**\*\*\*Note: This application is only for EFSP funding in the St. Clair County (IL) jurisdiction**

**ORGANIZATION CONTACT INFORMATION**

|  |  |
| --- | --- |
| **Agency Name**  |       |
| **Headquarter Address**  |       |
| **City, State, Zip Code**  |       |
| **Website URL** |       |
| **Executive Director/CEO Name** |       |
| **Executive Director/CEO Email** |       |
| **Executive Director/CEO Phone** |       |
| **Primary Contact Name (if different)** |       |
| **Primary Contact Title** |       |
|  **Primary Contact Email**  |       |
| **Primary Contact Phone**  |       |
| **Federal Tax ID Number** |       |
| **DUNS Number** |       |
| To meet minimum eligibility criteria for funding, agencies that are not United Way member agencies must submit the following documentation along with this application (use check boxes to indicate that they have been attached):[ ]  Current Proof of 501(c)(3) Status (U.S. Department of Treasury, IRS Determination Letter)[ ]  Certificate of Corporate Good Standing (for Missouri or Illinois)[ ]  Most current Audit Report or financial statement including auditor opinion, comments, etc.[ ]  Current year operating budget[ ]  Agency policy on non-discrimination[ ]  Board of Directors Roster (including work affiliation and titles)**Email a PDF attachment of these items to** **efs@stl.unitedway.org**. Without these attachments, your application will be incomplete and will not be considered for funding. |
| After completing this application, use the list below to review submission of all appropriate materials:[ ]  Section I: Organizational Overview Section II: Services Application (Complete all questions for the service areas in which you are applying for funds; these funds are only for the Madison County (IL) jurisdiction)[ ]  1 Food Assistance [ ]  2 Housing Assistance [ ]  3 Utility Assistance  |
| [ ]  By checking here you authorize submission of this application to the United Way of Greater St. Louis, agree that the information is accurate, and that funds will be used for the intended purpose as outlined within this application.  |

**SECTION I: ORGANIZATION OVERVIEW**

1. Has your organization previously received EFSP Funds? [ ]  **YES** [ ]  **NO**
2. Do you have any outstanding EFSP Compliance Exceptions? [ ]  **YES** [ ]  **NO**
3. Is your organization a United Way Member Agency? [ ]  **YES** [ ]  **NO**
4. Briefly describe your agency’s mission, goals, programs, and history of providing the proposed activities. [*Open Text – 1000 character limit]*

1. Does the organization have the ability to absorb the cost of delayed reimbursement from the National EFSP Board?

[ ]  **YES** [ ]  **NO**

1. Is the facility for services accessible for persons with disabilities?

[ ]  **YES** [ ]  **NO**

1. Briefly describe your agency’s response to COVID-19 up to this point, please include the number of clients served in this jurisdiction and organizations/groups your agency partnered with to provide COVID-19 emergency assistance. [*Open Text – 1000 character limit]*

**SECTION II: SERVICES APPLICATION**

**1. Is the organization applying for FOOD ASSISTANCE in the St. Clair County (IL) jurisdiction?** [ ]  **YES** [ ]  **NO**

If yes, please complete 1a-1c, if no please move to #2.

**1a.** Please complete the table below with the following information related to FOOD ASSISTANCE

* Service to be provided
	+ Served Meals (on site)
		- If yes is selected, enter the dollar amount requested for meals served
	+ Food Pantry
		- If yes is selected, enter the dollar amount requested for food pantry
* Name of the program in your agency that will be receiving funding from the FOOD ASSISTANCE funding request
* Hours of operation/availability for food distribution
* Number of meals to be served within the spending period
* Number of individuals to be served within the spending period
	+ Please check YES if this is an unduplicated count

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Service to be Provided?** | **Funding Requested**  | **Program Name** | **Hours of Operation/ Availability for Food Distribution** | **# of meals to be served within spending period** | **# of individuals to be served**  | **Max # of times a household can receive food assistance per year** |
|  |  | **Unduplicated Count?** |  |
| **Served Meals (on Site)** | [ ]  **YES**  | **$** |  |  |  |  | [ ]  **YES**  |  |
| **Food Pantry** | [ ]  **YES**  | **$** |  |  |  |  | [ ]  **YES**  |  |

* Maximum number of times a household can receive food assistance per year from your organization’s food pantry (for example: 12 = once per month)

**1b. Please briefly describe how FOOD ASISSTANCE funds will be used, method of service delivery, and your organization’s methods for tracking and evaluation. Include a description of the organization’s experience in providing services in the area(s) of request.**  [*Open Text – 2000 character limit*].

