal **\$289,796.00**

*b. Applicant **\$68,999.00**

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL **\$358,795.00**

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

a. This application was made available to the State under the Executive Order 12372 Process for review on

b. Program is subject to E.O. 12372 but has not been selected by the State for review.

c. Program is not covered by E.O. 12372

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

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: Nicole

Middle Name:

*Last Name: Ward

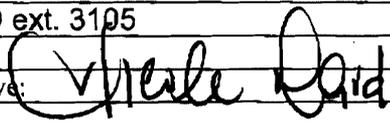
Suffix:

*Title: Regional Operations Coordinator

*Telephone Number: 310-348-7600 ext. 3105

Fax Number: 310-645-2605

*Email: nward@usvetsinc.org

*Signature of Authorized Representative: 

Date Signed: 10/13/2011

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input checked="" type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	
*3. Date Received:		4. Application Identifier:	
5a. Federal Entity Identifier:		*5b. Federal Award Identifier: CA0484B9D001003	
RECEIVED			
		OCT 14 2011	
		STATE CLEARING HOUSE	
State Use Only:			
6. Date Received by State:		7. State Application Identifier:	
8. APPLICANT INFORMATION:			
* a. Legal Name: The Los Angeles Gay and Lesbian Community Services Center			
* b. Employer/Taxpayer Identification Number (EIN/TTN): 95-3567895		*c. Organizational DUNS: 07-723-5034	
d. Address:			
*Street 1: 1625 N. Schrader Boulevard			
Street 2:			
*City: Los Angeles			
County: Los Angeles			
*State: California			
Province:			
Country: USA		*Zip/ Postal Code: 90028-6213	
e. Organizational Unit:			
Department Name: Children, Youth & Family Services		Division Name: Youth Services	
f. Name and contact information of person to be contacted on matters involving this application:			
Prefix: Middle Name: Therese		First Name: Karen	
*Last Name: O'Brien			
Suffix:			
Title: Grants Manager			
Organizational Affiliation: L.A. Gay & Lesbian Center			
*Telephone Number: (323) 993-7634		Fax Number: (323) 308-4014	
*Email: kobrien@laqaycenter.org			

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit Type of Applicant 2: Select Applicant Type: - Select One - Type of Applicant 3: Select Applicant Type: - Select One - *Other (specify):
*10. Name of Federal Agency: · U.S. Department of Housing & Urban Development
11. Catalog of Federal Domestic Assistance Number: 14.235 CFDA Title: Supportive Housing Program
*12. Funding Opportunity Number: FR-5500-N-34 *Title: Continuum of Care Homeless Assistance Competition
13. Competition Identification Number: Title:
14. Areas Affected by Project (Cities, Counties, States, etc.): Los Angeles County
*15. Descriptive Title of Applicant's Project: The Kruks/Tilsner Transitional Living Program offers a 24-bed, 18 months project designed to assist at-risk youth ages 17-25 make the transition from life on the streets to self-supporting, independent living.
Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of: Los Angeles County

*a. Applicant CA-033

*b. Program/Project: CA-033

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

See Attachment

17. Proposed Project:

*a. Start Date: 02/01/2012

*b. End Date: 01/31/2013

18. Estimated Funding (\$):

*a. Federal	\$367,493.00
*b. Applicant	\$225,510.00
*c. State	\$0.00
*d. Local	\$0.00
*e. Other	\$0.00
*f. Program Income	\$0.00
*g. TOTAL	\$593,003.00

***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 10/14/11
- 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: Michael

Middle Name: John

*Last Name: Holtzman

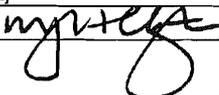
Suffix:

*Title: Chief Financial Officer

*Telephone Number: (323) 993-7615

Fax Number: (323) 308-4425

*Email: mholtzman@lagaycenter.org

*Signature of Authorized Representative: 

Date Signed: 10/14/11

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission:		*2. Type of Application		* If Revision, select appropriate letter(s)
<input checked="" type="checkbox"/> Preapplication	<input checked="" type="checkbox"/> New	<input checked="" type="checkbox"/> Continuation	*Other (Specify)	
<input type="checkbox"/> Application	<input type="checkbox"/> Revision			
<input type="checkbox"/> Changed/Corrected Application				

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 Nevada

*b. Employer/Taxpayer Identification Number (EIN/TIN): 94-6000526	*c. Organizational DUNS: 010979029
---	--

d. Address:

***Street 1:** 950 Majdu Avenue

Street 2: _____

***City:** Nevada City

County: Nevada

***State:** California

Province: _____

***Country:** United States

***Zip / Postal Code** 95959

e. Organizational Unit:

Department Name: CDA-Planning	Division Name: Housing
---	----------------------------------

