CITY OF CLEVELAND DEPARTMENT OF PUBLIC HEALTH

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)

2025-2027

Request for Proposals

Date of Issuance:

Monday, November 4, 2024

Applications Due:

Friday, December 6, 2024, at 4:00 p.m.

The City of Cleveland
Application to Request Funding

2025 HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)

Due via email to OHAS@ClevelandOhio.gov by Friday, December 6, 2024

Projected Funding Available:　　　**$1,587,572 plus other funds as they become available**

Funding Period:　　　January 1, 2025, through December 31, 2025

Eligible Applicants:

Private, non-profit organizations incorporated in Ohio serve clients living within the city of Cleveland with valid 501(c)3 status from the IRS and local government units.

Eligible Recipients:

Low-income persons (80% or below median area income) diagnosed with HIV/AIDS and their family members.

Eligible Activities:

1. Tenant-based rental assistance
2. Short-term rent, mortgage, and utility payments
3. Permanent housing placement
4. Short-term supported housing
5. PLWHA housing related supportive services
   a. Housing information services
   b. CBI/case management
   c. Nutrition
   d. Workforce development

Program Requirements:
All applicants must adhere to program regulations published within The Code of Federal Regulations for the Department of Housing and Urban Development about the HOPWA program [24 CFR Chapter V Part 574].

Submission and Review:
Email one application to OHAS@ClevelandOhio.gov by Friday, December 6, 2024.

Proposals will be reviewed objectively to make funding recommendations to the City of Cleveland. The recommendations will be presented to the CDPH administration for consideration. Final funding decisions will be made by the Director and presented to Cleveland City Council for approval.

APPLICATION INSTRUCTIONS:
- All new and existing projects will be required to answer all applicable questions in this application form.
- To complete this form, click on the boxes highlighted in gray and enter your response.
- For each section, please check the 'Yes' or 'No' box that corresponds with the program you are applying for.
- Please do not change the form, rearrange the questions, or delete any sections.
- Please ensure you submit all required attachments in Section 9.
- If you have questions regarding this application, please contact HIV/STI, Project Coordinator Tiffany Greene at TGreene@ClevelandOhio.gov

2025 HOPWA Program Application

Applicant: [   ]

(Full legal name as it appears on your agency's Articles of Incorporation)

Address: [   ]

City: [   ] County: [   ] State: [   ] Zip: [   ]

Executive Director's Name: [   ]

Grant Contact Person's Name: [   ]

Telephone: [   ] Fax: [   ]

Email: [   ]

Applicant Federal Tax ID Number: [   ]

The City of Cleveland HOPWA funding is limited to service for those persons with HIV/AIDS who reside in one of the following counties. Please identify which county or counties your project proposes to serve (double click on the box and choose "checked"):

Ohio: ☐ Cuyahoga ☐ Geauga ☐ Lake ☐ Lorain ☐ Medina

Project Identification: [   ]

(Name of Agency)

Total amount of funds requested under this application: $ [   ]

To the best of my knowledge and belief, all data in this application are true and correct. The application has been duly authorized by the governing body of the applicant, and the applicant will comply with all federal HOPWA program regulations (i.e. 24 CFR part 574) and local government reporting requirements if granted.

Name of Authorized Representative & Title	Telephone Number
Signature of Authorized Representative*	**Date Signed**

* You may print/sign/scan, enter initials, or paste an electronic signature.

1. TENANT-BASED RENTAL ASSISTANCE (TBRA)

This is a request for TBRA: ☐ **YES** ☐ **NO**

Amount being requested for TBRA activities: $ _____
Anticipated program income: $ _____
Total TBRA budget: $ _____

Briefly describe how you propose to use the TBRA funds requested. If your agency currently receives TBRA funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1. Number of persons with HIV/AIDS to receive HOPWA TBRA (primary client only)	
2. Number of other persons in household to receive HOPWA TBRA	
3. Total number of persons to receive HOPWA TBRA (line 1+2)	

2. SHORT-TERM RENT, MORTGAGE, AND UTILITY (STRMU) ASSISTANCE

This is a request for STRMU ASSISTANCE: ☐ **YES** ☐ **NO**

Amount being requested for STRMU activities: $ _____
Anticipated program income: $ _____
Total STRMU budget: $ _____

