Hunger Prevention Nutrition Assistance Program

OPERATIONS SUPPORT APPLICATION 2010-2011

(Please type or clearly print all responses)

Please return 7 copies of the completed application to Foodlink. Applications must be received by **May 18th, 2010**

Name of Emergency Food Program: ____

Address: ____

City: ______________ **State**: _____________ **Zip Code**: _____________ **County**: ______________

Foodlink Customer number: _________________ **Five-digit HPNAP ID**: ________________

Person(s) to be contacted regarding the administration of this grant and documentation:

Names(s): ____________________________________ Position: ______________________________

Phone(s): _________________________________FAX number: ______________________________

Email: ____

When did your emergency food program begin operating? Month ________ Year ________

***Programs in operation for less than 6 months are Not-Eligible for this grant**

Have you ever received Operation Support funding in the past? _______ **How much?** ___________

(First Time OS recipients are subject to on-site inspection before funds are received)

SPECIFIC GRANT REQUESTS:

Please fill out a budget page for each category of Operations Support you are requesting funding for. Please do not include pages that you leave blank.

You may only apply for a maximum of two funding categories. Due to funding limitations, we may not have the ability to fund all categories requested. Please list from highest priority (1) to lowest priority (2), the categories you are requesting.

Funding Category	**Amount of Request**	**Priority # (1st, 2nd)**
Staff	$	
Utilities	$	
Space	$	
Disposables	$	
Transportation	$	

Total Request Funds	$

Name of Person Completing Application: ____________________________ Phone: _________________

I verify that the information provided in this application is true to the best of my knowledge.

Signature: ____ Date: _________________

This application must be received by ***May 18th, 2010***

Send 7 collated and stapled copies of the completed application to:

Foodlink, Inc.
936 Exchange Street
Rochester, NY 14608-2924
Attn: Operation Support 10-11

DO NOT send copies of the instruction section: only send the application pages that you filled out. An incomplete application form will automatically disqualify the agency's request. The NYS Department of Health and Foodlink, Inc. reserve the right to reject or lower funding allocations based on responses submitted.

*****IMPORTANT*****

ALL APPLICANTS MUST COMPLETE THIS SECTION AND THE BUDGET PAGE FOR THE CAEGORY (OR CATEGORIES) OF FUNDING REQUESTED.

Nutritional Services

a) Do you distribute fresh produce? YES☐ NO☐
If "No" please explain:
____

b) Promoting Healthy Eating: *Obesity and heart related conditions have a significant impact on low-income populations. Adequate nutrient intake also influences energy level and work performance.* What does your program do to improve health through nutrition?

☐Provide Meals or Food Packages with an Abundance of Fruits and Vegetables
☐Provide/Promote Protein and Dairy Products which are Low in Saturated Fat
☐Provide Recipes for Nutritious Foods
☐Provide Handouts that Promote Healthy Eating ☐ Healthy Cooking Classes
☐Host Demonstrations for Fruits and Vegetables ☐ Other

Collaboration

a) What additional services / referrals does your progrm provide.
☐Child Health Plus/Family Health Plus ☐ Companionship/Emotional Support ☐ Other
☐DSS/Medicaid ☐ WIC
☐ Food Stamps ☐ Smoking Cessation

b) Please list three organizations that you frequently take referrals from:

(1)___________________________ (2) ________________________ (3)__________________________

c) What other Emergency Food Providers operate in your service area? (Please list name & type of program):

a. How do you coordinate with these providers in order to maximize your resources?

d) Over the past year, have you attended:
Foodlink's Annual Agency Conference and workshop day YES☐ NO☐
If No, why not? ____

a. Any local or regional meetings on hunger issues YES☐ NO☐

Please list name & location of meetings in your area: ___________________________________

IMPORTANT

ALL APPLICANTS MUST COMPLETE THIS SECTION AND THE BUDGET PAGE FOR THE CAEGORY (OR CATEGORIES) OF FUNDING REQUESTED.

Impact and/or Uniqueness of Program in the Community:

This application will be reviewed by a small committee. In deciding on awards, committee members are asked to consider the impact and/or uniqueness of your program in its community. On previous pages you have provided information about the number of meals you provide; in the space below, please describe how your program's emergency food assistance efforts make a difference in your community. This may include, but is not limited to, the following: how people learn about the program, client eligibility criteria, how this program cooperates with other agencies, how program services complement those of other agencies, unique services or efforts to meet special needs or the needs of specific groups, growth of services over time, etc. **(**Attach additional sheets if needed.**)**

