Multifamily Housing Service Coordinator
First-Time Funding Request

OMB Approval Number 2502-0447
(exp. 01/31/2007)

Name and Address of Applicant/Owner:

1. Project Information: Please provide the information for every project included in your request; add more rows if needed.

a. Project Name and Address	b. Project Type *(I.e. Sec. 202, 236, 221(d)(3)BMIR, or Sec. 8)*	c. FHA or Project Number	d. Section 8 Number	e. # of Subsidized Rental Units

f. Resident Information	Number of Residents	% of Total Residents
Estimate # of Frail Elderly	_____	0% %
Estimate # of at Risk Elderly	_____	0% %
Estimate # Non-Elderly People w/ Disabilities	_____	0% %
Remaining Residents	_____	0% %
Total	0	100%

g. If the SC will serve multiple eligible projects, give proportionate amount of time planned for each site.

Project Name(s)	# of Hours per week

h. Is there an SC currently working at this project? _____ Yes _____ No

If yes: 1. How many hours per week does the Service Coordinator currently work?	2. How many hours per week do you want to add to your program?	3. Will you extend current employees hours or hire additional staff?

2. Budget Information**

a. Personnel (Direct Labor/Salary) *Identify Position - SC or Aide*	**Hours**	**Rate per Hour**	**Year1**	**Year 2**	**Year 3**	**Tot 3-Year**
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
Total Direct Labor Cost			0.00	0.00	0.00	0.00

b. Fringe Benefits	Rate (%)	Base	Year1	Year 2	Year 3	Tot 3-Year
	0.00%		0.00			0.00
	0%		0.00			0.00
	0%		0.00			0.00
	0%		0.00			0.00
	0%		0.00			0.00
	0%		0.00			0.00
Total Fringe Benefits Cost			0.00	0.00	0.00	0.00

c. Quality Assurance/Program Evaluation (cap - 10% of line "a", Personnel)	Hours	Rate Per Hour	Year1	Year 2	Year 3	Tot 3-Year
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
Total Quality Assurance			0.00	0.00	0.00	0.00

d. Training	Hours	Rate Per Hour	Year 1	Year 2	Year 3	Tot 3-Year
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
Total Training			0.00	0.00	0.00	0.00

e. Travel *(Indicate local private vehicle, (mileage and rate per mile) airfare (trips and fare), other (quantity and unit cost), per diem (days and rate per day).*	Year 1	Year 2	Year 3	Tot 3-Year
				0.00
				0.00
				0.00
				0.00
				0.00
Total Travel	0.00	0.00	0.00	0.00

f. Supplies and Materials	Quantity	Unit Cost	Year 1	Year 2	Year 3	Tot 3-Year
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
Total Supplies and Materials			0.00	0.00	0.00	0.00

g. Start-up Costs						
1. Creating Private Office Space	**Quantity**	**Unit Cost**	**Year 1**	**Year 2**	**Year 3**	**Tot 3-Year**
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
Subtotal for Private Office Space			0.00			0.00
2. Office Furniture/Equipment	**Quantity**	**Unit Cost**	**Year 1**	**Year 2**	**Year 3**	**Tot 3-Year**
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
Subtotal Cost of Furniture/Equipment			0.00			0.00
Total Start-Up Costs			0.00			0.00
h. Other Direct Costs	**Quantity**	**Unit Cost**	**Year 1**	**Year 2**	**Year 3**	**Tot 3-Year**
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
Total Other Direct Costs			0.00	0.00	0.00	0.00
Subtotal of Direct Costs			0.00	0.00	0.00	0.00
I. Indirect Costs	**Quantity**	**Unit Cost**	**Year 1**	**Year 2**	**Year 3**	**Tot 3-Year**
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
			0.00			0.00
Total Indirect Costs			0.00	0.00	0.00	0.00
j. Total Estimated Costs			0.00	0.00	0.00	0.00

** Please note: You may increase costs from year to year by no more than 3%.

k. Contracts: If you plan to contract out for a Service Coordinator or for Quality Assurance, list related cost. Give item and related cost.

l. Quality Assurance is _____% of line a, "Personnel (Direct Labor)". (Cannot exceed 10%.)

3. Funding Sources and Time Periods (Indicate all that apply.)

Grant	$ Amount	# of Years	# of Months		
Section 8 Operating Funds (i.e. Budget-based)	$ Amount	# of Years	# of Months	From Date	To Date
Residual Receipts	$ Amount	# of Years	# of Months	From Date	To Date
Excess Income	$ Amount	# of Years	# of Months	From Date	To Date

Signature: _____ Date: _____

Contact Name: _____ Phone #: _____ Email: _____

Project Information: Please provide the information for every project included in your request; add more rows if needed.

