



## **ETHNIC COMMUNITY SELF-HELP (ECSH) PROGRAM PRE-MONITORING QUESTIONNAIRE**

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*To be completed and submitted to ORR no later than Close of Business on the date specified in the Notification Letter*

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**ECSH Program Grantee**

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**Program Director**

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**Program Address**

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**Telephone**

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**Site Visit Date**

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: Through this information collection, ACF is gathering information to monitor compliance with federal practice, guidelines and requirements, provide oversight of federal funds, and provide support as needed. Information collected will be used directly to guide site visits, identify areas for technical assistance, and support recommendations and corrective actions. Public reporting burden for this collection of information is estimated to average 20 hours per grantee, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information under INA § 412(c)(1)(A), 8 U.S.C. 1522(c)(1)(A). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is 0970-0558 and the expiration date is 11/30/2023. If you have any comments on this collection of information, please contact Zahra Cheema at [Zahra.Cheema@acf.hhs.gov](mailto:Zahra.Cheema@acf.hhs.gov) or Yasmin Hussein at [Yasmin.Hussein@acf.hhs.gov](mailto:Yasmin.Hussein@acf.hhs.gov).



### Description of Local Service Provider Site

1. How many clients have been served in the ECSH program during the current project period?

2. What geographical area(s) is the ECSH program implemented?

3. List and briefly describe the services you provide under the ECSH program (expand as needed). Please specify any activities focused on serving a certain demographic such as women, older refugees, etc.

Service	Description

4. Please indicate whether you provide the following services:

Service	Description
<input type="checkbox"/>	
<input type="checkbox"/>	



5. List who you partner with to provide ECSH services (expand as needed).

Name of Provider/Partner	Service Provided

a. Do you have contracts or MOUs with the above agencies? If so, please attach a copy

b. How do you ensure services are not duplicated?

c. How do you receive information/feedback on client progress from the above-mentioned partner agencies?

6. Describe the nature of your program's relationship with local resettlement agencies and other local service providers, including referrals, coordinating measures, communications, and community outreach efforts.

7. Provide a summary of key activities supporting capacity building that may include, but are not limited to, board and/or staff training, strategic planning, external relationship building, diversifying funding, etc.



### Staffing

8. List all current Board members for your organization (include any vacant positions and expand as needed).

Name	Profession	Refugee/Individual of refugee origin (Please indicate with 'Yes' when applicable)

9. List all staff members (including paid interns, consultants, interpreters, etc.) supported with ECSH program funds using the following format (include any vacant positions).

Name	Title	FTE	Languages Spoken	# Years with Program	Main Job Duties



10. Do you have an organizational chart or document establishing clear lines of responsibility and authority? ☐ Yes ☐ No  
If so, please attach a copy.

11. Describe the process to ensure correct reporting of administrative staff time for each activity/grant.  
(For example, if one full-time staff person works in two different programs within your agency, how is their staff time reported?)

#### **Budget/Financial**

12. What is your annual operating budget for the ECSH program?

13. Who is responsible for monitoring program expenditures, including administration and operations?

14. If applicable, who is authorized to sign checks (make payments to clients)? Please note dollar amounts and level of authorization.

15. If payments are made to clients, what is the purpose of those payments?

16. Has an independent auditor examined your ECSH program directly or indirectly in the last two years? ☐ Yes ☐ No



If yes, attach report of findings. Were the findings in the audit addressed and resolved?

17. What non-Federal funding sources, if any, contribute to the ECSH program? Please note the amount and source of these funds (expand as needed):

Source of Funds	Amount

18. Do you have an inventory of items purchased with grant funds? If so, who maintains this?

#### Service Delivery

19. How do you determine that clients are eligible for services and who to enroll in the ECSH program?

20. Describe your enrollment and orientation process.

21. How does your staff work with clients to determine what services they need (to develop an individualized service plan, etc.)? And what is the process for tracking and evaluating client progress?



22. How do you ensure compliance with Title VI as it pertains to language access? Include information on items ‘a’ thru ‘e’ below in your response:

- a. Accessibility of written Limited English Proficiency (LEP) policies and procedures in your office
- b. Staff training by type, frequency, etc.
- c. Methods for notifying clients of their right to language assistance without charge
- d. Mechanisms to ensure that the language assistance provided is effective
- e. Procedures for addressing clients who decline language assistance/interpreter services in favor of assistance from family or friends.

23. What is your policy on record retention (both programmatic and financial)?

24. What mechanisms do you use to receive feedback from clients (e.g., surveys, focus groups, etc.) and how often does this occur?

25. What specific practices, if any, have you implemented to improve ECSH program outcomes? Please describe the practices and any related outcomes.