Briefly describe how you propose to use the STRMU funds requested. If your agency currently receives HOPWA STRMU funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1. Number of persons with HIV/AIDS to receive HOPWA STRMU housing services (primary client only)	
2. Number of other persons in household to receive HOPWA STRMU housing services	
3. Total number of persons to receive HOPWA STRMU housing services (line 1+2)	

3. PERMANENT HOUSING PLACEMENT (PHP)

This is a request for PHP: ☐ YES ☐ NO

Amount being requested for PHP activities: $ _____
Anticipated program income: $ _____
Total PHP budget: $ _____

Briefly describe how you propose to use the PHP funds requested. If your agency currently receives HOPWA PHP funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1. Number of persons with HIV/AIDS to receive HOPWA PHP 2. (primary client only)	
3. Number of other persons in household to receive HOPWA PHP	
4. Total number of persons to receive HOPWA PHP (line 1+2)	

4. SHORT-TERM SUPPORTED HOUSING (STSH)

This is a request for STSH: ☐ YES ☐ NO

Amount being requested for STSH activities: $ _____
Anticipated program income: $ _____
Total STSH budget: $ _____

Briefly describe how you propose to use the STSH funds requested. If your agency currently receives HOPWA STSH funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1. Number of persons with HIV/AIDS served by HOPWA STSH funds (primary client only)	
2. Number of other persons in household served by HOPWA STSH funds	
3. Total number of persons served by HOPWA STSH funds (line 1+2)	

5. PLWHA HOUSING RELATED SUPPORTIVE SERVICES

a) HOUSING INFORMATION SERVICES

This is a request for HOUSING INFORMATION SERVICES: ☐ **YES** ☐ **NO**

Amount being requested for housing information services: $ _____
Anticipated program income: $ _____
Total housing information services budget: $ _____

Briefly describe how you propose using the housing information services funds requested. If your agency currently receives HOPWA housing information services, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1. Number of persons with HIV/AIDS to receive HOPWA housing information services (primary client only)	
2. Number of other persons in household to receive HOPWA housing information services	
3. Total number of persons to receive HOPWA housing information services (line 1+2)	

b) CBI/CASE MANAGEMENT

This is a request for CBI/CASE MANAGEMENT: ☐ **YES** ☐ **NO**

Amount being requested for CBI/case management services: $ _____
Anticipated program income: $ _____
Total CBI/case management budget: $ _____

Briefly describe how you propose using the CBI/case management funds requested. If your agency currently receives HOPWA CBI/case management funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1. Number of persons with HIV/AIDS to receive HOPWA CBI/case management services (primary client only)	
2. Number of other persons in household to receive HOPWA CBI/case management services	
3. Total number of persons to receive HOPWA CBI/case management services (line 1+2)	

c) NUTRITION SERVICES

This is a request for NUTRITION SERVICES: ☐ **YES**   ☐ **NO**

Amount being requested for nutrition activities: $ _____
Anticipated program income: $ _____
Total nutrition services budget: $ _____

Briefly describe how you propose using the nutrition funds requested. If your agency currently receives HOPWA nutrition funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1. Number of persons with HIV/AIDS to receive HOPWA nutrition services (primary client only)	
2. Number of other persons in household to receive HOPWA nutrition services	
3. Total number of persons to receive HOPWA nutrition services (line 1+2)	

d) WORKFORCE DEVELOPMENT

This is a request for WORKFORCE DEVELOPMENT: ☐ YES   ☐ NO

Amount being requested for workforce development activities: $ _____
Anticipated program income: $ _____
Total workforce development budget: $ _____

Briefly describe how you propose using the work development funds requested. If your agency currently receives HOPWA work development funds, please describe any adjustments you would like to make to the program.

Please note that you will also complete and attach a Supplemental Program Budget detailing the proposed use of requested funds more specifically.

Project Outputs and Goals	Projections for 1/1/2025-12/31/2025
1. Number of persons (staff or non-staff) to participate in HOPWA work development.	

8. PROGRAM AND AGENCY DESCRIPTION

All agencies are requested to answer the following questions. Those with an asterisk (*) denotes factors identified by the Cleveland Department of Public Health as pertinent to funding allocation decisions.

