

## Before Starting the Project Application

**To ensure that the Project Application is completed accurately, ALL project applicants should review the following information BEFORE beginning the application.**

### Things to Remember

- Additional training resources can be found on the HUD Exchange at <https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources/> - Program policy questions and problems related to completing the application in e-snaps may be directed to HUD via the HUD Exchange Ask A Question.
- Project applicants are required to have a Data Universal Numbering System (DUNS) number and an active registration in the Central Contractor Registration (CCR)/System for Award Management (SAM) in order to apply for funding under the Fiscal Year (FY) 2017 Continuum of Care (CoC) Program Competition. For more information see FY 2017 CoC Program Competition NOFA.
- To ensure that applications are considered for funding, applicants should read all sections of the FY 2017 CoC Program NOFA and the FY 2016 General Section NOFA.
- Detailed instructions can be found on the left menu within e-snaps. They contain more comprehensive instructions and so should be used in tandem with onscreen text and the hide/show instructions found on each individual screen.
- Before starting the project application, all project applicants must complete or update (as applicable) the Project Applicant Profile in e-snaps.
- Carefully review each question in the Project Application. Questions from previous competitions may have been changed or removed, or new questions may have been added, and information previously submitted may or may not be relevant. Data from the FY 2016 Project Application will be imported into the FY 2017 Project Application; however, applicants will be required to review all fields for accuracy and to update information that may have been adjusted through the FY 2016 post award process or a grant agreement amendment. Data entered in the post award and amendment forms in e-snaps will not be imported into the project application.
- Expiring Shelter Plus Care projects requesting renewal funding for the first time under 24 CFR part 578, and rental assistance projects can only request the number of units and unit size as approved in the final HUD-approved Grant Inventory Worksheet (GIW).
- Expiring Supportive Housing Projects requesting renewal funding for the first time under 24 CFR part 578, transitional housing, permanent supportive housing with leasing, rapid re-housing, supportive services only, renewing safe havens, and HMIS can only request the Annual Renewal Amount (ARA) that appears on the CoC's HUD-approved GIW. If the ARA is reduced through the CoC's reallocation process, the final project funding request must reflect the reduced amount listed on the CoC's reallocation forms.
- HUD reserves the right to reduce or reject any renewal project that fails to adhere to 24 CFR part 578 and the application requirements set forth in the FY 2017 CoC Program Competition NOFA.

## 1A. SF-424 Application Type

1. **Type of Submission:** Application  
2. **Type of Application:** Renewal Project Application

If "Revision", select appropriate letter(s):

If "Other", specify:

3. **Date Received:** 08/18/2017

4. **Applicant Identifier:**

5a. **Federal Entity Identifier:**

5b. **Federal Award Identifier:** NY0988

**This is the first 6 digits of the Grant Number, known as the PIN, that will also be indicated on Screen 3A Project Detail. This number must match the first 6 digits of the grant number on the HUD approved Grant Inventory Worksheet (GIW).**

**Check to confirm that the Federal Award Identifier has been updated to reflect the most recently awarded grant number**

6. **Date Received by State:**

7. **State Application Identifier:**

## 1B. SF-424 Legal Applicant

### 8. Applicant

**a. Legal Name:** Westchester County Dept. of Social Services

**b. Employer/Taxpayer Identification Number (EIN/TIN):** 13-6007353

|  |                                |           |               |      |
|--|--------------------------------|-----------|---------------|------|
|  | <b>c. Organizational DUNS:</b> | 072705213 | <b>PLUS 4</b> | 1112 |
|--|--------------------------------|-----------|---------------|------|

