APPLICATION PACKAGE

Minnesota Department of Human Services, Homelessness, Housing and Support Services Administration

Request for Proposals to provide emergency shelter, drop-in/day shelter or street outreach through the Emergency Services Program for individuals and families experiencing homelessness.

Application Documentation Checklist

☐ Form 1 Completed (answer all questions)

☐ Form 2 Completed (answer all questions)

☐ Form 3 Completed (answer all questions) **not required for Tribal government applicants*

☐ Form 4 – 7 Completed (answer all questions based on the activities (s) you are applying for)

☐ Form 8 Only for collaborative (multi-agency) proposals

☐ Form 9 Only for collaborative (multi-agency) proposals

Additional Documents You MUST ATTACH to be Considered for Funding:

☐ Responder Information and Declarations Form (**DHS-7020-ENG**)

☐ Exceptions to Sample Contract and RFP Terms Form (**DHS-7019-ENG**)

☐ Documentation to Establish Financial Stability (**DHS-7896-ENG**)

Responder must complete the ***Documentation to Establish Financial Stability*** form (DHS-7896-ENG) and attach one of the following financial documents *based on your organization's annual revenue. County governments do not need to submit this information.*

☐ Board Reviewed Financial Statement if Annual Revenue is <$50K **OR**

☐ IRS Form 990 if Annual Revenue is $50K-$750K **OR**

☐ Certified Financial Audit if Annual Revenue is >$750K

☐ Supplemental Professional Responsibility and Data Privacy Information *(if applicable)*

☐ Responder Information and Declarations Form

☐ Professional Responsibility and Data Privacy Information

☐ Exceptions to Sample Contract and RFP Terms Form

☐ Disclosure of Funding Form

☐ Documentation to Establish Financial Stability

☐ Financial Document *(one of the documents below must be submitted based on your annual revenue-County agencies do not need to submit this information)*

FORM 1: APPLICATION COVER PAGE

Type of Application (check one)

☐ Single provider application

☐ Collaborative or multi-provider application
See *Section 2.3 of the Request for Proposals for more information:*

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Applicant Information		
Legal Name: Kahari Smith-Brewer		
Address: 375 Jackson St.	**City: Saint Paul**	**Zip +4: 55101-2537**
Telephone: 651-391-1645	**Grantee Web Site URL: https://www.stpaul.gov/**	
Counties/Area Served: Ramsey County	**Federal ID Number:**	
UEI Number: NAWUYFNLSK35	**State Tax ID:**	
Contacts		
Executive Director or Tribal Leader's name: Angie Weise		
Telephone: 651-746-4050	**Email: angie.weise@ci.stapul.mn.us**	
Board Chair's Name:		
Telephone:	**Email:**	
Fiscal Director's Name:		
Telephone:	**Email:**	
Grant Program Contact (Note: These are persons who should receive communication about this application)		
Program Contact #1 Name: Kahari Smith-Brewer		
Contact #1 Telephone: 651-391-1645	**Contact #1 Email: Kahari.smith-brewer@ci.stpaul.mn.us**	
Program Contact #2 Name: David Hoban		
Contact #2 Telephone: 651-318-9547	**Contact #2 Email: David.hoban@ ci.stpaul.mn.us**	
Reporting Contact:		
Contact Telephone:	**Contact Email:**	

FORM 2: PROVIDER INFORMATION

1. **Type of Applicant** (Must be one of the following to be eligible for these funds)
   - ☐ Nonprofit or non-governmental agency
   - ☒ Municipal government
   - ☐ Tribal Nation

2. **Data Privacy**: (*3.2(E) of the Request for Proposals for more information)*:

   Did this agency, or any proposed subcontractor, in the past five years, suffer any breach or loss of personal, financial or other data considered private or confidential? ☐ Yes ☒ No

   If yes, provide a description of such breaches, and provide details on what steps were taken to address the issue both in the short term and the long term to prevent such a breach/loss from happening again.