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

Prefix: Mr. ***First Name:** Kyle

Middle Name: _____

***Last Name:** Thompson

Suffix: _____

Title: Manager

Organizational Affiliation:

***Telephone Number:** 530-265-7256 **Fax Number:** 530-265-9851

***Email:** kyle.thompson@co.nevada.ca.us

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:**

USDA Rural Development, Housing and Community Facilities Program

11. Catalog of Federal Domestic Assistance Number:

10.433

CFDA Title:

Rural Housing Preservation Grants

***12 Funding Opportunity Number:**

USDA-RD-HCFP-HPG-2011

*Title:

Rural Housing Preservation Grants

13. Competition Identification Number:

HPG-2011

Title:

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

Nevada County will use the HPG funds in the unincorporated areas of Nevada County.

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

Low and very low-income single family home rehabilitation grant in the unincorporated areas of Nevada County California

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant: CA 004

*b. Program/Project: CA 004

17. Proposed Project:

*a. Start Date: 10/01/2011

*b. End Date: 09/30/2012

18. Estimated Funding (\$):

*a. Federal	_____	\$ 100,000
*b. Applicant	_____	
*c. State	_____	
*d. Local	_____	\$ 120,000
*e. Other	_____	
*f. Program Income	_____	
*g. TOTAL	_____	\$ 220,000

***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 08/08/11
- 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: Joe _____

Middle Name: _____

*Last Name: Christoffel _____

Suffix: _____

*Title: Deputy County Executive Officer

*Telephone Number: 530-265-7040

Fax Number: 530-265-9851

* Email: ceo.@co.nevada.ca.us

*Signature of Authorized Representative:

*Date Signed:

OMB Number: 4040-0004
Expiration Date: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

*1. Type of Submission		*2. Type of Application		*If Revision, select appropriate letter(s):	
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New			
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation		* Other (Specify)	
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision			
*3. Date Received:		4. Application Identifier: CHOISS SPA 2			
5a. Federal Entity Identifier: 610043135		*5b. Federal Award Identifier:			
		STATE CLEARING HOUSE			
State Use Only:					
6. Date Received by State:			7. State Application Identifier:		
8. APPLICANT INFORMATION:					
* a. Legal Name: Alliance for Housing and Healing dba The Serra Project					
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4147364			*c. Organizational DUNS: 610043135		
d. Address:					
*Street1: 825 Colorado Blvd. Street 2: Suite 100					
*City: Los Angeles County: Los Angeles					
*State: CA Province: Country: USA					
*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					

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*Other (specify):

*10. Name of Federal 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: FR-5500-N-34

*Title: Continuum of Care Homeless Assistance Program

13. Competition Identification Number: CoC-01

Title:

2011 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.

OMB Number: 4040-0004
Expiration Date: 04/31/2012**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

17. Proposed Project:

*a. Start Date: 12/1/12

*b. End Date: 11/30/13

18. Estimated Funding (\$):

*a. Federal \$303,173.00

*b. Applicant \$22,954.00

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$326,127.00

*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 10/14/11
- 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: 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: 

Date Signed: 10/14/11

OMB Number: 4040-0004
Expiration Date: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):	
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	<div style="border: 1px solid black; padding: 5px; text-align: center;"> RECEIVED OCT 14 2011 STATE CLEARING HOUSE </div>	
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation		* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision		
*3. Date Received:		4. Application Identifier: CHOISS SPA 8		
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 dba The Serra Project				
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4147364		*c. Organizational DUNS: 610043135		
d. Address:				
*Street1: 825 Colorado Blvd. Street 2: Suite 100 *City: Los Angeles County: Los Angeles *State: CA Provinc: Country: USA				
		*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. Middle Name:		First Name: Susan		
*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: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*Other (specify):

*10. Name of Federal 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: FR-5500-N-34

*Title: Continuum of Care Homeless Assistance Program

13. Competition Identification Number: CoC-01

Title:

2011 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.

Attach supporting documents as specified in agency instructions.

OMB Number: 4040-0004
Expiration Date: 04/31/2012**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

17. Proposed Project:

*a. Start Date: 1/1/13

*b. End Date: 12/31/13

18. Estimated Funding (\$):

*a. Federal	\$326,848.00
*b. Applicant	\$27,792.00
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	\$354,640.00

***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 10/14/11
- 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.