### d. Address

**Street 1:** 112 East Post Road

**Street 2:**

**City:** White Plains

**County:** Westchester

**State:** New York

**Country:** United States

**Zip / Postal Code:** 10601

### e. Organizational Unit (optional)

**Department Name:**

**Division Name:**

### f. Name and contact information of person to be contacted on matters involving this application

**Prefix:** Mr.

**First Name:** Craig

**Middle Name:**

**Last Name:** Wong

**Suffix:**

**Title:** Program Administrator-Homeless Services

**Organizational Affiliation:** Westchester County Dept. of Social Services

**Telephone Number:** (914) 995-1014

**Extension:**

**Fax Number:** (914) 995-5334

**Email:** [cqw1@westchestergov.com](mailto:cqw1@westchestergov.com)

## 1C. SF-424 Application Details

**9. Type of Applicant:** B. County Government

**10. Name of Federal Agency:** Department of Housing and Urban Development

**11. Catalog of Federal Domestic Assistance Title:** CoC Program

**CFDA Number:** 14.267

**12. Funding Opportunity Number:** FR-6100-N-25

**Title:** Continuum of Care Homeless Assistance Competition

**13. Competition Identification Number:**

**Title:**

## 1D. SF-424 Congressional District(s)

**14. Area(s) affected by the project (State(s) only):** New York  
(for multiple selections hold CTRL key)

**15. Descriptive Title of Applicant's Project:** Turning Point

**16. Congressional District(s):**

**a. Applicant:** NY-016, NY-017, NY-018  
(for multiple selections hold CTRL key)

**b. Project:** NY-016, NY-017, NY-018  
(for multiple selections hold CTRL key)

**17. Proposed Project**

**a. Start Date:** 08/01/2018

**b. End Date:** 07/31/2019

**18. Estimated Funding (\$)**

**a. Federal:**

**b. Applicant:**

**c. State:**

**d. Local:**

**e. Other:**

**f. Program Income:**

**g. Total:**

## 1E. SF-424 Compliance

**19. Is the Application Subject to Review By State Executive Order 12372 Process?** b. Program is subject to E.O. 12372 but has not been selected by the State for review.

**If "YES", enter the date this application was made available to the State for review:**

**20. Is the Applicant delinquent on any Federal debt?** No

**If "YES," provide an explanation:**

## 1F. SF-424 Declaration

By signing and submitting this application, I certify (1) to the statements contained in the list of certifications\*\* and (2) that the statements herein are true, complete, and accurate to the best of my knowledge. I also provide the required assurances\*\* and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

I AGREE:

### 21. Authorized Representative

**Prefix:** Mr.

**First Name:** Kevin

**Middle Name:**

**Last Name:** McGuire

**Suffix:**

**Title:** Commissioner

**Telephone Number:** (914) 995-5501  
**(Format: 123-456-7890)**

**Fax Number:** (914) 995-3015  
**(Format: 123-456-7890)**

**Email:** kmm9@westchestergov.com

**Signature of Authorized Representative:** Considered signed upon submission in e-snaps.

**Date Signed:** 08/18/2017



# 1G. HUD 2880

**Applicant/Recipient Disclosure/Update Report - Form 2880**  
**U.S. Department of Housing and Urban Development**  
**OMB Approval No. 2510-0011 (exp.11/30/2018)**

## Applicant/Recipient Information

### 1. Applicant/Recipient Name, Address, and Phone

**Agency Legal Name:** Westchester County Dept. of Social Services

**Prefix:** Mr.

**First Name:** Kevin

**Middle Name:**

**Last Name:** McGuire

**Suffix:**

**Title:** Commissioner

**Organizational Affiliation:** Westchester County Dept. of Social Services

**Telephone Number:** (914) 995-5501

**Extension:**

**Email:** kmm9@westchestergov.com

**City:** White Plains

**County:** Westchester

**State:** New York

**Country:** United States

**Zip/Postal Code:** 10601

**2. Employer ID Number (EIN):** 13-6007353

**3. HUD Program:** Continuum of Care Program

**4. Amount of HUD Assistance Requested/Received:** \$2,698,758.00

(Requested amounts will be automatically entered within applications)

**5. State the name and location (street address, city and state) of the project or activity:** Turning Point 112 East Post Road White Plains New York

Refer to project name, addresses and CoC Project Identifying Number (PIN) entered into the attached project application.

**Part I Threshold Determinations**

**1. Are you applying for assistance for a specific project or activity?** Yes  
(For further information, see 24 CFR Sec. 4.3).