2. a. Project Name and Address	b. Project Type *(I.e. Sec. 202, 236, 221(d)(3)BMIR, or Sec. 8)*	c. FHA or Project Number	d. Section 8 Number	e. # of Subsidized Rental Units

f. Resident Information	Number of Residents	% of Total Residents
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Estimate # of at Risk Elderly	_____	0%
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Remaining Residents	_____	0%
Total	0	100%

g. If the SC will serve multiple eligible projects, give proportionate amount of time planned for each site.

Project Name(s)	# of Hours per week

h. Is there an SC currently working at this project? _____ Yes _____ No

If yes: 1. How many hours per week does the Service Coordinator currently work?	2. How many hours per week do you want to add to your program?	3. Will you extend current employees hours or hire additional staff?

Project Information:

3. a. Project Name and Address	b. Project Type *(I.e. Sec. 202, 236, 221(d)(3)BMIR, or Sec. 8)*	c. FHA or Project Number	d. Section 8 Number	e. # of Subsidized Rental Units

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Instructions for completing the HUD-91186	
Section 2: Budget Information	
a. Personnel (Direct Labor)	This section should show the labor costs for The Service Coordinators and/or aides. Use the hourly labor cost for salaried employees (use 2080 hours per year or the value your organization uses to perform this calculation). You may include payroll taxes here. Do not show fringe or other indirect costs in this section.
b. Fringe Benefits	Use the same standard fringe rate used by your organization. You may use a single fringe rate (a percentage of the total direct labor) or list each of the individual fringe charges. Use the Total Direct Labor Cost as the base for the fringe calculation. If your organization calculates fringe benefits differently, use a different base and discuss how you calculate fringe as a comment.
c. Quality Assurance	Give the title of the professional (e.g. MSW) or agency who will be performing QA, the number of hours over the year you expect to use them, and their hourly rate. Quality Assurance is limited to program evaluation activities and cannot exceed 10% of line a, Personnel.
d. Training	Give fees and rates for appropriate training programs, to the extent known. Otherwise estimate and provide basis for the anticipated cost.
e. Travel	Provide mileage and cost estimates for use of private vehicles or public transportation; show the estimated cost of airfare required to attend training programs, and list necessary per diem rates in accordance with your organization's policies. Give travel destinations if known.
f. Supplies and Materials	List the supplies you propose to purchase. You can use an anticipated consumption rate to estimate the cost of office or other common supplies, (e. g. 1 box paper clips every 3 months). Include replacement of office equipment. List items individually along with the quantity and their anticipated cost.
g.1. Creating Private Office Space	List expenses associated with setting up a private office for the Service Coordinator. List each anticipated cost. You may incur These costs only during the first year of your program.
g.2. Office Furniture and Equipment	List start-up expenses related to furniture, computers, printers, and other office equipment. List the quantity and unit cost.
Total Start-Up Costs	Sum of lines g.1 and g.2.
h. Other Direct Costs	Include costs such as telephone and Internet Service, printing, postage, and maintenance of office equipment, when such costs are attributable to the SC program only.
i. Indirect Costs	OMB Circular A87 defines indirect costs as those that have been incurred by multiple programs for common or joint purposes. Indirect costs are associated with the centralized services distributed throughout your agency and cannot be readily identified with one particular program. Additionally, the costs should not be otherwise treated as direct costs. If your organization already has an established indirect cost rate, use this rate and explain how it is calculated.
j. Grand Total	Sum lines "a" through "i" for each year. Then add the annual totals together to get to the total 3-year amount. You may increase costs from year to year by no more than 3%.
k. Contracts (Sub-Grantees)	If you will contract with a public or private agency to provide the Service Coordinator or Quality Assurance, list the activities and costs included in the contract in this section.

l. Quality Assurance Percent of line a, Personnel	Quality Assurance costs cannot exceed 10% of your total Personnel/Direct labor cost. Calculate your percentage and include on this line, to ensure you are within the 10% cap.
Section 3: Funding Sources and Time Periods	
Housing owners can use any of the four funding sources to pay the costs of a Service Coordinator program. You may use these resources individually or in combination with each other. Indicate which funding sources you propose to use, by giving the dollar amount, the number of years and months during which you will use the funds, and the dates of the time period, if known (e.g. from May 1, 2004 to April 30, 2005).	