



## **MICROENTERPRISE DEVELOPMENT PROGRAM PRE-MONITORING QUESTIONNAIRE**

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*To be completed and submitted to ORR no later than Close of Business [Enter Date]*

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**Program Name**

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**Program Director**

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 5 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 11/30/2026. If you have any comments on this collection of information, please contact Kendall Souders at [Kendall.Souders@acf.hhs.gov](mailto:Kendall.Souders@acf.hhs.gov).

In immediate response to priorities of the current administration, this form has been updated with the following changes prior to approval by the Office of Management and Budget (OMB), as required by the Paperwork Reduction Act (PRA) of 1995 (44. USC. 3501 et seq.). The PRA requires that agencies obtain OMB approval before requesting information from the public, and OMB review and approval for most changes to an approved information. ACF is working to process these changes through OMB to come into compliance with the PRA but has implemented changes to the OMB-approved form to ensure compliance with the following Executive Orders: Executive Order(s) 14168 and/or 14151, 14173, 14224. Other than these changes, this form is approved under OMB #: 0970-0558.



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**Authorized Representative**

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**Monitoring Date(s)**

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## Description of Local Service Provider Site

| 1. MED Caseload Information                                                                                                                                                                                       | Responses       |                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------|
| a. How many total clients have you ever enrolled into the MED Program during the 5-year project period? (Count total enrollments to date, from beginning of this project cycle. Count each enrollment only once.) | #               |                       |
| b. How many clients did you aim to serve for the entire project period in your original proposal?                                                                                                                 | #               |                       |
| c. What are the three nationalities most represented in your current caseload?                                                                                                                                    |                 |                       |
| d. Compared with the nationalities you identified in 1c above, what are the nationalities of clients resettled in your area currently?                                                                            |                 |                       |
| e. What is the breakdown of MED clients during the 5-year project period to date according to sex?                                                                                                                | Male: #         |                       |
|                                                                                                                                                                                                                   | Female: #       |                       |
|                                                                                                                                                                                                                   |                 |                       |
| 2. MED Program Information                                                                                                                                                                                        | Using ORR Funds | Using Leveraged Funds |
| a. How many credit builder loans have you disbursed during the 5-year project period to date?                                                                                                                     | #               | #                     |
| b. How many total credit builder loans did you aim to disburse in your original proposal, for the entire project period?                                                                                          | #               | #                     |
| c. What is the \$ amount of CBL loans you have disbursed during the 5-year                                                                                                                                        | \$              | \$                    |



|                                                                                                                                       |    |    |
|---------------------------------------------------------------------------------------------------------------------------------------|----|----|
| project period to date?                                                                                                               |    |    |
| d. How many MED startup loans have you disbursed during the 5-year project period to date?                                            | #  | #  |
| e. How many total MED startup loans did you aim to disburse in your original proposal, for the entire project period?                 | #  | #  |
| f. What is the \$ amount of MED startup loans you have disbursed during the 5-year project period to date?                            | \$ | \$ |
| g. How many MED stabilization/expansion loans have you disbursed during the 5-year project period to date?                            | #  | #  |
| h. How many total MED stabilization/expansion loans did you aim to disburse in your original proposal, for the entire project period? | #  | #  |
| i. What is the \$ amount of MED stabilization/expansion loans you have disbursed during the 5-year project period to date?            | \$ | \$ |

| <b>MED Program Technical Assistance and Jobs Information</b>                                                                    | <b>Responses</b> |
|---------------------------------------------------------------------------------------------------------------------------------|------------------|
| j. How many hours of pre-loan technical assistance did you provide during the 5-year project period to date?                    | #                |
| k. How many total hours of pre-loan technical assistance did you list in your original proposal, for the entire project period? | #                |
| l. How many hours of post-loan technical assistance did you provide during the 5-year project period to date?                   | #                |
| m. How many hours of post-loan technical assistance did you list in your original proposal, for the entire project period?      | #                |
| n. How many jobs did you create during the 5-year project period to date?                                                       | #                |
| o. How many total jobs did you aim to create in your original proposal, for the entire project period?                          | #                |
| p. How many jobs did you retain during the 5-year project period to date?                                                       | #                |
| q. How many jobs did you aim to retain in your original proposal, for the entire project period?                                | #                |

3. Please list and briefly describe the services you provide in the MED Program. Using the drop-down, select whether the service is provided in-house or through a partner. Expand as needed.



| Service | Service Description | Select In-house or Partner |
|---------|---------------------|----------------------------|
|         |                     | Choose an item.            |
|         |                     | Choose an item.            |
|         |                     | Choose an item.            |
|         |                     | Choose an item.            |
|         |                     | Choose an item.            |

4. ORR seeks to disseminate promising practices that are identified in the course of monitoring. Please describe any potentially unique or innovative MED programmatic or operational activities you currently implement that could serve as a model to other MED programs. (Responding to this question is optional.):

*Please also answer these questions:*

- How has implementing this activity improved operations or contributed to positive outcomes for refugees?
  - What types of data do you have that show it is making a difference?
  - Do you believe this activity could be adapted at other agencies and in other contexts?
- 5a. Describe any external and/or internal conditions or factors (both positive and negative) that have impacted or may impact MED Program performance.
- 5b. What measures have you taken to overcome any negative conditions or factors that have impacted or may impact MED Program performance?
- 5c. What evidence do you have that any of these measures may have improved performance?