**2. Have you received or do you expect to receive assistance within the jurisdiction of the Department (HUD), involving the project or activity in this application, in excess of \$200,000 during this fiscal year (Oct. 1 - Sep. 30)? For further information, see 24 CFR Sec. 4.9.** Yes

**Part II Other Government Assistance Provided or Requested/Expected Sources and Use of Funds**

Such assistance includes, but is not limited to, any grant, loan, subsidy, guarantee, insurance, payment, credit, or tax benefit.

| Department/Local Agency Name and Address   | Type of Assistance                     | Amount Requested / Provided | Expected Uses of the Funds                          |
|--|--|-----------------------------|---|
| Westchester County Dept. of Social Services 112 East Post Road, White Plains NY 10601      | direct staffing, grants, and contracts | \$194,031.00                | Supportive services staff and HMIS data entry staff |
| Westchester-Putnam Workforce Investment Board 120 Bloomingdale Road White Plains, NY 10605 | grant                                  | 10972.0                     | Supportive services staff                           |
|  |  |                             |   |
|  |  |                             |   |
|  |  |                             |   |

**Part III Interested Parties**

You must disclose:

1. All developers, contractors, or consultants involved in the application for the assistance or in the planning, development, or implementation of the project or activity and
2. any other person who has a financial interest in the project or activity for which the assistance is sought that exceeds \$50,000 or 10 percent of the assistance (whichever is lower).

| Alphabetical list of all persons with a reportable financial interest in the project or activity (For individuals, give the last name first) | Social Security No. or Employee ID No. | Type of Participation                 | Financial Interest in Project/Activity (\$) | Financial Interest in Project/Activity (%) |
|--|--|---------------------------------------|---|--|
| Caring for the Homeless of Peekskill   | 133437332                              | Permanent Supportive Housing provider | \$250,061.00                                | 5%   |
| Children's Village   | 131739945                              | Transitional Housing provider         | \$368,097.00                                | 8%   |
| Daniel Gore Consulting   | 901137448                              | HMIS Administrator                    | \$126,000.00                                | 3%   |
| Eccovia  | 870412185                              | HMIS Software provider                | \$87,401.40                                 | 2%   |
| see Other Attachments page for additional agencies   |  |                                       |   |  |

**Certification**

Warning: If you knowingly make a false statement on this form, you may be subject to civil or criminal penalties under Section 1001 of Title 18 of the United States Code. In addition, any person who knowingly and materially violates any required disclosures of information, including intentional nondisclosure, is subject to civil money penalty not to exceed \$10,000 for each violation.

I certify that this information is true and complete.

**I AGREE:**

**Name / Title of Authorized Official:** Kevin McGuire, Commissioner

**Signature of Authorized Official:** Considered signed upon submission in e-snaps.

**Date Signed:** 08/13/2017

# 1H. HUD 50070

## HUD 50070 Certification for a Drug Free Workplace

**Applicant Name:** Westchester County Dept. of Social Services

**Program/Activity Receiving Federal Grant Funding:** CoC Program

**Acting on behalf of the above named Applicant as its Authorized Official, I make the following certifications and agreements to the Department of Housing and Urban Development (HUD) regarding the sites listed below:**

|   |  |
|---|--|
| I certify that the above named Applicant will or will continue to provide a drug-free workplace by:   |  |
| a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Applicant's workplace and specifying the actions that will be taken against employees for violation of such prohibition.   | e. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph d.(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federalagency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;   |
| b. Establishing an on-going drug-free awareness program to inform employees ---<br>(1) The dangers of drug abuse in the workplace<br>(2) The Applicant's policy of maintaining a drug-free workplace;<br>(3) Any available drug counseling, rehabilitation, and employee assistance programs; and<br>(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace. | f. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph d.(2), with respect to any employee who is so convicted ---<br>(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or<br>(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; |
| c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph a.;  | g. Making a good faith effort to continue to maintain a drugfree workplace through implementation of paragraphs a. thru f.   |
| d. Notifying the employee in the statement required by paragraph a. that, as a condition of employment under the grant, the employee will ---<br>(1) Abide by the terms of the statement; and<br>(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;                      |  |

### Sites for Work Performance.

The Applicant shall list (on separate pages) the site(s) for the performance of work done in connection with the HUD funding of the program/activity shown above: Place of Performance shall include the street address, city, county, State, and zip code. Identify each sheet with the Applicant name and address and the program/activity receiving grant funding.)

Workplaces, including addresses, entered in the attached project application. Refer to addresses entered into the attached project application.