FOR SHELTER PROGRAMS ONLY:

a) Is this shelter a Tier 2 Shelter under NYS OTDA? YES☐ NO☐
(Tier 2 Shelters are not eligible for O.S. awards)

b) Do you receive a per diem rate (amount) from DSS (Department of Social Services) or DHS (Department of Homeless Services)? YES☐ NO☐

c) If yes, what is your per diem rate? _________________________

d) Average number of days each month that your shelter is open for guests to spend the night: _____

e) Number of months per year shelter is in operation: _____________

f) Average number of guests sheltered each month: ______________

g) Average length of stay for shelter guests: _________________

h) Average number of meals served per month from April 1, 2009 – March 31, 2010
(or other recent 12-month period)
Total meals served in the year: __________ divided by 12= _______ Average number meals/month

i) Average number of meals served daily to shelter guests:
_____Breakfast _____Lunch _____Snack _____Dinner

j) Days of week and hours of food service: _____________________________________

k) Describe the manner that clients/guests access meals (check all that apply):
- ☐ Cook/chef prepares meals on-site for clients/guests to consume.
- ☐ Residents plan and prepare meals together.
- ☐ Residents and cook/chef plan and prepare meals for clients/guests.
- ☐ Residents prepare their own individual meals on-site.
- ☐ Meals are consumed off premises.
- ☐ Residents have access to food at all times.
- ☐ Residents access meals at scheduled meal times.
- ☐ Residents receive food from local food pantry.
- ☐ Other, describe: ____

____
____
____

l) Please attach a recent menu.

m) Which meals (breakfast, lunch and/or dinner) are you requesting funding for and why?
____
____

FOR FOOD PANTRIES ONLY:

a) **Average people served per month** from April 1, 2009 – March 31, 2010*
(or other recent 12 month period, use the number for the monthly reports submitted to Foodlink)

Total people served in the year: _________ divided by 12 = ______ Average number people per month
*Please do not include numbers from mass distributions provided by Foodlink – These have different reporting forms.

b) What days and times is your pantry open to the public for regular food distributions?

Day of the Week	Number of days open per month	Hours Open
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Total Days open per month:		

☐On Call or By Appointment Only
☐Delivery Only

c) If you have no "open" hours, please describe how pantry service is made available to the public:

d) Please describe the geographical area you serve, including zip codes:

e) How many days worth of food do you provide per household?
☐ 3-day package ☐ 5-day package ☐Other: ________________________

f) Please check the method of your regular food distribution:
☐ Client Choice ☐ Pre-packed bags ☐Other: ________________________
Please explain how food is distributed, if using client choice; what model is being used?
____
____

g) How often will you provide food assistance to a household?
_____No set limit (need is assessed each time)
_____Once per month or once every 30 days
_____Once every three months
_____Other-please describe: ____

FOR SOUP KITCHENS ONLY:

a) **Average number of meals** served per month from April 1, 2009 – March 31, 2010
(or other recent 12 month period, use the number for the monthly reports submitted to Foodlink)

Total meals served in the year: ___________ divided by 12= _______ Average number meals/month

b) **Service Schedule:** (actual days the doors are open to actively prepare and serve food to guests)

- How many days are you open? ____ days per week **or** ____ days per month
- Which days of the week does your program serve meals? (Please check):

_____Monday _____Tuesday _____Wed _____Thursday _____Friday _____Sat _____Sun

- If your program does not have the same schedule each week (for example, if it is open one week per month), please describe the schedule:

- If your site is usually closed any month (e.g. during the summer), list what months it is closed:

c) **Which meals does your site provide**?
Check meal(s) served and write in hours: (ie. 11am – 2pm)

	Hours Served:		**Hours Served:**
_____Breakfast	___________	_____Lunch	___________
_____Dinner	___________	_____Other (please explain)	___________

d) Does your facility hold a current permit from the County or State Department of Health?
YES☐ NO☐

e) Please attach a Sample Menu, or describe any additional food-related services provided by the program.

f) Food Safety
1) When was the last time staff attended food safety training with Foodlink? ______________
2) Monroe County Agencies: please list the names your L1 and L2 certified food handlers:
Person with L1 Certification: ________________ expiration date: ____________________
Person with L2 Certification: _________________ expiration date: ____________________

FOR YOUTH SERIVCE PROGRAMS ONLY:

Please note that Youth Service Programs must provide a complete meal, must have applied for and been deemed ineligible for the Child and Adult Care Food Program (CACFP), and be serving a low income population to be eligible for an award. Kids Cafes receiving CACFP funding are not eligible for an award.

a) Do you receive CACFP funding? YES☐ NO☐

b) Have you applied for CACFP funding and been rejected or denied funding?
YES☐ NO☐

If Yes, please state reason of denial received from CACFP.

c) Are you serving a primarily low income population? YES☐ NO☐
If yes, describe this population and/or attach proof that they are low income.

d) Check the category to identify the meals you offer and fill in a number for the average number of children served per meal.

