

**U.S. DEPARTMENT OF HOUSING
 AND URBAN DEVELOPMENT
 OFFICE OF PUBLIC AND INDIAN HOUSING**

ROSS SERVICE COORDINATORS – NEEDS and SERVICE PARTNERS

Public reporting burden for the collection of information is estimated to average 4 hours per response. This includes the time for collecting, reviewing, and reporting the data. The information will be used for the ROSS grant. Response to this request for information is required in order to receive the benefits to be derived. 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. This information will allow HUD to determine eligibility for the ROSS SC Program. This information does not lend itself to confidentiality.

*****PLEASE READ NOFA CAREFULLY FOR DIRECTIONS AND MINIMUM REQUIREMENTS.*****

Name of Applicant _____

PHA/Tribe/TDHE(s) to be Served _____

| NEEDS | NEED? (check all that apply – see NOFA for requirements) | SERVICE PROVIDER/PARTNER(s) (list all) | Value of Match* |
|--|---|---|------------------------|
| Life Skills Training | | | |
| Financial Literacy/Credit Counseling/Credit Repair | | | |
| Literacy Training | | | |
| ESL | | | |
| GED/High School Equiv. | | | |
| Mentoring | | | |
| Job Soft Skills Training | | | |
| Job Hard Skills Training/Certification | | | |
| Job Search and Placement | | | |
| Job Retention/Promotion | | | |
| ISAs/IDAs | | | |
| Homeownership Counseling | | | |
| Computer Classes | | | |
| Drug/Alcohol Treatment | | | |
| Mental Health Treatment | | | |
| Health/Dental Care | | | |
| Home Maintenance classes | | | |
| Parenting classes | | | |

| | | | |
|--|--|--------------|-----------|
| Nutrition classes | | | |
| Youth Programming – tutoring/mentoring/after school/summer | | | |
| Child Care | | | |
| Transportation | | | |
| Tax Preparation Assistance | | | |
| Community Safety | | | |
| Resident Empowerment/Capacity Building | | | |
| Resident Business Development | | | |
| Assistance with Activities of Daily Living | | | |
| Meals to meet nutritional need for Elderly | | | |
| Disability Services Counseling | | | |
| Personal Emergency Response Resources | | | |
| Wellness Programs | | | |
| Other (please describe) | | | |
| Other | | | |
| Other | | | |
| Other | | | |
| Other | | | |
| | | TOTAL | \$ |

*I _____, certify that the match recorded here is supported by letters on file from community or other partners which certify to this amount of match funding (cash or in-kind) and that this represents the total match for the term of the grant.

Total Grant Requested \$ _____

Total Match Documented \$ _____

Match is _____ % of Grant Requested (must be at least 25% to qualify)

 Signature of Authorized Representative

 Title