**I hereby certify that all the information stated herein, as well as any information provided in the accompaniment herewith, is true and**

X

**accurate.**

Warning: HUD will prosecute false claims and statements. Conviction may result in criminal and/or civil penalties. (18 U.S.C. 1001, 1010, 1012; 31 U.S.C. 3729, 3802)

**Authorized Representative**

**Prefix:** Mr.

**First Name:** Kevin

**Middle Name**

**Last Name:** McGuire

**Suffix:**

**Title:** Commissioner

**Telephone Number:** (914) 995-5501  
**(Format: 123-456-7890)**

**Fax Number:** (914) 995-3015  
**(Format: 123-456-7890)**

**Email:** kmm9@westchestergov.com

**Signature of Authorized Representative:** Considered signed upon submission in e-snaps.

**Date Signed:** 08/18/2017

## **CERTIFICATION REGARDING LOBBYING**

### **Certification for Contracts, Grants, Loans, and Cooperative Agreements**

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### **Statement for Loan Guarantees and Loan Insurance**

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file

**the required statement shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.**

**I hereby certify that all the information stated herein, as well as any information provided in the accompaniment herewith, is true and accurate:**

|   |
|---|
| X |
|---|

**Warning: HUD will prosecute false claims and statements. Conviction may result in criminal and/or civil penalties. (18 U.S.C. 1001, 1010, 1012; 31 U.S.C. 3729, 3802)**

**Applicant's Organization:** Westchester County Dept. of Social Services

**Name / Title of Authorized Official:** Kevin McGuire, Commissioner

**Signature of Authorized Official:** Considered signed upon submission in e-snaps.

**Date Signed:** 08/18/2017

# 1J. SF-LLL

## DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352.

Approved by OMB0348-0046

HUD requires a new SF-LLL submitted with each annual CoC competition and completing this screen fulfills this requirement.

Answer "Yes" if your organization is engaged in lobbying associated with the CoC Program and answer the questions as they appear next on this screen. The requirement related to lobbying as explained in the SF-LLL instructions states: "The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action."

Answer "No" if your organization is NOT engaged in lobbying.

**Does the recipient or subrecipient of this CoC grant participate in federal lobbying activities (lobbying a federal administration or congress) in connection with the CoC Program?** No

**Legal Name:** Westchester County Dept. of Social Services

**Street 1:** 112 East Post Road

**Street 2:**

**City:** White Plains

**County:** Westchester

**State:** New York

**Country:** United States

**Zip / Postal Code:** 10601

**11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.**

I certify that this information is true and complete.

X



**Authorized Representative**

**Prefix:** Mr.

**First Name:** Kevin

**Middle Name:**

**Last Name:** McGuire

**Suffix:**

**Title:** Commissioner

**Telephone Number:** (914) 995-5501  
**(Format: 123-456-7890)**

**Fax Number:** (914) 995-3015  
**(Format: 123-456-7890)**

**Email:** kmm9@westchestergov.com

**Signature of Authorized Official:** Considered signed upon submission in e-snaps.

**Date Signed:** 08/18/2017

## **Additional Information**

**Now that you have completed Part 1 of the application, please review Parts 2-7, which are in Read Only mode. Screen 3C, which is mandatory for all PH-PSH projects and screens 6D, 7A and 7B which are mandatory for all projects will be editable and must be answered prior to submission.**



**Once you are done reviewing, you will be guided to a "Submissions without Changes" screen. At this screen if you decide no edits or updates are required to any screens other than the mandatory questions for 3C and/or 6D,7A and 7B, you are allowed to submit the application without ever needing to edit the rest of the application. However, if you determine that changes need to be made to the application, we have given you the ability to open up individual screens for edit, instead of the entire application.**

**Once you select the screens you want to edit via checkboxes, you will click "Save", and those screens will be available for edit. An important reminder, once you make those selections and click "Save", you cannot uncheck those boxes. You are allowed to select additional boxes even after saving your initial selections. Again, you must click "Save" for those newly selected screens to be available for edit.**

**If your project is a First Time Renewal, your project will not be able to utilize the "Submit Without Changes" function. The Submissions Without Changes page will be automatically set to "Make Changes" and you will be required to input data into the application for all required fields relevant to the component type.**

## 2A. Project Subrecipients

**This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.**

**This form lists the subrecipient organization(s) for the project. To add a subrecipient, select the  icon. To view or update subrecipient information already listed, select the view  option.**