OMB Number: 4040-0004
Expiration Date: 04/31/2012**Application for Federal Assistance SF-424**

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	
*3. Date Received:		4. Application Identifier: CHOISS SPA 2	
5a. Federal Entity Identifier: 610043135		*5b. Federal Award Identifier:	
RECEIVED OCT 14 2011 STATE CLEARING HOUSE			
State Use Only:			
6. Date Received by State:		7. State Application Identifier:	
8. APPLICANT INFORMATION:			
* a. Legal Name: Alliance for Housing and Healing dba The Serra Project			
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4147364		*c. Organizational DUNS: 610043135	
d. Address:			
*Street1: 825 Colorado Blvd. Street 2: Suite 100 *City: Los Angeles County: Los Angeles *State: CA Province: Country: USA			
*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. Middle Name:		First Name: Susan	
*Last Name: McGinnis Suffix:			
Title: Director of Operations			
Organizational Affiliation:			
*Telephone Number: 323 344-4898		Fax Number: 323 254-2956	
*Email: smcginnis@alliancehh.org			

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*Other (specify):

*10. Name of Federal 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: FR-5500-N-34

*Title: Continuum of Care Homeless Assistance Program

13. Competition Identification Number: CoC-01

Title:

2011 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.

OMB Number: 4040-0004
Expiration Date: 04/31/2012**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

17. Proposed Project:

*a. Start Date: 12/1/12

*b. End Date: 11/30/13

18. Estimated Funding (\$):

*a. Federal \$303,173.00

*b. Applicant \$22,954.00

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$326,127.00

*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 10/14/11
- 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: Terry

Middle Name:

*Last Name: Goddard

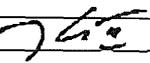
Suffix:

*Title: Executive Director

*Telephone Number: 323 344-4899

Fax Number: 323 254-2956

*Email: tgoddard@alliancehh.org

*Signature of Authorized Representative: 

Date Signed: 10/14/11

OMB Number: 4040-0004
Expiration Date: 04/31/2012

Application for Federal Assistance SF-424		Version 02
*1. Type of Submission		*2. Type of Application
<input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision
		*If Revision, select appropriate letter(s): * Other (Specify)
*3. Date Received:		4. Application Identifier: CHOISS SPA 8
5a. Federal Entity Identifier: 610043135		*5b. Federal Award Identifier: STATE CLEARING HOUSE
State Use Only:		
6. Date Received by State:		7. State Application Identifier:
8. APPLICANT INFORMATION:		
* a. Legal Name: Alliance for Housing and Healing dba The Serra Project		
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4147364		*c. Organizational DUNS: 610043135
d. Address:		
*Street1: 825 Colorado Blvd. Street 2: Suite 100 *City: Los Angeles County: Los Angeles *State: CA Province: Country: USA		
*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. Middle Name:		First Name: Susan
*Last Name: McGinnis Suffix:		
Title: Director of Operations		
Organizational Affiliation:		
*Telephone Number: 323 344-4898		Fax Number: 323 254-2956
*Email: smcginnis@alliancehh.org		

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit
Type of Applicant 2: Select Applicant Type: - Select One -
Type of Applicant 3: Select Applicant Type: - Select One -
*Other (specify):
*10. Name of Federal 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: FR-5500-N-34 *Title: Continuum of Care Homeless Assistance Program
13. Competition Identification Number: CoC-01 Title: 2011 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.
Attach supporting documents as specified in agency instructions.

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

17. Proposed Project:

*a. Start Date: 1/1/13

*b. End Date: 12/31/13

18. Estimated Funding (\$):

*a. Federal \$326,848.00

*b. Applicant \$27,792.00

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$354,640.00

*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 10/14/11 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)

 **1 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

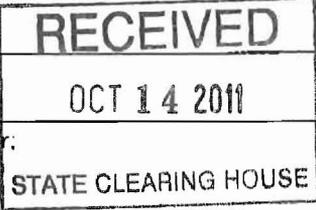
*Signature of Authorized Representative: *TG*

Date Signed: 10/14/11

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application		*2. Type of Application <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision		*If Revision, select appropriate letter(s): * Other (Specify)	
*3. Date Received:			4. Application Identifier:		
Sa. 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: South Central Health & Rehabilitation Program	
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4482413	*c. Organizational DUNS: 077169170
d. Address:	
*Street1: 2610 Industry Way, Suite A	
Street 2:	
*City: Lynwood	
County: Los Angeles	
*State: CA	
Province:	
Country: USA	
*Zip/ Postal Code: 90262	
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: Julie
Middle Name:	
*Last Name: Elder	
Suffix:	
Title: Contract Specialist	
Organizational Affiliation: South Central Health & Rehabilitation Program	
*Telephone Number: 310 631-8004	Fax Number: 310 631-5875
*Email: skvelder1@earthlink.net	

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5030-N-34

*Title: Continuum of Care Homeless Assistance Competition

13. Competition Identification Number:

Title:

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

Los Angeles County

*15. Descriptive Title of Applicant's Project:

Dual Diagnosis Supportive Services Program
Oasis House 5201 S. Vermont Ave. Los Angeles, CA 90037**Attach supporting documents as specified in agency instructions.**