**1c. Please select “YES” in the table below if the organization will use the listed criteria to award FOOD ASSISTANCE EFSP funds.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Proof of Income** | **Photo ID** | **Social Security cards for all members of household** | **Proof of Residency** | **Other (Please specify)** |
| FOOD ASSISTANCE CRITERIA | [ ]  **YES** | [ ]  **YES** | [ ]  **YES** | [ ]  **YES** |  |

**2. Is the organization applying for HOUSING ASSISTANCE in the St. Clair County (IL) jurisdiction?** [ ]  **YES** [ ]  **NO**

If yes, please complete 2a-2c, if no please move to #3.

**2a.** Please complete the table below with the following information related to HOUSING ASSISTANCE

* Service to be provided
	+ Rent/Mortgage Assistance
		- If yes is selected, enter the dollar amount requested for rent/mortgage assistance
* Name of the program in your agency that will be receiving funding from the HOUSING ASSISTANCE funding request
* Hours of operation/availability for housing assistance
* Number of individuals to be served within the spending period (this includes every family member helped with assistance)
* Number of unduplicated households to be served within the spending period (number of requests that received housing assistance)
* Maximum number of times a household can receive housing assistance per year from your organization (for example: 12 = once per month)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Service to be Provided** | **Funding Requested**  | **Program Name** | **Hours of Operation/ Availability for Housing Assistance** | **# of Individuals to be Served**  | **# of Unduplicated Households to be Served** | **Max # of times a household can receive housing assistance per month** |
| **Rent Assistance** | [ ]  **YES**  | **$** |  |  |  |  |  |
| **Mortgage Assistance** | [ ]  **YES** | **$** |  |  |  |  |  |
| **Mass Shelter** | [ ]  **YES** | **$** |  |  |  |  |  |

**\***Note the “number of individuals” category would include every family member helped with assistance. Households would be the number of requests that received housing assistance.

**2b. Please briefly describe how HOUSING ASISSTANCE funds will be used, method of service delivery, and your organization’s methods for tracking and evaluation. Include a description of the organization’s experience in providing services in the area(s) of request.**  [*Open Text – 2000 character limit*].

**2c. Please select “YES” in the table below if the organization will use the listed criteria to award HOUSING ASSISTANCE EFSP funds.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Proof of Income** | **Photo ID** | **Social Security cards for all members of household** | **Proof of Residency** | **Other (Please specify)** |
| HOUSING ASSISTANCE CRITERIA | [ ]  **YES** | [ ]  **YES** | [ ]  **YES** | [ ]  **YES** |  |

**3. Is the organization applying for UTILITY ASSISTANCE in the St. Clair County (IL) jurisdiction?** [ ]  **YES** [ ]  **NO**

If yes, please complete 3a-3c, if no you are finished.

**3a.** Please complete the table below with the following information related to UTILITY ASSISTANCE

* The dollar amount requested for utility assistance
* Name of the program in your agency that will be receiving funding from the UTILITY ASSISTANCE funding request
* Hours of operation/availability for utility assistance
* Number of individuals to be served within the spending period (this includes every family member helped with assistance)
* Number of unduplicated households to be served within the spending period (number of requests that received utility assistance)
* Maximum number of times a household can receive utility assistance per year from your organization (for example: 12 = once per month)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Service to be provided?** | **Funding Requested**  | **Program Name** | **Hours of Operation/ Availability for Utility Assistance** | **# of Individuals to be Served**  | **# of Unduplicated Households to be Served** | **Max # of times a household can receive utility assistance per year** |
| **Utility Assistance** | [ ]  **YES** | **$** |  |  |  |  |  |

**\***Note the “number of individuals” category would include every family member helped with assistance. Households would be the number of requests that received utility assistance.

**3b. Please briefly describe how UTILITY ASISSTANCE funds will be used, method of service delivery, and your organization’s methods for tracking and evaluation. Include a description of the organization’s experience in providing services in the area(s) of request.**  [*Open Text – 2000 character limit*].

**3c. Please select “YES” in the table below if the organization will use the listed criteria to award UTILITY ASSISTANCE EFSP funds.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Proof of Income** | **Photo ID** | **Social Security cards for all members of household** | **Proof of Residency** | **Other (Please specify)** |
| UTILITY ASSISTANCE CRITERIA | [ ]  **YES** | [ ]  **YES** | [ ]  **YES** | [ ]  **YES** |  |