1. **Describe the organization's history and mission.** (500 words or less)

2. **Describe the proposed HOPWA project(s), including the housing and supportive services the project will provide.** (500 words or less)

3. **Using data, describe the need for the proposed project within the geographic area to be served. Include information on how the proposed project impacts the community efforts to provide quality housing services to persons with HIV/AIDS. *** (500 words or less)

4. **What was the process used to determine whether these services were appropriate and needed for the area? Who was involved, and in what way were persons with HIV/AIDS included in the planning process?** (500 words or less)

5. **Describe the coordination of the proposed project with other programs serving persons with HIV/AIDS within the geographic area. Include how you will ensure that there is no duplication of services.** (500 words or less)

6. **Describe your project's plan for connecting your participants with healthcare, particularly to HIV/AIDS diagnosis-specific healthcare. Provide data on successful healthcare enrollment. *** (500 words or less)

7. **Using data, describe how your project successfully reduces participants' viral load while enrolled in housing/services. *** (500 words or less)

8. **Explain the organization's capacity to implement the planned HOPWA activities successfully.** (500 words or less)

9. **Discuss the organization's ability to manage the grant, including any previous HOPWA grant management experience and experience with other city or federal grants. * (**500 words or less)

10. **Describe your history of handling HOPWA funding and whether your agency/project was the subject of any HOPWA Administrative body monitoring concerns. For renewal and existing applicants, provide details on any Single Audit/Financial audit concerns. *** (500 words or less)

11. State whether your agency/project timely submitted billing invoices to CDPH.
   (500 words or less)

12. State whether your project met the expected pace of spending or had funding give back for the prior operating year. * (500 words or less)

13. Describe the extent of inclusion of persons with HIV/AIDS in the project's planning.
   * (500 words or less)

14. Describe any challenges and barriers faced by your current and/or expected participants that you believe could make their needs particularly acute and or that could make providing services particularly difficult or cost intensive. *
   (500 words or less)

15. Describe other successes and challenges the project has faced in providing services.
   * (500 words or less)

9. REQUIRED ATTACHMENTS: Please submit the documents listed below with your application.

1. Corporate Resolution, signed by a representative of your Board of Directors, stating the name and title of the agency's authorized representative to enter into a contract with Cleveland Department of Public Health, should this application be approved. (Note: The signature on the letter and the authorized representative of the agency may not be the same person)

2. List of the Board of Directors/Trustees

3. Certification that no part of the net earnings of the organization are used to the benefit of any board member, founder, contributor, or individual who is not a consumer of the organization.

4. Copy of the organization's program termination and/or tenant/resident eviction policy for programs requesting Housing funds.

AGENCIES NOT CURRENTLY OPERATING A HOPWA PROGRAM MUST ALSO ATTACH:

1. Non-profit certification-IRS 501(c)3 ruling letter

2. Most recent audit. If a most recent audit is not complete prior to the application deadline, the audit must be submitted to the city within 30 days after the receipt of the auditor's report, but not later than nine months after the end of your fiscal year.

3. Proof that among the organization's purposes (as stated in the by-laws or articles of incorporation), significant activities related to providing services or housing to persons with acquired immunodeficiency syndrome or related diseases are included.

PROGRAM BUDGET FORM

Name of Agency:_____ Name of Fiscal/Lead Agency: _____ Name of Program/Project:_____	Total Project Budget: _____ Total request to CDPH: _____		
Project Income	**Anticipated**	**Committed**	**Total**
Income/Revenue			
CDPH (Itemize below)			
Foundations			
Government Contracts			
Corporations			
Other			
Total Project Income			
Expenses	**CDPH Request**	**Other Funding**	**Total**
Direct Program/Project Expenses			
Personnel Expenses			
Salaries and Wages			
Benefits			
Non-Personnel Expenses			
Contract Services/Consultant Fees			
Program supplies			
Transportation/mileage			
Other (specify)			
Subtotal Direct Program/Project Expenses			
Overhead			
Rent			
Utilities			
Technology Costs			
Shared Office Supplies			
Development/Fundraising			
Accounting/Audit			
Insurance			
Other (specify)			
Subtotal Overhead (not to exceed 10% of project/program expenses subtotal)			
Total Expenses			
Excess (Deficiency)			