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant

CA-039

*b. Program/Project:

CA-033

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

17. Proposed Project:

*a. Start Date: 2/1/2012

*b. End Date: 1/31/2013

18. Estimated Funding (\$):

*a. Federal	\$224,760.00
*b. Applicant	\$56,190.00
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	\$280,950.00

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

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

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

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: Jack

Middle Name:

*Last Name: Barbour

Suffix: MD

*Title: Co-Director

*Telephone Number: 310 631-8004

Fax Number: 310 631-5875

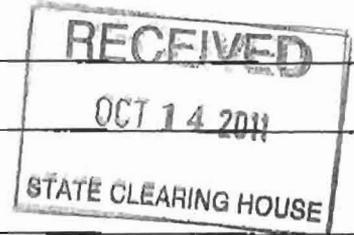
*Email: jmbarbour@earthlink.net

*Signature of Authorized Representative: *Jack Barbour* Date Signed: 10-14-2011

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application		*2. Type of Application <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision		*If Revision, select appropriate letter(s): * Other (Specify)
*3. Date Received: 10/14/2011		4. Application Identifier:		
5a. Federal Entity Identifier:		*5b. Federal Award Identifier: CA0384B9D001003		



State Use Only:

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

& APPLICANT INFORMATION:

* a. Legal Name: Gramercy Housing Group	
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-4396861	*c. Organizational DUNS: 874617103
d. Address: *Street1: 1824 4th Avenue Street 2: *City: Los Angeles County: *State: CA Province: Country: *Zip/ Postal Code: 90019	

e. Organizational Unit:

Department Name: Gramercy Court	Division Name:
---	-----------------------

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

Prefix: Ms. Middle Name:	First Name: Katherine
*Last Name: Hill Suffix:	
Title: Director of Program Development	
Organizational Affiliation: Gramercy Housing Group, PATH	

*Telephone Number: 323-644-2229	Fax Number: 323-644-2288
*Email: katieh@epath.org	

Application for Federal Assistance SF-424

Version 02

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

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5500-N-34**

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

13. Competition Identification Number: **CoC-01**

Title:

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

Los Angeles County, California

*15. Descriptive Title of Applicant's Project:

Supportive Services Program - Gramercy Court

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant **33**

*b. Program/Project: **33**

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

17. Proposed Project:

*a. Start Date: **July 1, 2012**

*b. End Date: **June 30, 2013**

18. Estimated Funding (\$):

*a. Federal	\$210,960.00
*b. Applicant	\$7,223.00
*c. State	\$44,812.00
*d. Local	
*e. Other	\$0.00
*f. Program Income	\$0.00
*g. TOTAL	\$262,995.00

*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 **10/14/2011**
- 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: **Katie**

Middle Name:

*Last Name: **Hill**

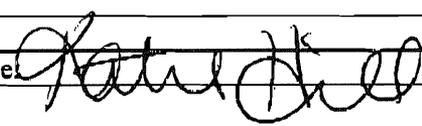
Suffix:

*Title: **Director of Program Development**

*Telephone Number: **323-644-2229**

Fax Number: **323-644-2288**

*Email: **katieh@epath.org**

*Signature of Authorized Representative: 

Date Signed: **10/14/11**

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input checked="" type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	
*3. Date Received:		4. Application Identifier:	
5a. Federal Entity Identifier:		*5b. Federal Award Identifier:	
		STATE CLEARING HOUSE	
State Use Only:			
6. Date Received by State:		7. State Application Identifier:	
8. APPLICANT INFORMATION:			
* a. Legal Name: VETERANS FIRST			
* b. Employer/Taxpayer Identification Number (EIN/TIN): 23-7143157		*c. Organizational DUNS: 153760405	
d. Address:			
*Street1: 1540 East Edinger Avenue			
Street 2: Suite D			
*City: Santa Ana			
County: Orange			
*State: CA			
Province:			
Country: USA		*Zip/ Postal Code: 92705	
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: Deanne	
Middle Name:			
*Last Name: Tate			
Suffix:			
Title: President/CEO			
Organizational Affiliation:			
*Telephone Number: 714-547-0615		Fax Number: 714-547-8678	
*Email: dtate@veteransfirstoc.org			

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5500-N-01

*Title: 2011 Continuum of Care Homeless Assistance Program

13. Competition Identification Number:

Title:

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

Orange County, California

*15. Descriptive Title of Applicant's Project:

Veterans Family Housing

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant 46, 47, 48

*b. Program/Project: 47

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

17. Proposed Project:

*a. Start Date: 01/01/2012

*b. End Date: 12/31/2012

18. Estimated Funding (\$):

*a. Federal \$213,188.00

*b. Applicant

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$213,188.00

***19. Is Application Subject to Review By State Under Executive Order 12372 Process?** a. This application was made available to the State under the Executive Order 12372 Process for review on b. Program is subject to E.O. 12372 but has not been selected by the State for review. c. Program is not covered by E.O. 12372