**Total Expected Sub-Awards: \$2,610,481**

| Organization                         | Type                               | Type                               | Sub-Award Amount |
|--------------------------------------|------------------------------------|------------------------------------|------------------|
| Caring for the Homeless of Peekskill | M. Nonprofit with 501C3 IRS Status | M. Nonprofit with 501C3 IRS Status | \$250,061        |
| Family Service Society of Yonkers    | M. Nonprofit with 501C3 IRS Status | M. Nonprofit with 501C3 IRS Status | \$244,924        |
| Lifting Up Westchester , Inc.        | M. Nonprofit with 501C3 IRS Status | M. Nonprofit with 501C3 IRS Status | \$516,129        |
| The Guidance Center, Inc.            | M. Nonprofit with 501C3 IRS Status | M. Nonprofit with 501C3 IRS Status | \$520,312        |
| Westhab, Inc.                        | M. Nonprofit with 501C3 IRS Status | M. Nonprofit with 501C3 IRS Status | \$1,079,055      |

## 2A. Project Subrecipients Detail

**a. Organization Name:** Caring for the Homeless of Peekskill

**b. Organization Type:** M. Nonprofit with 501C3 IRS Status

**c. Employer or Tax Identification Number:** 13-3437332

|  |                                  |           |               |  |
|--|----------------------------------|-----------|---------------|--|
|  | <b>* d. Organizational DUNS:</b> | 115715877 | <b>PLUS 4</b> |  |
|--|----------------------------------|-----------|---------------|--|

### e. Physical Address

**Street 1:** 200 North Water Street

**Street 2:**

**City:** Peekskill

**State:** New York

**Zip Code:** 10566

**f. Congressional District(s):** NY-017  
(for multiple selections hold CTRL key)

**g. Is the subrecipient a Faith-Based Organization?** No

**h. Has the subrecipient ever received a federal grant, either directly from a federal agency or through a State/local agency?** Yes

**i. Expected Sub-Award Amount:** \$250,061

### j. Contact Person

**Prefix:** Ms.

**First Name:** Donna

**Middle Name:**

**Last Name:** Besteiro

**Suffix:**  
**Title:** Executive Director  
**E-mail Address:** donnachop@gmail.com  
**Confirm E-mail Address:** donnachop@gmail.com  
**Phone Number:** 914-736-2636  
**Extension:**  
**Fax Number:** 914-736-6396

Documentation of the subrecipient's nonprofit status is required with the submission of this application.

## 2A. Project Subrecipients Detail

**a. Organization Name:** Family Service Society of Yonkers

**b. Organization Type:** M. Nonprofit with 501C3 IRS Status

**c. Employer or Tax Identification Number:** 13-1739956

|  |                                  |           |               |  |
|--|----------------------------------|-----------|---------------|--|
|  | <b>* d. Organizational DUNS:</b> | 037144656 | <b>PLUS 4</b> |  |
|--|----------------------------------|-----------|---------------|--|

### e. Physical Address

**Street 1:** 30 South Broadway

**Street 2:**

**City:** Yonkers

**State:** New York

**Zip Code:** 10701

**f. Congressional District(s):** NY-016  
(for multiple selections hold CTRL key)

**g. Is the subrecipient a Faith-Based Organization?** No

**h. Has the subrecipient ever received a federal grant, either directly from a federal agency or through a State/local agency?** Yes

**i. Expected Sub-Award Amount:** \$244,924

**j. Contact Person**

**Prefix:** Mr.

**First Name:** Seth

**Middle Name:**

**Last Name:** Berman

**Suffix:**

**Title:** Executive Director

**E-mail Address:** sberman@fssy.org

**Confirm E-mail Address:** sberman@fssy.org

**Phone Number:** 914-963-5118

**Extension:**

**Fax Number:** 914-963-4313

Documentation of the subrecipient's nonprofit status is required with the submission of this application.