____Breakfast # of children_____
____ Lunch # of children______
____Dinner # of individuals _____

e) Which meal services are you requesting funding for (list all that apply; e.g. breakfast, lunch and dinner) and why?
____
____
____
____

New York State Department of Health
Hunger Prevention and Nutrition Assistance Program

Please Indicate Priority of this request: #______

OPERATIONS SUPPORT BUDGET PROPOSAL: STAFF

*** Please answer every question. Incomplete applications may be disqualified. ***

Amount requested $____________

1) Title of Staff Position: ____

List the specific duties this staff person performs. If operation of the food assistance program is only part of the position, list all tasks including those related to food assistance, **or**, attach the job description, highlighting the relevant duties.

2) Approximately how many hours per day or week does the staff person work on food assistance?

________hours per ________

What percentage of the salary will be covered by this grant ________%

3) What is the wage rate? ___________________

4) Did your program receive HPNAP Operation Support Staff funding in 2009-10?

YES☐ NO☐ If yes, How much? $________________

5) Please list the sources and approximate amounts of any other funding source(s) currently which contribute to funding this position:

6) How would the requested grant funds support or improve your program's ability to provide food assistance to needy people? Please be specific. List your program's goals to maintain or improve the quality and/or quantity of food assistance during the 2010-2011 grant year.

7) Check which form(s) of documentation your program can provide to verify the use of the grant funds:

____ Copies of the payroll register from an outside payroll source.

____ Copies of time cards or time sheets showing days and hours worked, and copies of the canceled pay checks.

8) Who will be responsible for submitting the documentation?

Name: ____________________________________ Phone: _____________________________

Email address: ____

New York State Department of Health
Hunger Prevention and Nutrition Assistance Program

Please Indicate Priority of this request: #______

OPERATIONS SUPPORT BUDGET PROPOSAL: UTLITIES

*** Please answer every question. Incomplete applications may be disqualified. ***

Amount requested $________

1) Explain clearly how this amount was estimated. (For example, was it based on expenses in the past, or did you use estimates of how much it costs to operate a freezer or other equipment?)
(Copies of bills are not required for the application, but are required for documentation if you receive a grant for utilities)

2) If only a proportion of a utility bill will be charged to the Operations Support grant, explain what percentage of the bill will be charged, and why. (For example, does the food pantry occupy a percentage of the space to be heated?)

___________%

3) Did your program receive HPNAP Operation Support Utilities funding in 2009-10?
YES☐ NO☐ If yes, how much? $__________

4) If any other funding source(s) currently contribute to funding this expense, please list the sources:

5) How would the requested grant funds support or improve your program's ability to provide food assistance to needy people? Please be specific. List your program's goals to maintain or improve the quality and/or quantity of food assistance during the 2010-2011 grant year.

6) Who will be responsible for submitting the documentation?

Name: __________________________________ Phone: ___________________________

Email address: ____

New York State Department of Health
Hunger Prevention and Nutrition Assistance Program

Please Indicate Priority of this request: #______

OPERATIONS SUPPORT BUDGET PROPOSAL: SPACE

*** Please answer every question. Incomplete applications may be disqualified. ***

Amount requested $__________

Important: **You must include** a *copy of the rental agreement or a letter stating the rent/user fee from the organization that provides the space*. Include this information, even if you previously received an Operations Support grant. Only space used for food service, distribution, or food storage are eligible for funding.

1) If only a proportion of your rent will be charged to the Operations Support grant, please give a clear explanation for what percentage of your rent will be paid by the OS grant. Please enclose a blueprint or sketched floor plan of the program space in relation to the whole rental unit.

   __________%

2) Did your program receive HPNAP Operation Support funding for space in 2009-10?
   YES☐ NO☐ If yes, how much? $_______

3) If any other funding source(s) currently contribute to funding the cost, please list the source(s).

4) How will the requested grant funds support or improve your program's ability to provide food assistance to needy people? Please be specific. List your program's goals to maintain or improve the quality and/or quantity of food assistance during the 2010-2011 grant year.

5) Who will be responsible for submitting the documentation?

   Name: ___________________________________ Phone: ____________________________
   Email address: ____

New York State Department of Health
Hunger Prevention and Nutrition Assistance Program

Please Indicate Priority of this request: #______

OPERATIONS SUPPORT BUDGET PROPOSAL: DISPOSABLES

*** Please answer every question. Incomplete applications may be disqualified. ***

Amount requested $________

1) List the specific disposable items you plan to buy, the amount of each, and the estimated price per case. (Please attach another sheet if you need more room.)

Item(s)	***Number of Cases***	***Price Per Case***	***Total Cost***
1.			
2.			
3.			
4.			
5.			
6.			
Total Cost for all items:			

2) Did your program receive HPNAP Operation Support funding for disposables in 2009-10?
YES☐ NO☐ If yes, How much $_________

3) If any other source(s) currently contribute to funding the disposables needed for your program, please list the sources and amounts from each.