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

 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: Deanne

Middle Name:

*Last Name: Tate

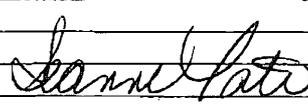
Suffix:

*Title: President/CEO

*Telephone Number: 714-547-0615

Fax Number: 714-547-8678

*Email: dtate@veteransfirstoc.org

*Signature of Authorized Representative: 

Date Signed: 10/14/2011

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	
*3. Date Received:		4. Application Identifier:	
Sa. 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: VETERANS FIRST			
* b. Employer/Taxpayer Identification Number (EIN/TIN): 23-7143157		*c. Organizational DUNS: 153760405	
d. Address:			
*Street1: 1540 East Edinger Avenue			
Street 2: Suite D			
*City: Santa Ana			
County: Orange			
*State: CA			
Province:			
Country: USA		*Zip/ Postal Code: 92705	
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: Deanne	
Middle Name:			
*Last Name: Tate			
Suffix:			
Title: President/CEO			
Organizational Affiliation:			
*Telephone Number: 714-547-0615		Fax Number: 714-547-8678	
*Email: dtate@veteransfirstoc.org			

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5500-N-01

*Title: 2011 Continuum of Care Homeless Assistance Program

13. Competition Identification Number:

Title:

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

Orange County, California

*15. Descriptive Title of Applicant's Project:

Veterans Village 1

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant

46, 47, 48

*b. Program/Project:

40, 46, 47

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

17. Proposed Project:

*a. Start Date: 08/01/2011

*b. End Date: 07/31/2012

18. Estimated Funding (\$):

*a. Federal

\$211,664.00

*b. Applicant

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL

\$211,664.00

***19. Is Application Subject to Review By State Under Executive Order 12372 Process?** a. This application was made available to the State under the Executive Order 12372 Process for review on b. Program is subject to E.O. 12372 but has not been selected by the State for review. c. Program is not covered by E.O. 12372

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

 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: Deanne

Middle Name:

*Last Name: Tate

Suffix:

*Title: President/CEO

*Telephone Number: 714-547-0615

Fax Number: 714-547-8678

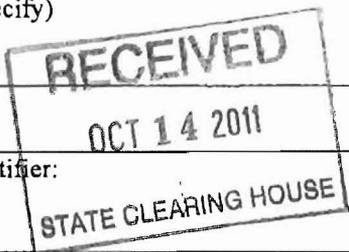
*Email: dtate@veteransfirstoc.org

*Signature of Authorized Representative: *Deanne Tate*

Date Signed: 10/14/2011

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	
*3. Date Received:		4. Application 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: VETERANS FIRST			
* b. Employer/Taxpayer Identification Number (EIN/TIN): 23-7143157		*c. Organizational DUNS: 153760405	
d. Address:			
*Street1: 1540 East Edinger Avenue			
Street 2: Suite D			
*City: Santa Ana			
County: Orange			
*State: CA			
Province:			
Country: USA		*Zip/ Postal Code: 92705	
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: Deanne	
Middle Name:			
*Last Name: Tate			
Suffix:			
Title: President/CEO			
Organizational Affiliation:			
*Telephone Number: 714-547-0615		Fax Number: 714-547-8678	
*Email: dtate@veteransfirstoc.org			

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5500-N-01

*Title: 2011 Continuum of Care Homeless Assistance Program

13. Competition Identification Number:

Title:

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

Orange County, California

*15. Descriptive Title of Applicant's Project:

Veterans Self-Determination Center

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant
46, 47, 48*b. Program/Project:
40, 42, 47

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

17. Proposed Project:

*a. Start Date: 08/31/2011

*b. End Date: 08/31/2012

18. Estimated Funding (\$):

*a. Federal \$159,700.00

*b. Applicant

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$159,700.00

19. Is Application Subject to Review By State Under Executive Order 12372 Process?** a. This application was made available to the State under the Executive Order 12372 Process for review on b. Program is subject to E.O. 12372 but has not been selected by the State for review. c. Program is not covered by E.O. 1237220. 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: Deanne

Middle Name:

*Last Name: Tate

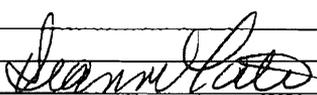
Suffix:

*Title: President/CEO

*Telephone Number: 714-547-0615

Fax Number: 714-547-8678

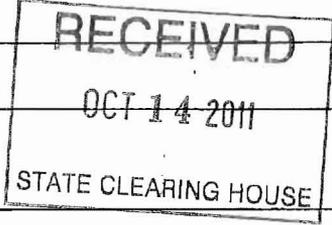
*Email: dtate@veteransfirstoc.org

*Signature of Authorized Representative: 