3. **Professional Responsibility** *(see 3.2(E) of the Request for Proposals for more information):*

   Has this agency had any complaints filed with or by professional, state and/or federal licensing/regulatory organizations within the past six years against your organization or employees relating to the provision of services. Or, has there been litigation, pending and/or resolved, within past two years that relates to the provision of services. ☐ Yes ☐ No

   If yes, attach a document that details the date of the lawsuit, nature of the lawsuit, the dollar amount being requested as damages, and if resolved, nature of the resolution. If such complaints exist, please include the date of the complaint(s), the nature of the complaint(s), and the resolution/status of the complaint(s), including any disciplinary actions taken.

NOTE: Government entities or tribal nations do not need to complete the remainder of Form 2

4. **Nonprofit /Organizational Status**
   1. How long has this agency been doing business? _____ years
   2. Does this agency currently hold 501(c)(3) status with the IRS?
      ☐Yes ☐No
   3. Has this agency had its 501(c)3 or other tax-exempt status revoked by the IRS in the past 12 months?
      ☐Yes ☐No

5. **Legal Affairs**

   a. Are there any current or pending lawsuits against this agency? ☐ Yes ☐ No
   b. If so, would there be an impact on agency's financial position? ☐ Yes ☐ No
   c. Has the agency lost any funding due to misuse, or fraud? ☐ Yes ☐ No

   If yes, describe the situation, including when it occurred:

6. **Board Governance**

   a. Does any staff member (including the Executive Director or CEO) serve as a member of the agency's board of directors? ☐ Yes ☐ No

   b. If yes, are they a voting member of the agency's board of directors? ☐Yes ☐ No

7. Financial Status

INCOME STATEMENT	Most Recently Completed Fiscal Year	Year to Date / Current (**as of** _____)
Total revenue in the most recently completed fiscal year?	$	
Total Expenses in the most recently completed fiscal year?	$	

Balance Sheet or Statement of Financial Position	Most Recently Completed Fiscal Year	Year to Date / Current **(as of** _____)
# of Days Cash on Hand		
Assets	$	
Liabilities	$	
Unrestricted Cash and Cash Equivalents	$	

8. What is your organization's fiscal year? _____

9. If the agency has a deficit in the previous or current fiscal year, how did the agency meet this shortfall?

a. Funded with operating reserve? ☐ Yes ☐ No

If yes, how much? _____

b. Other ☐ Yes ☐ No

please explain: _____

10. Has any debt been incurred in the last 24 months? ☐ Yes ☐ No

11. What was the reason for the new debt?

12. What is the funding source for paying back the new debt?

13. Does the agency have a line of credit or similar cash flow instrument? ☐ Yes ☐ No

a. If yes, what is the current balance on that line of credit? $ _____

Financial Policies

a. Does the agency have written policies and procedures for the following business processes?

Accounting
☐Yes ☐No ☐Not sure Please attach a copy of the **table of contents**.

Purchasing / Procurement
☐Yes ☐No ☐Not sure Please attach a copy of the **table of contents.**

Payroll
☐Yes ☐No ☐Not sure Please attach a copy of the **table of contents.**

FORM 3: EQUITY AND ACCESSIBILITY

**If you are applying as a tribal government, you are not required to complete Form 3.*

EQUITY

1. **Describe the demographics (race, ethnicity, gender identity, etc.) of staff, leadership, and board members and in what ways they reflect the population being served (use specific data in your response).**

2. **Explain any practices you use to hire and retain a diverse staff that reflects the population served. Include descriptions of specific efforts being made.**

3. **Provide *specific examples* of ways you respond to the unique needs of cultural and ethnic groups in order to offer culturally responsive and accessible programs and services. Include whether you identify as a culturally specific service provider.**

4. **Describe how you incorporate voices of BIPOC and people with histories of homelessness and housing instability in decision making and program evaluation.**