## 2A. Project Subrecipients Detail

**a. Organization Name:** Lifting Up Westchester , Inc.

**b. Organization Type:** M. Nonprofit with 501C3 IRS Status

**c. Employer or Tax Identification Number:** 13-3121606

|  |                                  |           |               |
|--|----------------------------------|-----------|---------------|
|  | <b>* d. Organizational DUNS:</b> | 625375811 | <b>PLUS 4</b> |
|--|----------------------------------|-----------|---------------|

**e. Physical Address**

**Street 1:** 35 Orchard Street

**Street 2:**

**City:** White Plains

**State:** New York

**Zip Code:** 10603

**f. Congressional District(s):** NY-017  
(for multiple selections hold CTRL key)

**g. Is the subrecipient a Faith-Based Organization?** No

**h. Has the subrecipient ever received a federal grant, either directly from a federal agency or through a State/local agency?** Yes

**i. Expected Sub-Award Amount:** \$516,129

**j. Contact Person**

**Prefix:** Mr.

**First Name:** Paul

**Middle Name:**

**Last Name:** Anderson-Winchell

**Suffix:**

**Title:** Executive Director

**E-mail Address:** pandersonwinchell@gcccares.org

**Confirm E-mail Address:** pandersonwinchell@gcccares.org

**Phone Number:** 914-949-3098

**Extension:**

**Fax Number:** 914-761-2105

Documentation of the subrecipient's nonprofit status is required with the submission of this application.

## 2A. Project Subrecipients Detail

**a. Organization Name:** The Guidance Center, Inc.

**b. Organization Type:** M. Nonprofit with 501C3 IRS Status

**c. Employer or Tax Identification Number:** 13-1839684

|  |                                  |           |               |  |
|--|----------------------------------|-----------|---------------|--|
|  | <b>* d. Organizational DUNS:</b> | 045669090 | <b>PLUS 4</b> |  |
|--|----------------------------------|-----------|---------------|--|

### e. Physical Address

**Street 1:** 256 Washington Street

**Street 2:**

**City:** Mount Vernon

**State:** New York

**Zip Code:** 10553

**f. Congressional District(s):** NY-016  
(for multiple selections hold CTRL key)

**g. Is the subrecipient a Faith-Based Organization?** No

**h. Has the subrecipient ever received a federal grant, either directly from a federal agency or through a State/local agency?** Yes

**i. Expected Sub-Award Amount:** \$520,312

### j. Contact Person

**Prefix:** Ms.

**First Name:** Amy

**Middle Name:**

**Last Name:** Gelles



**Suffix:**  
**Title:** Executive Director  
**E-mail Address:** agelles@theguidancecenter.org  
**Confirm E-mail Address:** agelles@theguidancecenter.org  
**Phone Number:** 914-636-4440  
**Extension:**  
**Fax Number:**

Documentation of the subrecipient's nonprofit status is required with the submission of this application.

## 2A. Project Subrecipients Detail

**a. Organization Name:** Westhab, Inc.

**b. Organization Type:** M. Nonprofit with 501C3 IRS Status

**c. Employer or Tax Identification Number:** 06-1064281

|  |                                  |           |               |  |
|--|----------------------------------|-----------|---------------|--|
|  | <b>* d. Organizational DUNS:</b> | 131372450 | <b>PLUS 4</b> |  |
|--|----------------------------------|-----------|---------------|--|

### e. Physical Address

**Street 1:** 8 Bashford St.

**Street 2:**

**City:** Yonkers

**State:** New York

**Zip Code:** 10701

**f. Congressional District(s):** NY-016  
(for multiple selections hold CTRL key)

**g. Is the subrecipient a Faith-Based Organization?** No

**h. Has the subrecipient ever received a federal grant, either directly from a federal agency or through a State/local agency?** Yes

**i. Expected Sub-Award Amount:** \$1,079,055

**j. Contact Person**

**Prefix:** Mr.

**First Name:** Richard

**Middle Name:**

**Last Name:** Nightingale

**Suffix:**

**Title:** President

**E-mail Address:** Richard.Nightingale@westhab.org

**Confirm E-mail Address:** Richard.Nightingale@westhab.org

**Phone Number:** 914-345-2800

**Extension:**

**Fax Number:**

Documentation of the subrecipient's nonprofit status is required with the submission of this application.