Date Signed: 10/14/2011

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	
*3. Date Received:		4. Application 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: VETERANS FIRST			
* b. Employer/Taxpayer Identification Number (EIN/TIN): 23-7143157		*c. Organizational DUNS: 153760405	
d. Address:			
*Street1: 1540 East Edinger Avenue			
Street 2: Suite D			
*City: Santa Ana			
County: Orange			
*State: CA			
Province:			
Country: USA		*Zip/ Postal Code: 92705	
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: Deanne	
Middle Name:			
*Last Name: Tate		Suffix:	
Title: President/CEO			
Organizational Affiliation:			
*Telephone Number: 714-547-0615		Fax Number: 714-547-8678	
*Email: dtate@veteransfirstoc.org			

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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-5500-N-01

*Title: 2011 Continuum of Care Homeless Assistance Program

13. Competition Identification Number:

Title:

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

Orange County, California

*15. Descriptive Title of Applicant's Project:

Veterans Housing Project

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant
46, 47, 48*b. Program/Project:
40, 46, 47

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

17. Proposed Project:

*a. Start Date: 11/1/2011

*b. End Date: 10/31/2012

18. Estimated Funding (\$):

*a. Federal \$254,804.00

*b. Applicant

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$254,804.00

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

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

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

 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: Deanne

Middle Name:

*Last Name: Tate

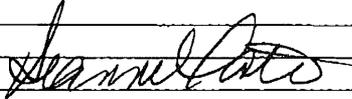
Suffix:

*Title: President/CEO

*Telephone Number: 714-547-0615

Fax Number: 714-547-8678

*Email: dtate@veteransfirstoc.org

*Signature of Authorized Representative:  Date Signed: 10/14/2011

Application for Federal Assistance SF-424		Version 02
*1. Type of Submission <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	*2. Type of Application <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision	*If Revision, select appropriate letter(s): * Other (Specify)
*3. Date Received:	4. Application Identifier:	
5a. Federal Entity Identifier:	*5b. Federal Award Identifier:	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> <p style="text-align: center; font-weight: bold; font-size: 1.2em;">RECEIVED</p> <p style="text-align: center;">OCT 14 2011</p> <p style="text-align: center;">STATE CLEARING HOUSE</p> </div>		
State Use Only:		
6. Date Received by State:	7. State Application Identifier:	
8. APPLICANT INFORMATION:		
* a. Legal Name: Weingart Center Association		
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6054617	*c. Organizational DUNS: 122-030-190	
d. Address:		
*Street1: 566 S. San Pedro Street Street 2: *City: Los Angeles County: Los Angeles *State: California Province: Country: *Zip/ Postal Code: 90013		
e. Organizational Unit:		
Department Name:	Division Name:	
f. Name and contact information of person to be contacted on matters involving this application:		
Prefix: Mr. Middle Name:	First Name: Vernon	
*Last Name: Nickerson Suffix:		
Title: Director of Contracts Compliance and Quality Assurance		
Organizational Affiliation:		
*Telephone Number: 213-689-2111 Fax Number: 213-623-0408		
*Email: vernonn@weingart.org		

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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 (SHP)

*12. Funding Opportunity Number: FR-5500-N-34

*Title: Notice of Funding Availability for Continuum of Care Homeless Assistance Programs

13. Competition Identification Number:

Title:

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

*15. Descriptive Title of Applicant's Project:

Substance Abuse/Multi-Diagnosed
Specialized Services Project**Attach supporting documents as specified in agency instructions.**

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant 34

*b. Program/Project: 34

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

17. Proposed Project:

*a. Start Date: March 1, 2012

*b. End Date: February 28, 2013

18. Estimated Funding (\$):

*a. Federal \$162,629.00

*b. Applicant \$40,733.00

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$203,362.00

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

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

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

 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: Kevin

Middle Name:

*Last Name: Murray

Suffix:

*Title: Interim President and CEO

*Telephone Number: 213-689-2180

Fax Number: 213-627-4031

*Email: kmurray@weingart.org

*Signature of Authorized Representative:



Date Signed:

6/14/11

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application		*If Revision, select appropriate letter(s):	
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New			
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation		* Other (Specify)	
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision			
*3. Date Received:			4. Application Identifier:		
5a. Federal Entity Identifier:			*5b. Federal Award Identifier:		
RECEIVED					
OCT 14 2011					
STATE CLEARING HOUSE					
State Use Only:					
6. Date Received by State:			7. State Application Identifier:		
8. APPLICANT INFORMATION:					
* a. Legal Name: Weingart Center Association					
* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6054617			*c. Organizational DUNS: 122-030-190		
d. Address:					
*Street1: 566 S. San Pedro Street					
Street 2:					
*City: Los Angeles					
County: Los Angeles					
*State: California					
Province:					
Country:					
*Zip/ Postal Code: 90013					
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: Vernon			
Middle Name:					
*Last Name: Nickerson					
Suffix:					
Title: Director of Contracts Compliance and Quality Assurance					
Organizational Affiliation:					
*Telephone Number: 213-689-2111			Fax Number: 213-623-0408		
*Email: vernonn@weingart.org					