5. **Describe how your program provides services in an affirming and responsive way to the LGBTQIAP2+ population. Describe policies and procedures related to gender identity and sexual orientation regarding intakes, sleeping arrangements in shelter and/or housing programs, and respect of the LGBTQIAP2+ population.**

6. **Describe how you are in alignment with HHSSA's expectations regarding gender-affirming services (see Appendix B). If you are not in alignment, describe steps you are taking to become in alignment.**

ACCESSIBILITY

7. **Provide a description of the specific actions you have taken to make services and programs accessible and responsive for individuals and families with Limited English proficiency (LEP).**

8. **Provide a description of the specific actions you have taken to make services and programs accessible and responsive to individuals with disabilities.**

FORM 4: STREET OUTREACH

Outreach Program		
Program Name:		
Continuum of Care Region(s): *Resource: Map of CoC Regions*	☐ Central ☐ Hennepin County ☐ Northeast ☐ Northwest ☐ Ramsey County	☐ Southeast (aka River Valleys) ☐ Southwest ☐ St. Louis County ☐ Suburban Metro ☐ West Central
County(s) Served:		
Current Capacity:	Daily # of Contacts:	Annual # of Contacts:
Proposed Capacity:	Daily # of Contacts:	Annual # of Contacts:
Target Population(s) Served: (Check all that apply)	**CHECK ALL THAT APPLY** **SINGLES** ☐Unaccompanied Minor Youth (under 18) ☐Unaccompanied Youth (18 through 24) ☐Single Adults or Couples without Children (25 and older) **FAMILIES** ☐Minor youth head household (under 18) ☐Youth headed household (18 through 24) ☐Adult headed household (25 and older)	
Purpose of Funding Request: (Check all that apply)	☐Sustain Program ☐Expand Program Capacity *(e.g., increase number of households served, etc.)* ☐Enhance Program Services *(e.g., add housing navigator positions, add mental health supports, increase staff to participant ratio, etc...)* ☐Enhance Staff Compensation/Support *(e.g., increased training, increased wages/benefits for existing staff, increasing self-care opportunities, etc.)* ☐New program	

1. **Program Summary/Narrative.** *Briefly summarize the program for which you are applying.*
   RECOMMENDED MAXIMUM WORD LIMIT: 200

2. **Purpose of Funding Request.** Based on "**Purpose of Funding Question**" in the table above

   a. **If you selected "*Sustain Programming,*" what will be the impact on your program if you do not receive the funding you are requesting?** Be specific and include the reason why you are unable to sustain programming without this funding.

   b. **If you selected expand program capacity, enhance program services, and/or enhance staff compensation/support, describe why these program expansions or enhancements are necessary.**

3. **Provide a description of your Outreach program model, including:**

   a. **Where outreach takes place**

   b. **Staffing model** *(Please include staffing levels/ratios, total number of staff, and number of FTEs.)*

   c. **Hours of operation/schedule**

   d. **Eligibility.** What criteria are used to determine eligibility to receive services? *(e.g., age, homelessness status, referral source, sobriety status, victim of domestic violence, residency requirements, etc.)*

4. **How do you provide outreach services to individuals staying in encampments or persons sleeping in places not designed for human habitation?**

5. **What is your program philosophy or practice around engaging with persons experiencing unsheltered homelessness, particularly those who may be reluctant to seek services (such as shelter or housing) and/or provide personally identifying information?**

6. **How do you assist unsheltered participants in accessing overnight emergency shelter? Please note any collaboration with overnight shelters in your area.**

7. **How do you assist participants in accessing housing and/or housing navigation services? Please note any partnerships with other area providers.**

8. **Describe the services provided to participants in your program in each area below. Include whether the services are provided directly by the program or by referral to an external resource.**

   a. **Accessing Mainstream Benefits (including but not limited to Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (MFIP), General Assistance/Emergency Assistance, Energy Assistance, etc.)**

   b. **Accessing physical, chemical, and mental health services**

   c. **Meeting basic survival needs (tents, sleeping bags, food, outerwear, warm clothing, etc.)**