## 2B. Recipient Performance

**This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.**

**1. Has the recipient successfully submitted the APR on time for the most recently expired grant term related to this renewal project request?** Yes

**2. Does the recipient have any unresolved HUD Monitoring and/or OIG Audit findings concerning any previous grant term related to this renewal project request?** No

**3. Has the recipient maintained consistent Quarterly Drawdowns for the most recent grant term related to this renewal project request?** Yes

**4. Have any Funds been recaptured by HUD for the most recently expired grant term related to this renewal project request?** Yes

**Explain the circumstances that led HUD to recapture funds from the most recently expired grant term related to this renewal project request.**

The FY2014 grant Turning Point NY0988L2T041400 had a large remaining balance of \$908,609.42. This is primarily because this was the initial grant for this project - there were few clients during the first few months of project operation. The project is currently being operated nearing target occupancy and we have more fully utilized HUD awarded funds during the FY2015 renewal.

### 3A. Project Detail

**1. Expiring Grant Number:** NY0988

(e.g., the "Federal Award Identifier" indicated on form 1A. Application Type)

**2a. CoC Number and Name:** NY-604 - Yonkers, Mount Vernon/Westchester County CoC

**2b. CoC Collaborative Applicant Name:** Westchester County Dept. of Community Mental Health

**3. Project Name:** Turning Point

**4. Project Status:** Standard

**5. Component Type:** PH

**6. Does this project use one or more properties that have been conveyed through the Title V process?** No

### **3B. Project Description**

**This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.**

**1. Provide a description that addresses the entire scope of the proposed project.**

WCDSS will subcontract with 5 experienced housing providers to provide 114 units of scattered-site permanent housing and mobile support services to DedicatedPLUS and chronically homeless individuals and families. Each provider has essential strengths. Westhab (46 units) is experienced with families, veterans, and locating apartments. Guidance Center of Westchester (23 units) is Westchester's only agency dually licensed to provide both mental health and substance use treatment. Family Service Society of Yonkers (11 units) has experience housing the physically disabled homeless and providing home health care, rep payee and legal guardianship services. Caring for the Homeless of Peekskill (11 units) is the hub of homeless outreach and shelter in northern Westchester. Lifting Up Westchester (23 units) is the hub of outreach, shelter & housing for homeless adults in central Westchester.

Our network of transitional shelters, low-demand overnight shelters and outreach teams will identify, engage and link potential participants to our rehousing process. Our Coordinated Assessment Process will use Length of Time Homeless and the VI- SPDAT in HMIS to prioritize placements. WCDSS OTHA's Services Division will prioritize assessments, assign participants to providers, and monitor housing plans. The providers will have 7.55 Case Managers with an average caseload of 12. They will provide needs assessment, home visits, referrals, advocacy, life skills training, service coordination, relapse prevention and crisis intervention. We will use a Housing First approach to offer eligible participants immediate access to permanent supportive housing.

WCDSS will assess recipients' eligibility for and enroll eligible individuals into Medicaid, Food Stamps and public assistance. Shelters and outreach programs enroll homeless people into SSI/SSD using the expedited SOAR process. GCW's PROS program will offer employment supports and life skills training for people with mental illness. Other employment services will be offered by Westhab, services embedded in substance use treatment programs, and USDOL-funded One-Stop Employment Centers. Case Managers will link participants to service coordination available through existing Medicaid Health Homes and Delivery System Reform Incentive Payment (DSRIP) networks now being formed. FSSY will offer in-home health aides and personal care aides. WCDCMH's Director of Adult Services will facilitate linkages to outpatient and inpatient mental health treatment as needed. WCDCMH's Director of Drug and Alcohol Services will facilitate linkages to outpatient and inpatient substance

use treatment as needed. Outreach and engagement will be coordinated by our CoC's VI-SPDAT Housing Team. Systemic barriers will be addressed by our CoC's Homeless System Transformation Team.

**2. Does your project have a specific population focus?** Yes

**2a. Please identify the specific population focus. (Select ALL that apply)**

|                        |                                     |                                   |                          |
|------------------------|-------------------------------------|-----------------------------------|--------------------------|
| Chronic Homeless       | <input checked="" type="checkbox"/> | Domestic Violence                 | <input type="checkbox"/> |
| Veterans               | <input type="checkbox"/>            | Substance Abuse                   | <input type="checkbox"/> |
| Youth (under 25)       | <input type="checkbox"/>            | Mental Illness                    | <input type="checkbox"/> |
| Families with Children | <input type="checkbox"/>            | HIV/AIDS                          | <input type="checkbox"/> |
|                        |                                     | Other<br>(Click 'Save' to update) | <input type="checkbox"/> |

Other:

