

**Housing Choice Voucher  
(HCV) Family Self-  
Sufficiency (FSS)  
Program Coordinator  
Funding**

**U.S. Department of Housing  
and Urban Development**  
Office of Public and Indian  
Housing

OMB Approval No. 2577-0178  
Exp. (07/31/2010)

Public reporting burden for this collection of information is estimated to average 0.75 hours. This includes the time for collecting, reviewing, and reporting the data. Information provided is to determine the eligibility of the applicant for funding for the salary of a program coordinator. HUD uses the information to determine eligibility of the applicant to receive funding. Information is required to obtain benefit under 24 CFR 982.302(b). The information is subject to the confidentiality requirements of the HUD Reform Legislation. This agency may not collect this information, and you are not required to complete this form unless it displays a currently valid OMB control number.

**PART I: General Information. (To be completed by all applicants.)**

Applicant Category: <input type="checkbox"/> PHAs Not Currently administering FSS <input type="checkbox"/> PHAs Currently administering FSS	Moving-to-Work PHA? <input type="checkbox"/> Yes <input type="checkbox"/> No  State or Regional PHA? <input type="checkbox"/> Yes <input type="checkbox"/> No	DUNS Number of Applicant:	Funding Request for Fiscal Year:
A. PHA Legal Name (For joint applicants, lead PHA name): Address: _____ City: _____ County: _____ State: _____ Zip Code: _____ PHA Number of Applicant: _____			
B. Legal Name of Joint Applicant PHA. (If applicable.) Address: _____ City: _____ County: _____ State: _____ Zip Code: _____ PHA Number of Applicant: _____			
Legal Name of Joint Applicant PHA. (If applicable.) Address: _____ City: _____ County: _____ State: _____ Zip Code: _____ PHA Number of Applicant: _____			
Legal Name of Joint Applicant PHA. (If applicable.) Address: _____ City: _____ County: _____ State: _____ Zip Code: _____ PHA Number of Applicant: _____ PHA Number of Applicant: _____			
<b>List any additional co-applicants on page 4</b>			
C. Evidence demonstrating salary comparability to similar positions in the local jurisdiction for each position requested is on file at the PHA.			<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Contact information person most familiar with application:			
Name: _____		Telephone Number: _____	
Email Address: _____			



**PART II: Funding/Positions Requested by PHAs that are Currently Administering HCV/FSS Programs**

**A. Previously Funded Positions**

FY Last Funded	Salary Amount Last Funded	Salary Requested Per Position ** under this NOFA	Number of Positions at salary level	Is applicants request above percentage allowed in the NOFA? 'Y' or 'N' ***

**B. New Positions –Total salary requested per position including fringe benefits, if applicable. If more than one position, list each separately:**

Salary Requested, including Fringe Benefits**

**C. Total Requested**

1.		Total number of positions requested in Part II
2.		Total \$ requested in Part II

\*\* Salary awards will not exceed the cap per position stated in the most recent HCV/FSS NOFA.  
 \*\*\* For any position, where the applicant is requesting a percentage increase above the amount provided for in the current HCV/FSS NOFA, the applicant must comply with justification requirements in the current HCV/FSS NOFA.

**Additional space for Part II A and B on page 4**

**PART III: Requests for PHAs that are NOT currently administering HCV/FSS Programs**

**A. FSS Action Plan Information:**

	The number of HCV/FSS program slots in the HUD-approved Action Plan. (For Joint applications, provide total approved slots for all joint applicant PHAs.)
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**B. Position/Salary Requested:**

Number of Positions	Salary Requested, including Fringe Benefits if applicable**

**Additional space for Part III B on page 4**

**C. Total Requested.**

1.		Total number of positions requested in Part III B
2.		Total \$ requested in Part III B

\*\* Salary awards will not exceed the cap per position stated in the most recent HCV/FSS NOFA.

**Continuation of Part I. B, Legal Name of Joint Applicant PHAs**

Legal Name of Joint Applicant PHA. (If applicable.)	
Address:	
City:	County:
State:	Zip Code:
PHA Number of Applicant:	
Legal Name of Joint Applicant PHA. (If applicable.)	
Address:	
City:	County:
State:	Zip Code:
PHA Number of Applicant:	
PHA Number of Applicant:	

**Continuation of Part II. A, Previously Funded Positions:**

FY Last Funded	Salary Amount Last Funded	Salary Requested Per Position ** under this NOFA	Number of Positions at salary level	Is applicants request above percentage allowed in the NOFA? 'Y' or 'N' ***

**Continuation of Part II. B, New Positions:**

Salary Requested, including Fringe Benefits**

**Continuation of Part III. B, Position/Salary Requested:**

Number of Positions	Salary Requested, including Fringe Benefits if applicable**