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*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 (SHP)

*12. Funding Opportunity Number: FR-5500-N-34

*Title:

Notice of Funding Availability for Continuum of Care Homeless Assistance Programs

13. Competition Identification Number:

Title:

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

*15. Descriptive Title of Applicant's Project:

Project Paycheck

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant 34

*b. Program/Project: 34

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

17. Proposed Project:

*a. Start Date: September 1, 2012

*b. End Date: August 31, 2013

18. Estimated Funding (\$):

*a. Federal \$299,503.00

*b. Applicant \$74,876.00

*c. State

*d. Local

*e. Other

*f. Program Income

*g. TOTAL \$374,379.00

19. Is Application Subject to Review By State Under Executive Order 12372 Process?** a. This application was made available to the State under the Executive Order 12372 Process for review on b. Program is subject to E.O. 12372 but has not been selected by the State for review. c. Program is not covered by E.O. 1237220. 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: Kevin

Middle Name:

*Last Name: Murray

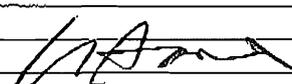
Suffix:

*Title: Interim President and CEO

*Telephone Number: 213-689-2180

Fax Number: 213-627-4031

*Email: kmurray@weingart.org

*Signature of Authorized Representative: 

Date Signed: 10/14/11

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

Version 02

Application for Federal Assistance SF-424

* 1. Type of Submission:

- Preapplication
- Application
- Changed/Corrected Application

* 2. Type of Application:

- New
- Continuation
- Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

* 3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

* 5b. Federal Award Identifier:

RECEIVED

OCT 14 2011

State Use Only:

6. Date Received by State:

7. State Application Identifier:

STATE CLEARING HOUSE

8. APPLICANT INFORMATION:

* a. Legal Name:

JWCH Institute, Inc.

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

95-2289916

* c. Organizational DUNS:

093059533

d. Address:

* Street1:

1910 W. Sunset Blvd., #650

Street2:

* City:

Los Angeles

County:

Los Angeles

* State:

California

Province:

* Country:

USA: UNITED STATES

* Zip / Postal Code:

90026

e. Organizational Unit:

Department Name:

Division Name:

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

Prefic

Ms.

* First Name:

Jeanne

Middle Name:

Gee

* Last Name:

Lam

Suffix:

Title:

Chief Financial Officer

Organizational Affiliation:

* Telephone Number:

213-484-1186

Fax Number:

213-484-6165

* Email:

jlam@jwchinstitute.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 Education)

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:

Supportive Housing Program (SHP)

*** 12. Funding Opportunity Number:**

FR-5500-N-34

*** Title:**

Continuum of Care Homeless Assistance Competition (CoC)

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:**

Healthcare & Supportive Services Intervention Team

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 - 034

* b. Program/Project CA-031, 034, 038

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

[Empty box for additional list of Congressional Districts]

17. Proposed Project:

* a. Start Date: 07/01/2012

* b. End Date: 06/30/2013

18. Estimated Funding (\$):

- * a. Federal 308,999
- * b. Applicant 283,211
- * c. State
- * d. Local
- * e. Other
- * f. Program Income
- * g. TOTAL 572,210

* 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 10/14/2011
- 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.

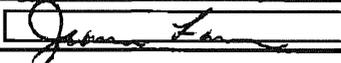
Authorized Representative:

Prefix: Ms. * First Name: Jeanne
 Middle Name: Gee
 * Last Name: Lam
 Suffix: [Empty]

* Title: Chief Financial Officer

* Telephone Number: 213-484-1186 Fax Number: 213-484-6165

* Email: jlam@jwchinstitute.org

* Signature of Authorized Representative:  * Date Signed: 10/14/2011

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission		*2. Type of Application	*If Revision, select appropriate letter(s):
<input type="checkbox"/> Preapplication		<input type="checkbox"/> New	
<input checked="" type="checkbox"/> Application		<input checked="" type="checkbox"/> Continuation	* Other (Specify)
<input type="checkbox"/> Changed/Corrected Application		<input type="checkbox"/> Revision	

*3. Date Received: 10/14/2011	4. Application Identifier:
----------------------------------	----------------------------

5a. Federal Entity Identifier:	*5b. Federal Award Identifier: CA0341B9D001003
--------------------------------	---

