**Community Services Block Grant (CSBG)**

***CARES Act CSBG Supplemental Application for Funds***

**Due: COB Friday, June 12, 2020**

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| **Program Information** |
| **Grantee:** | Click here to enter text. | **Projected Allocation Amount:** | **$**Click here to enter text. |
| **Eligible Entity Type:** | Choose an item. | **Federal Tax ID #:** | Click here to enter text. |
| **Service Area** *(by county)***:** | Click here to enter text. | **DUNS #:** | Click here to enter text. |
| **Sub-Grantees:** | [ ]  Yes [ ]  No | **If yes, how many Sub-Grantees will receive funds?** | Choose an item. |

*The CSP will not consider incomplete applications, including missing attachments or other requested documentation, for award of funds. Applications turned in for final submission must include all needed information by close of business Friday, June 12, 2020. All required attachments can be found on the CSP website, at:* [*https://health.wyo.gov/publichealth/rural/wyoming-community-services-program/*](https://health.wyo.gov/publichealth/rural/wyoming-community-services-program/)

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| **Checklist of Required Attachments** |
|[ ]  CARES Budget *(for Grantee and each Sub-Grantee(s))* | Section 2 |
|[ ]  CARES Mapping Worksheet *(for each program and Sub-Grantee(s))* | Section 4.C |
|[ ]  CARES Community Action Plan (CAP) | Section 5.A |
|[ ]  Assurances  | CSBG Act |

**CARES Act CSBG Supplemental funds must be tracked separately than your regular CSBG allocations. Please ensure your financial management systems allow for this. You will be receiving a separate voucher for reimbursements for each funding stream.**

1. **GENERAL INFORMATION**
2. **Contract Signatory**

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| --- | --- | --- | --- |
| **Name:** | Click here to enter text. | **Title:** | Click here to enter text. |
| **Mailing Address:** | Click here to enter text. | **Phone:** | Click here to enter text. |
| **City/Zip:** | Click here to enter text. | **Email:** | Click here to enter text. |

1. **Point of Contact**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | Click here to enter text. | **Title:** | Click here to enter text. |
| **Mailing Address:** | Click here to enter text. | **Phone:** | Click here to enter text. |
| **City/Zip:** | Click here to enter text. | **Email:** | Click here to enter text. |

1. **BUDGET**

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| Please complete a CARES Budget for the Grantee and all Sub-grantees (if applicable) as an attachment for this section.  |

1. **Salaries and Wages Detail**

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| *Only complete if you are using CARES Act funds to pay a portion or all of employees’ salaries and wages.* |

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| **Title/Position** | **Annual Salary** | **# of Months** | **Time Spent on CSBG (%)** | **CSBG Portion of Salary** |
| Click here to enter text. | **$**Click here to enter text. | Choose an item. | Click here to enter text. | **$** Click here to enter text. |
| Click here to enter text. | **$**Click here to enter text. | Choose an item. | Click here to enter text. | **$** Click here to enter text. |
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| Click here to enter text. | **$**Click here to enter text. | Choose an item. | Click here to enter text. | **$** Click here to enter text. |

1. **SERVICE DELIVERY**
2. **Funded Projects**

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| *If you will not be funding Sub-Grantees this year, please just list your agency’s information and leave the remainder of the cells blank.*  |

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| **Sub-Grantee/Program Name** | **Allocation Amount** | **DUNS #** | **Service/Project Description** | **Need(s) Met by Service Provision as Listed in your COVID-19 CNA Addendum** |
| Click here to enter text. | **$**Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | **$**Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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1. **Services Provided**

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| *Please provide a narrative of the services that your programs and/or your Sub-Grantees will be providing with the CARES Act CSBG Supplemental funds.*  |
| Click here to enter text. |

1. **DATA REPORTING**
2. **Federal Objectives**

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| *Select one or more federal objectives, as listed in Information Memorandum #152, to be addressed through the service provision of the Grantee and/or Sub-Grantee(s).* |

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|[ ]  **Employment** |
|[ ]  **Education and Cognitive Development** |
|[ ]  **Income, Infrastructure, and Asset Building** |
|[ ]  **Housing** |
|[ ]  **Health and Social/Behavioral Development (include Nutrition)** |
|[ ]  **Civic Engagement and Community Involvement** |
|[ ]  **Services Supporting Multiple Domains** |
|[ ]  **Linkages (e.g. partnerships that support these domains)** |
|[ ]  **Agency Capacity Building** |
|[ ]  **Other (e.g. emergency management/disaster relief)** |

1. **National Goals**

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| *Select one or more National Goals to be addressed through the service provision of the Grantee and/or Sub-Grantee(s).* |

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|[ ]  **Goal 1: Individuals and families with low-incomes are stable and achieve economic security.** |
|[ ]  **Goal 2: Communities where people with low-incomes live are healthy and offer economic opportunity.** |
|[ ]  **Goal 3: People with low-incomes are engaged and active in building opportunities in communities.**  |

1. **National Performance Indicators**

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| Please complete a CARES Mapping Worksheet for all programs, including Sub-Grantees (if applicable) as an attachment(s) for this section. |

1. **PLANNING**
2. **Community Action Plan**

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| Please complete a CARES Community Action Plan as an attachment for this section.  |

**Official Tripartite Board Action**

*Submission of this form indicates official action taken by the applicant’s governing Tripartite Board authorizing application for these funds.*

[ ] I certify that CSBG funds will not be used for construction-related expenses.

[ ] I certify that CSBG funds will not be used for any type of political activity.

[ ] I certify that CSBG funds will be used in accordance to the OMB Uniform Guidance and the CSBG Act.

**The undersigned hereby certifies that the CARES Act CSBG Supplemental Application for Funds, and the accompanying attachments, was reviewed and approved by the governing body of this organization on** Click here to enter a date.**.**

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Signature, Board Chair/President/Contract Signatory

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Printed Name, Board Chair/President/Contract Signatory

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Title

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Date