Outreach Program Budget & Budget Narrative

Budget Category	Budget Amount for each category (7/1/2025 – 6/30/2027)	**Narrative:** Program Request Budget **must be supported by a detailed Budget Narrative below.** - Type and amount of costs included in that budget category (e.g. staff, rent, contracted cleaning, etc.) - The basis for that funding request (e.g. 2 FTE @ 40,000/year each, 24 months contract @ 4,000/mos., increase of $3/hr. for all staff-14 FTE x $3/hr.)
a. Administration (Limited to 15 pct.)	$	
b. Operations	$	
c. Support Services	$	
TOTAL Program Funding Request (7/1/2025 – 6/30/2027)	$	

Outreach Program Total Revenue

List all *current, projected,* and *secured* revenue and other sources of support for the program. **Be specific. Include the amount and source of funding, such as funds directly from the county, Housing Support, CoC funding, Federal RHY funds, etc.** You may add lines to the funding table to describe all sources. *Include HHSSA funds being requested through this RFP*

Source	Current SFY2025 (7/1/24-6/30/25) Funds	Projected SFY2026 (7/1/25-6/30/26) Funds	SFY2026 Funding Secured?
HHSSA funds (including this request)	$	$	☐
	$	$	☐
	$	$	☐
	$	$	☐
	$	$	☐
	$	$	☐
Total Program Budget:	$	$	

FORM 5: DROP-IN CENTER/DAY SHELTER

Drop-in Center/Day Shelter Overview		
Program Name:		
Continuum of Care Region(s): *Resource: Map of CoC Regions*	☐ Central ☐ Hennepin County ☐ Northeast ☐ Northwest ☐ Ramsey County	☐ Southeast (aka River Valleys) ☐ Southwest ☐ St. Louis County ☐ Suburban Metro ☐ West Central
County(s) Served:		
Current Capacity:	Daily # of Households:	Annual # of Households:
Proposed Capacity:	Daily # of Households:	Annual # of Households:
Target Population(s) Served: (Check all that apply)	**CHECK ALL THAT APPLY** **SINGLES** ☐Unaccompanied Minor Youth (under 18) ☐Unaccompanied Youth (18 through 24) ☐Single Adults or Couples w/out Children (25 and older) **FAMILIES** ☐Minor youth head household (under 18) ☐Youth headed household (18 through 24) ☐Adult headed household (25 and older)	
Purpose of Funding Request: (Check all that apply)	☐Sustain Program ☐Expand Program Capacity *(e.g., increase number of available units, increase number of households served, etc.)* ☐Enhance Program Services *(e.g., add housing navigator positions, add mental health supports, increase staff to participant ratio, etc.)* ☐Enhance Staff Compensation/Support *(e.g., increased training, increased wages/benefits for existing staff, increasing self-care opportunities, etc.)* ☐New program	

1. **Program Summary/Narrative.** *Briefly summarize the program for which you are applying.*
   RECOMMENDED MAXIMUM WORD LIMIT: 200

2. **Purpose of Funding Request.** Based on "**Purpose of Funding Question**" in the table above

   a. **If you selected "*Sustain Programming,*" what will be the impact on your program if you do not receive the funding you are requesting? Be specific and include the reason why you are unable to sustain programming without this funding**.

   b. **If you selected expand program capacity, enhance program services, and/or enhance staff compensation/support, describe why these program expansions or enhancements are necessary.**