## Staffing

- 6a. Using the following table, list all paid staff members (including paid interns) supported with MED Program funds. Include any vacant positions.



ADMINISTRATION FOR  
**CHILDREN & FAMILIES**

Office of Refugee Resettlement | 330 C Street, S.W., Washington, DC 20201  
www.acf.hhs.gov/programs/orr

| Name | Position Title | Hours/<br>Week | FTE | Languages | # Years<br>Worked on<br>MED<br>Program | Primary Functions |
|------|----------------|----------------|-----|-----------|----------------------------------------|-------------------|
|      |                |                |     |           |                                        |                   |
|      |                |                |     |           |                                        |                   |
|      |                |                |     |           |                                        |                   |
|      |                |                |     |           |                                        |                   |
|      |                |                |     |           |                                        |                   |

6b. Please list the total MED hours per week and FTEs in the table below.

|                                           |   |
|-------------------------------------------|---|
| <b>Total Hours/Week:</b>                  | # |
| <b>Total FTE Paid with Program Funds:</b> | # |

7. Do you have an organizational chart or document establishing clear lines of responsibility and authority?

Choose an item.

If yes, please attach a copy.

8. Answer the following if you utilize volunteers/interns to assist in delivering MED services:

| Questions                                                                                                                    | Responses |
|------------------------------------------------------------------------------------------------------------------------------|-----------|
| a. How are volunteers -<br>i. Recruited?                                                                                     |           |
| ii. Screened?                                                                                                                |           |
| iii. Trained?                                                                                                                |           |
| iv. Supervised?                                                                                                              |           |
| b. How do you document<br>volunteer services?                                                                                |           |
| c. What is the total number<br>of hours volunteers<br>contributed in support of<br>the MED Program in the<br>last 12 months? | #         |
| d. What tasks do volunteers                                                                                                  |           |



|                                                                                 |  |
|---------------------------------------------------------------------------------|--|
| typically perform?                                                              |  |
| e. Approximately how many hours per week do volunteers contribute to each task? |  |

## Budget and Financial

9. How does your current (actual) spending compare to your projected spending for the program this budget year?
10. What systems are in place to ensure that expenditure reports represent accurate, allowable costs spent according to the budget?
11. Please describe how interest accrued on MED loans is tracked and utilized.
12. What other non-federal funding sources, if any, contribute to the MED Program? Please note the source and amount of these funds, expanding as needed.

| Source of Funds | Amount |
|-----------------|--------|
|                 | \$     |
|                 | \$     |
|                 | \$     |
|                 | \$     |
|                 | \$     |

13. Describe the process to ensure correct reporting of administrative staff time for each activity/grant (per 45. CFR 400.206-207).

## Technical Assistance

14. Describe the technical assistance you provide through your program or through a partnering agency. You must address how you provide the required MED training/technical assistance and you may also detail any additional type of technical assistance your program or partners provide. Expand as needed.



| Type of Technical Assistance (MED or Other – specify) | Technical Assistance Provider (In-house, Agency/Partner name, or if Other, please specify) | Topics Covered | Duration |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------|----------|
|                                                       |                                                                                            |                | # hours  |
|                                                       |                                                                                            |                | # hours  |
|                                                       |                                                                                            |                | # hours  |
|                                                       |                                                                                            |                | # hours  |

15. Has any of your technical assistance content and/or method of delivery changed from what you identified in your original proposal? If so, please describe.

## Portfolio Quality

16. What is your PAR30 for ORR loans ((Outstanding Balance on Arrears over 30 days)/Total Outstanding Loan Portfolio)?

17. What is your Write-Off Ratio for ORR loans ((Write-Offs)/Average Gross Loan Portfolio)?

18. What is your Risk Coverage Ratio for ORR loans ((Loan Loss Reserve)/PAR30)?

## Other

19a. Describe your outreach strategy for client recruitment.

19b. Have you encountered any obstacles to your original plan? If so, how are you working through those obstacles?

20. Describe the nature of your program's relationship with the following stakeholders, including descriptions of coordination, communication, and community outreach measures:

- State Refugee Coordinator (SRC): (In addition to addressing the question above, please also include the date of your last interaction with the SRC and the nature of the interaction.)



b. Local refugee resettlement agencies:

c. Other local service providers:

21. List any partners (formal and/or informal), including any training partners, which contribute to your MED Program. Expand as needed.

| Name of Partner | Type of Service Provider | Nature of the Collaboration |
|-----------------|--------------------------|-----------------------------|
|                 |                          |                             |
|                 |                          |                             |
|                 |                          |                             |

22. How do you ensure the MED Program can deliver services in a way that will facilitate participant understanding and progress towards identified program goals ?

23. How are you reviewing existing programming and develop new programming without discrimination on the basis of race, color, religion, nationality, sex, political opinion, age, or disability?

24. What mechanisms do you use to receive feedback from clients and how often does this occur?

25. Please describe your organization's process for handling client grievances.

26. How do you ensure the utmost protection of any personally identifiable information (PII) collected?

27. What have been the opportunities and challenges for your organization in implementing the project?

28. Please describe your organization's process for assessing program performance and effectiveness. Include the methods and tools used, types of data collected and analyzed, roles of key staff involved, and how often this process occurs.