Multifamily Housing Service Coo	rdinator				OM	IB Approval Number 2502-0447
First-Time Funding Request						(exp. 01/31/2007)
The public reporting burden for this collection of information for the Mul and maintaining the data needed, and completing and reviewing the co information under Section 671 of the Housing and Community Develop Department of Housing and Urban Development Reform Act of 1989 (4)	ollection of information. HUD may rument Act of 1992, and uses the in	not conduct, and a person is not re formation to determine an applica	equired to respond to, a collectiont's need for and capacity to adr	n of information unless the colle	ction displays a valid control num	ber. HUD collects the
Name and Address of Aprilla and Open and						
Name and Address of Applicant/Owner:						
1. Project Information: Please provide the inf	ormation for every proj	ect included in your re-	guest; add more rows	if needed.		
a. Project Name and Addre		b. Project Type (I.: 221(d)(3)BMI	e. Sec. 202, 236,	c. FHA or Project Number	d. Section 8 Number	e. # of Subsidized Rental Units
f. Resident Information Estimate # of Frail Elderly	Number of Residents	% of Total Residents	g. If the SC will serve multiple eligible projects, give proportionate amount of time planned for each site.			
Estimate # of at Risk Elderly				Name(s)	# of Hours	
Estimate # Non-Elderly People w/ Disabilities		% %	-	•		
Remaining Residents		%				
Total		100%				
h. Is there an SC currently working at this proje	ect? Yes	No				
If yes: 1. How many hours per week does the scurrently work?		How many hours per to add to your progran		3. Will you extend cu hours or hire addition	• •	
2. Budget Information**				1		
a. Personnel (Direct Labor/Salary) Identify Position - SC or Aide	Hours	Rate per Hour	Year1	Year 2	Year 3	Tot 3-Year

Total Direct Labor Cost

b. Fringe Benefits	Rate (%)	Base	Year1	Year 2	Year 3	Tot 3-Year
Total Fringe Benefits Cost						
c. Quality Assurance/Program Evaluation (cap - 10% of line "a", Personnel)	Hours	Rate Per Hour	Year1	Year 2	Year 3	Tot 3-Year
Tatal Quality Assurance						
Total Quality Assurance						
d. Training	Hours	Rate Per Hour	Year 1	Year 2	Year 3	Tot 3-Year
Total Training						
e. Travel (Indicate local private vehicle, (mileag other (quantity and unit cost), per diem (days a		rfare (trips and fare),	Year 1	Year 2	Year 3	Tot 3-Year
	T					
Total Travel						
f. Supplies and Materials	Quantity	Unit Cost	Year 1	Year 2	Year 3	Tot 3-Year
Total Supplies and Materials						
rotal Supplies and ividterials	1			1		

. Start-up Costs						
Creating Private Office Space	Quantity	Unit Cost	Year 1	Year 2	Year 3	Tot 3-Year
				_/ /		
				- /		
				\dashv		
				\dashv		
				\dashv / \setminus		
Subtotal for Private Office Space				_/ \		
Office Furniture/Equipment	Quantity	Unit Cost	Year 1	Year 2	Year 3	Tot 3-Year
				_ \ _ /		
				- \ /		
				- X	$ \times $	
				$+$ / \setminus		
Subtotal Cost of Furniture/Equipment				+ / $-$		
Total Start-Up Costs				┦/ \	\'	
•						
Other Direct Costs	Quantity	Unit Cost	Year 1	Year 2	Year 3	Tot 3-Year
Total Other Direct Costs		<u> </u>				
ubtotal of Direct Costs						
Indirect Costs	Quantity	Unit Cost	Year 1	Year 2	Year 3	Tot 3-Year
Total Indirect Costs						
Total Estimated Costs						
			.		<u> </u>	
Please note: You may increase costs fro	om year to year by no more	e than 3%.				

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. Contracts: If you plan to contract out fo	r a Service Coordinator or f	or Quality Assurance,	list related cost. Giv	e item and related (cost.
Quality Assurance is% of line	·)". (Cannot exceed 10)%.)		
3. Funding Sources and Time Periods Grant	(Indicate all that apply.) \$ 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:			I
Contact Name:	Phone #	:	Email: _		

Project Information: Please provide the information	mation for every projec	t included in your requ	est; 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)			d. Section 8 Number	e. # of Subsidized Rental Units
f. Resident Information Estimate # of Frail Elderly	Number of Residents	% of Total Residents			Itiple eligible projects, ime planned for each	
Estimate # of at Risk Elderly			Project	Name(s)	# of Hours	s per week
Estimate # Non-Elderly People w/ Disabilities						
Remaining Residents						
Total		100%				
h. Is there an SC currently working at this proje	ect? Yes	No			<u> </u>	
If yes: 1. How many hours per week does the scurrently work?		2. How many hours pe to add to your progran		3. Will you extend cu hours or hire addition		
				I	I	Γ
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
f. Resident Information	Number of Residents	% of Total Pecidents	a li	f the SC will serve mu	Itiple eligible projects,	give
Estimate # of Frail Elderly	Number of Residents	70 OF TOTAL RESIDENTS			ime planned for each	
Estimate # of at Risk Elderly				Name(s)		s per week
Estimate # Non-Elderly People w/ Disabilities			•	, ,		•
Remaining Residents						
Total		100%				

h. Is there an SC currently working at this proje	ect? Yes	No				
		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?		
	1			_	1	1
Ducient Information:						
Project Information:				a FIIA or Droipet	d Castian O Number	
4. 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 Estimate # of Frail Elderly	Number of Residents	% of Total Residents			Iltiple eligible projects,	
Estimate # of Frail Elderly Estimate # of at Risk Elderly		⁷⁰		Name(s)	time planned for each	s per week
Estimate # Or at NSK Elderly Estimate # Non-Elderly People w/ Disabilities			FTOJECE	ivaille(5)	# 01 110013	s per week
Remaining Residents						
Tremaining resolutions						
Total		100%				
h. Is there an SC currently working at this proje	ect? Yes	No			•	
If yes: 1. How many hours per week does the currently work?		How many hours per to add to your program		3. Will you extend cu hours or hire addition		
Project Information:		ı		T	T	T
5. a. Project Name and Add	Iress	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
	No and an af Death and	0/ - £ T - £ - 1 D : - 1 £ -	- 4	5 4la - 00 - dll	dela la all'alla la anala de	
Estimate # of Frail Elderly	Number of Residents	% of Total Residents %			Iltiple eligible projects, time planned for each	
Estimate # of at Risk Elderly				Name(s)		s per week
Estimate # Non-Elderly People w/ Disabilities		%	.,			
Remaining Residents		%				
_						
Total		100%				
h. Is there an SC currently working at this proje		No		T		
If yes: 1. How many hours per week does the Service Coordinator		How many hours per week do you want to add to your program?		Will you extend current employees hours or hire additional staff?		

Instructions for completing the HUD-91186				
Section 2: Budget Information	on			
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 h. Other Direct Costs	Sum of lines g.1 and g.2. 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.			

I. Quality Assurance Percent of	Quality Assurance costs cannot exceed 10% of your total Personnel/Direct
line a, Personnel	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).