State Use Only:	6. Date Received by State:	7. State Application Identifier:
------------------------	----------------------------	----------------------------------

8. APPLICANT INFORMATION:

* a. Legal Name: Asian Pacific Women's Center, Inc.	
* b. Employer/Taxpayer Identification Number (EIN/TIN): 931102854	*c. Organizational DUNS: 08-003-9832

d. Address:	
*Street1: 1145 Wilshire Blvd., Suite 102	
Street 2:	
*City: Los Angeles	
County:	
*State: CA	
Province:	
Country: Los Angeles	*Zip/ Postal Code: 90017

e. Organizational Unit:	
Department Name:	Division Name:

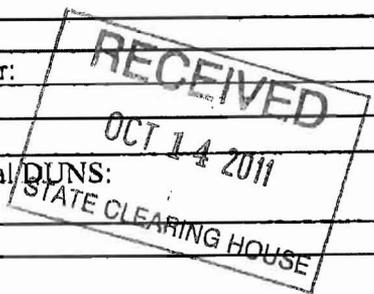
f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Mr.	First Name: Tong
Middle Name: Cho	
*Last Name: Kim	
Suffix:	

Title: Executive Director

Organizational Affiliation:

*Telephone Number: 213-250-2977	Fax Number: 213-250-2949
*Email: tckimofca@yahoo.com	



Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type: M. Nonprofit

Type of Applicant 2: Select Applicant Type:

- Select One -

Type of Applicant 3: Select Applicant Type:

- Select One -

*Other (specify):

*10. Name of Federal 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: FR-5500-N-34

*Title: Continuum of Care Homeless Assistance Program

13. Competition Identification Number: Coc-01

Title:

2011 SuperNOFA Continuum of Care

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

Los Angeles

*15. Descriptive Title of Applicant's Project:

APWC Transitional Housing Program

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:
 *a. Applicant **34** *b. Program/Project: **33**

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

17. Proposed Project: **APWC Transitional Housing Program**
 *a. Start Date: **05/01/2012** *b. End Date: **04/30/2013**

18. Estimated Funding (\$):

*a. Federal	\$149,813.00
*b. Applicant	\$50,000.00
*c. State	
*d. Local	
*e. Other	\$137,017.00
*f. Program Income	
*g. TOTAL	\$336,830.00

***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 **10/14/2011**
 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: **Tong**

Middle Name: **Cho**

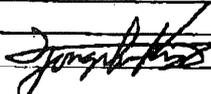
*Last Name: **Kim**

Suffix:

*Title: **Executive Director**

*Telephone Number: **213-250-2977** Fax Number: **213-250-2949**

*Email: **tckimofca@yahoo.com**

*Signature of Authorized Representative:  Date Signed: **10/14/2011**

APPLICATION FOR FEDERAL ASSISTANCE

OMB Approved No. 3076-0046

Version 7/03

1. TYPE OF SUBMISSION: Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction	<input type="checkbox"/> Pre-application <input checked="" type="checkbox"/> Construction <input checked="" type="checkbox"/> 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: Covenant House California Organizational DUNS: 617537436 Address: Street: 1325 N. Western Avenue City: Hollywood County: Los Angeles State: CA Country: U.S.A.	Organizational Unit: Department: Transitional Living Programs-Los Angeles Division: Supportive Apartment Program Name and telephone number of person to be contacted on matters involving this application (give area code) Prefix: Ms. First Name: Regina Middle Name: M. Last Name: Klein Suffix: Email: rklein@covca.org
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RECEIVED
 OCT 14 2011
 STATE CLEARING HOUSE

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
 13-3391210

7. TYPE OF APPLICANT: (See back of form for Application Types)
 0- Not for profit organization
 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 Housing and Urban Development

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
 14-235

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
 CovHseCA Supportive Apartment Program

12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.):
 Hollywood, Los Angeles, Los Angeles County, California

13. PROPOSED PROJECT
 Start Date: 12/01/2011 Ending Date: 11/30/2012

14. CONGRESSIONAL DISTRICTS OF:
 a. Applicant 30 b. Project 30, 31

15. ESTIMATED FUNDING:

a. Federal	\$	129,736 ⁰⁰
b. Applicant	\$	24,433 ⁰⁰
c. State	\$	0 ⁰⁰
d. Local	\$	0 ⁰⁰
e. Other	\$	0 ⁰⁰
f. Program Income	\$	0 ⁰⁰
g. TOTAL	\$	154,169 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: 10/14/2011
 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 George	Middle Name R.
Last Name Lozano	Suffix	
b. Title Executive Director	c. Telephone Number (give area code) (323) 461-3131, x248	
d. Signature of Authorized Representative <i>George R. Lozano</i>	e. Date Signed 11/14/2011	