3. **Provide the following information regarding your Drop-in Center/Day Shelter program model:**

   a. **Brief description of facility**

   b. **Staffing model** *(Please include staffing levels/ratios, total number of staff, and number of FTEs.)*

   c. **Hours of operation/schedule**. (*Include whether participants can remain in the center/facility for the duration of the time it is open, and if appointments are necessary for any services provided)*

   d. **Eligibility.** What criteria are used to determine eligibility to receive services? *(e.g., age, homelessness status, referral source, sobriety status, victim of domestic violence, residency requirements, etc.)*

4. **Provide specific examples of how you implement the best practice of harm reduction in this program.**

5. **Please provide a detailed description of the services provided at your drop-in center or day shelter. Include information on the following:**

   a. **Accessing Mainstream Benefits (including but not limited to Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (MFIP), General Assistance/Emergency Assistance, Energy Assistance, etc.)**

   b. **Accessing physical, chemical, and mental health services**

   c. **Meeting basic survival needs (tents, sleeping bags, food, outerwear, warm clothing, etc.)**.

   d. **Does your facility offer shower, laundry or other resting areas that participants can use while at the drop-in/day shelter?**

6. **Describe how you assist unsheltered participants in accessing overnight emergency shelter. Please note any collaboration with overnight shelters in your area:**

7. **Describe how you assist participants in accessing housing and/or housing navigation services. Please note any partnerships with other area providers.**

8. **Do you have any amenities, services, or programming not otherwise mentioned that further support participant needs or add to the participant experience?**

Drop-in Center/Day Shelter Program Budget & Budget Narrative		
Budget Category	**Budget Amount for each category (7/1/2025 – 6/30/2027)**	**Narrative:** Program Request Budget **must be supported by a detailed Budget Narrative below.** - Type and amount of costs included in that budget category (e.g. staff, rent, contracted cleaning, etc.) - The basis for that funding request (e.g. 2 FTE @ 40,000/year each, 24 months contract @ 4,000/mos.)
a. Administration (Limited to 15 pct.)	$	
b. Operations	$	
c. Support Services	$	
TOTAL Program Funding Request (7/1/2025 – 6/30/2027)	$	

Drop-In Center/Day Shelter Program Total Revenue

List all *current, projected,* and *secured* revenue and other sources of support for the program. **Be specific. Include the amount and source of funding, such as funds directly from the county, Housing Support, CoC funding, Federal RHY funds, etc.** You may add lines to the funding table to describe all sources. *Include HHSSA funds being requested through this RFP*

Source	Current SFY2025 (7/1/24-6/30/25) Funds	Projected SFY2026 (7/1/25-6/30/26) Funds	SFY2026 Funding Secured?
HHSSA funds (including this request)	$	$	☐
	$	$	☐
	$	$	☐
	$	$	☐
	$	$	☐
	$	$	☐
Total Program Budget:	$	$	

FORM 6: EMERGENCY SHELTER

Emergency Shelter Program Overview		
Program Name:		
Continuum of Care Region(s): *Resource: Map of CoC Regions*	☐ Central ☐ Hennepin County ☐ Northeast ☐ Northwest ☐ Ramsey County	☐ Southeast (aka River Valleys) ☐ Southwest ☐ St. Louis County ☐ Suburban Metro ☐ West Central
County(s) Served:		
Current Capacity:	Daily # of Households:	Annual # of Households:
Proposed Capacity:	Daily # of Households:	Annual # of Households:
Target Population(s) Served: (Check all that apply)	**CHECK ALL THAT APPLY** **SINGLES** ☐Unaccompanied Minor Youth (under 18) ☐Unaccompanied Youth (18 through 24) ☐Single Adults or Couples w/out Children (25 and older) **FAMILIES** ☐Minor youth head household (under 18) ☐Youth headed household (18 through 24) ☐Adult headed household (25 and older)	
Purpose of Funding Request: (Check all that apply)	☐Sustain Program ☐Expand Program Capacity *(e.g., increase number of available units, increase number of households served, etc.)* ☐Enhance Program Services *(e.g., add housing navigator positions, add mental health supports, increase staff to participant ratio, etc.)* ☐Enhance Staff Compensation/Support *(e.g., increased training, increased wages/benefits for existing staff, increasing self-care opportunities, etc.)* ☐New program	