4) How will the requested grant funds support or improve your program's ability to provide food assistance to needy people? List your program's goals to maintain or improve the quality and/or quantity of food assistance during the 2010-2011 grant year.

5) Who will be responsible for submitting the copies of vendor invoices (or itemized cash register receipts) and copies of cancelled checks to document the use of these funds?

Name: ____________________________________ Phone: ____________________________

Email address: ____

New York State Department of Health
Hunger Prevention and Nutrition Assistance Program

Please Indicate Priority of this request: #______

OPERATIONS SUPPORT BUDGET PROPOSAL: TRANSPORTATION

*** Please answer every question. Incomplete applications may be disqualified. ***

Amount requested $___________

1) Explain clearly and in detail how the amount requested was estimated, (for example, was it based on expenses in the past or did you use estimates of how much it costs to transport food from source to EFRO/Program site? Attach an extra sheet if necessary).

2) Describe how you plan to use the requested funds for transporting food from a source to your program. (Note: HPNAP funds cannot be used to deliver food to clients).

3) Where will you pick up food, how often and how many miles do you need to transport it? (Mileage allowance is $0.55 cents per mile: Multiply miles by .55)

4) If you are requesting funds to rent a vehicle, what size of vehicle will you need? (Please attach another sheet of paper if needed).

5) Did your program receive HPNAP funding for transportation in 2009-2010?

   YES☐ NO☐ If yes, how much? $_________

6) If any other source(s) currently contribute to funding the food transportation needed for your program, please list the sources and the amounts from each.

Continue on next page

7) How will the requested funds support or improve your program's ability to provide food assistance to needy people? How much food (estimate pounds or cases) will you transport?

8) To verify transportation costs, the following documentation must be maintained:

- records indicating the payment of funds for vehicle rental/lease option
- mileage logs showing dates, destination, and odometer reading of mileage incurred on vehicles
- records (receipts, invoices, bills of lading, etc.) indication that the transportation costs charged to the state were required to move food from source to EFRO site.

Please attach the following:

1. Two (2) quotes from separate truck rental companies
2. A copy of your current contract and payment receipts.

Please be aware that Operation Support DOES NOT cover the cost of mileage or gas when renting a truck. Rental Truck receipts must show payment to be accepted.

9) Who will be responsible for submitting the documentation?

Name: ___________________________________ Phone: ____________________________

Email address: ____

New York State Department of Health
Hunger Prevention and Nutrition Assistance Program

Please Indicate Priority of this request: #______

OPERATIONS SUPPORT BUDGET PROPOSAL: CAPITAL EQUIPMENT (FOOD SERVICE EQUIPMENT)

*** Please answer every question. Incomplete applications may be disqualified. ***

Amount requested: $________

- List the equipment item(s) you are requesting and give a brief description of each. Include the brand, model number and total cost. **At least 2(two) written quotes** from different vendors must be provided for comparable models for each item requested. **Temporary (sale) price quotes will not be accepted, On-line quotes will now be accepted for the first time**. *Warranty and delivery charges can only be considered if they are part of one package price for the equipment. These expenses cannot be considered if listed separately. Ask the vendors to include warranty and delivery in a package price.*
- **IMPORTANT –** Any equipment bought with HPNAP funds must be NEW. No used or second-hand equipment may be purchased with this grant. All equipment will be 100% owned by the State of New York.
- HPNAP prefers to fund commercial and industrial grade equipment due to its durability and longevity. You must provide additional rationale for any non-commercial request (attach additional pages if more space is needed).

Item(s)	Brand & Model # Total Cost (Quote #1-lowest)	Brand & Model # Total Cost (Quote #2)
1.		
2.		
3		
Total cost for all items:		

1. Describe why HPNAP monies should be used to purchase each item requested. (If replacing equipment, explain why the current equipment needs to be replaced. If purchasing additional equipment, explain why the equipment will allow your program to serve more people, and/or enable the program to provide better quality service or foods.) Attach additional pages if needed.

Continue on next page

2. Explain how your agency will cover any costs for installing, operating, maintaining and securing the requested equipment. If capital improvements become necessary because of the equipment selected, the applicant must explain how these costs will be covered with other than HPNAP funds (for example, any cost of plumbing, electricity, or building alterations)

3. Please list all the food service equipment currently in operation at your program, including refrigerators, freezers, stoves/ranges, dishwashers, and other capital equipment. Please note if equipment was purchased with HPNAP capital equipment funds.

Equipment Item	**Brand**	**HPNAP or non-HPNAP**

4. Please give the address(es) where the requested equipment will be used:

5. Who will be responsible for submitting the copies of vendor invoices or other proof of purchase and copies of cancelled checks to document the use of these funds?

   Name: ____ Phone: _______________________

   Email address: ____