1. **Program Summary/Narrative.** *Briefly summarize the program for which you are applying.*
RECOMMENDED MAXIMUM WORD LIMIT: 200

2. **Purpose of Funding Request.** Based on "**Purpose of Funding Question**" in the table above

    a. If you selected "*Sustain Programming,*" what will be the impact on your program if you do not receive the funding you are requesting? Be specific and include the reason why you are unable to sustain programming without this funding.

    b. If you selected expand program capacity, enhance program services, and/or enhance staff compensation/support, describe why these program expansions or enhancements are necessary.

3. **Provide the following information regarding your Emergency Shelter program model:**

    a. **Brief description of facility**

    b. **Staffing model** *(Please include staffing levels/ratios, total number of staff, and number of FTEs.)*

    c. **Hours of operation/schedule**

4. **Describe the following program policies and procedures:**

    a. **Eligibility.** What criteria are used to determine eligibility to receive services? *(e.g., age, homelessness status, sobriety status, victim of domestic violence, residency requirements, criminal history, etc.)*

        i. **Describe how program eligibility is low barrier. If there are barriers to program entry based on eligibility, please briefly explain.**

    b. **Access/Admission.** Describe the process for accessing a shelter stay (e.g., documentation required, referral source, hours of intake, etc.)

        i. **Describe how you ensure access to your program is low barrier with few obstacles or requirements for admission:**

    c. **Describe your discharge policy.** Include under what circumstances you ask participants to leave your program involuntarily, how you ensure consistency in decision making, what steps you take with a participant prior to termination, how you work to ensure the participants safety after exit, and your participant appeals process.

5. **What is the average length of stay in your program? _____ days**

    a. **If this has been increasing or decreasing over time, describe the factors that may be contributing to this change.**

    b. **Describe your policies around length of stay, and whether these are clearly communicated to participants? (number of days, availability of extensions, criteria used for extensions, etc.)**

c. **How do staff engage participants regarding their length of stay and eventual discharge from emergency shelter?**

6. **Emergency Shelter Program outcomes:**
   a. **How does your program address shelter participant barriers to permanent housing?**

   b. **How do you minimize discharges of shelter participants back to homelessness?**

   c. **In what ways do your services aim to end the cycle of homelessness?**

7. **Please provide a detailed description of the services provided at your shelter. Include information on the following:**
   a. **Meeting basic needs**

   b. **Access/referral to specialized services to meet specific needs such as health, employment, and children's needs, if applicable**.

8. **Please describe how your program will address one or more of the reasons that unsheltered individuals may not access shelter:**
   a. **Crowding/Facility Size:**
   b. **Safety:**
   c. **Pets:**
   d. **Partners:**
   e. **Culturally specific services:**
   f. **Other innovative solution to address unsheltered homelessness:**

9. **<u>FOR SHELTERS USING A ROTATING-SITE, HOTEL/MOTEL, AND/OR EMERGENCY APARTMENT MODEL ONLY.</u> Please provide the following information:**

   a. **Process for selecting site(s) and what agreements are in place with owners of identified site(s) (if not owned by the service provider).**

   b. **Transportation assistance for participants to shelter site(s).**

   c. **Type and frequency of training and support provided to staff not employed by the homeless service provider) and volunteers at the emergency shelter site(s). For example, employees of a hotel being used for emergency shelter, or volunteers at a congregation hosting guests for overnight shelter.**

Emergency Shelter Program Budget & Budget Narrative		
Budget Category	**Budget Amount for each category (7/1/2025 – 6/30/2027)**	**Narrative:** Program Request Budget **must be supported by a detailed Budget Narrative below.** - Type and amount of costs included in that budget category (e.g. staff, rent, contracted cleaning, etc.) - The basis for that funding request (e.g. 2 FTE @ 40,000/year each, 24 months contract @ 4,000/mos.)
a. Administration (Limited to 15 pct.)	$	
b. Operations	$	
c. Support Services	$	
TOTAL Program Funding Request (7/1/2025 – 6/30/2027)	$	

Emergency Shelter Program Total Revenue

List all *current, projected,* and *secured* revenue and other sources of support for the program. **Be specific. Include the amount and source of funding, such as funds directly from the county, Housing Support, CoC funding, Federal RHY funds, etc.** You may add lines to the funding table to describe all sources. *Include HHSSA funds being requested through this RFP*

Source	Current SFY2025 (7/1/24-6/30/25) Funds	Projected SFY2026 (7/1/25-6/30-26) Funds	SFY2026 Funding Secured?
HHSSA Funds (including this request)	$	$	☐
	$	$	☐
	$	$	☐
	$	$	☐
	$	$	☐
	$	$	☐
Total Program Budget:	$	$	

FORM 7: Priority Application Areas

1. **For projects with a DHS-funded Shelter Capital Projects that will be operational by July 2026 that have expanded shelter capacity and/or increased operating costs due to the Shelter Capital Project:**

    a. **Describe the timeline of your capital project and when you will begin incurring additional operating expenses due to the completion of the project:**

    b. **Describe in detail how your Shelter Capital Project expands shelter capacity and/or increases operational/service costs:**

2. **If you identified as a culturally specific provider in Form 3: Equity and Accessibility (Question 3)**

    a. **Are you proposing new, expanded, or sustained services targeting the unsheltered, urban (7-county metro) American Indian Community?** ☐Yes ☐No

    b. **If yes, describe your project and how it will meet unmet service needs for the American Indian Community:**

FORM 8: Collaborative Proposal Budget

Note: this form is only for collaborative (multi-agency) proposals.

Total Proposal Budget & Sub-Applicant Detail			
Budget Category	**Budget Amount for each category (7/1/2025 – 6/30/2027)**		**Amount for Each Sub-Applicant (including Lead Applicant)** (7/1/2025 – 6/30/2027)**
a. Administration (Combined administrative costs across all applicants is limited to 15 pct.)	$	**Sub-Applicant**	**Amount**
b. Operations	$	**Sub-Applicant**	**Amount**
c. Support Services	$	**Sub-Applicant**	**Amount**
TOTAL Program Funding Request * (7/1/2025 – 6/30/2027)	$	**Sub-Applicant**	**Amount**

* **This total should include all funding being requested under this proposal, including for Lead Applicants and all sub-applicants. DHS may not award more than what is included here on this total request.**

** **These amounts must match the sub-applicant budgets from Activity Forms 4-6. This budget is intended to encompass all sub-applicant budgets**

FORM 9: Collaborative Proposal Certifications

Note: this form is only for collaborative (multi-agency) proposals.

(Add additional Sub-Applicant Information tables as needed)

Information and Signatures must be complete for ALL participating sub-applicants.

Sub-Applicant #1	
Legal Name:	**Federal ID Number:**
Address:	**State Tax ID:**
Executive Director or Tribal Leader:	**Telephone:**
Email:	
By signing below, I agree to participate in this collaborative application. _____ **Signature of Executive Director or Tribal Leader:**	

Sub-Applicant #2	
Legal Name:	**Federal ID Number:**
Address:	**State Tax ID:**
Executive Director or Tribal Leader:	**Telephone:**
Email:	
By signing below, I agree to participate in this collaborative application. _____ **Signature of Executive Director or Tribal Leader:**	

Sub-Applicant #3	
Legal Name:	**Federal ID Number:**
Address:	**State Tax ID:**
Executive Director or Tribal Leader:	**Telephone:**
Email:	
By signing below, I agree to participate in this collaborative application. _____ **Signature of Executive Director or Tribal Leader:**	