**3. Housing First**

**3a. Does the project quickly move participants into permanent housing?** Yes

**3b. Does the project ensure that participants are not screened out based on the following items? Select all that apply.**

|  |                                     |
|--|-------------------------------------|
| Having too little or little income   | <input checked="" type="checkbox"/> |
| Active or history of substance use   | <input checked="" type="checkbox"/> |
| Having a criminal record with exceptions for state-mandated restrictions           | <input checked="" type="checkbox"/> |
| History of victimization (e.g. domestic violence, sexual assault, childhood abuse) | <input checked="" type="checkbox"/> |
| None of the above  | <input type="checkbox"/>            |

**3c. Does the project ensure that participants are not terminated from the program for the following reasons? Select all that apply.**

|   |                                     |
|---|-------------------------------------|
| Failure to participate in supportive services | <input checked="" type="checkbox"/> |
|---|-------------------------------------|

|   |                                     |
|---|-------------------------------------|
| Failure to make progress on a service plan  | <input checked="" type="checkbox"/> |
| Loss of income or failure to improve income   | <input checked="" type="checkbox"/> |
| Any other activity not covered in a lease agreement typically found for unassisted persons in the project's geographic area | <input checked="" type="checkbox"/> |
| None of the above   | <input type="checkbox"/>            |

**3d. Does the project follow a "Housing First" approach?** Yes

**4. Does the PH project provide PSH or RRH?** PSH

### 3C. Dedicated Plus

#### Dedicated and DedicatedPLUS

**A “100% Dedicated” project is a permanent supportive housing project that commits 100% of its beds to chronically homeless individuals and families, according to NOFA Section III.3.b.**

**A “DedicatedPLUS” project is a permanent supportive housing project where 100% of the beds are dedicated to serve individuals with disabilities and families in which one adult or child has a disability, including unaccompanied homeless youth, that at a minimum, meet ONE of the following criteria according to NOFA Section III.3.d:**

- (1) experiencing chronic homelessness as defined in 24 CFR 578.3;
- (2) residing in a transitional housing project that will be eliminated and meets the definition of chronically homeless in effect at the time in which the individual or family entered the transitional housing project;
- (3) residing in a place not meant for human habitation, emergency shelter, or safe haven; but the individuals or families experiencing chronic homelessness as defined at 24 CFR 578.3 had been admitted and enrolled in a permanent housing project within the last year and were unable to maintain a housing placement;
- (4) residing in transitional housing funded by a joint TH and PH-RRH component project and who were experiencing chronic homelessness as defined at 24 CFR 578.3 prior to entering the project;
- (5) residing and has resided in a place not meant for human habitation, a safe haven, or emergency shelter for at least 12 months in the last three years, but has not done so on four separate occasions; or
- (6) receiving assistance through a Department of Veterans Affairs(VA)-funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system.

A renewal project where 100 percent of the beds are dedicated in their current grant as described in NOFA Section III.A.3.b. must either become DedicatedPLUS or remain 100% Dedicated. If a renewal project currently has 100 percent of its beds dedicated to chronically homeless individuals and families and elects to become a DedicatedPLUS project, the project will be required to adhere to all fair housing requirements at 24 CFR 578.93. Any beds that the applicant identifies in this application as being dedicated to chronically homeless individuals and families in a DedicatedPLUS project must continue to operate in accordance with Section III.A.3.b. Beds are identified on Screen 4B.

**1. Indicate whether the project is "100% Dedicated", "DedicatedPLUS", or "N/A", according to the information provided above.**



## 4A. Supportive Services for Participants

**This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.**

**1. For all supportive services available to participants, indicate who will provide them and how often they will be provided.  
 Click 'Save' to update.**

| Supportive Services                    | Provider     | Frequency |
|--|--------------|-----------|
| Assessment of Service Needs            | Subrecipient | Monthly   |
| Assistance with Moving Costs           | Subrecipient | As needed |
| Case Management                        | Subrecipient | Weekly    |
| Child Care                             |              |           |
| Education Services                     |              |           |
| Employment Assistance and Job Training | Subrecipient | As needed |
| Food                                   | Applicant    | Monthly   |
| Housing Search and Counseling Services | Subrecipient | As needed |
| Legal Services                         | Non-Partner  | As needed |
| Life Skills Training                   | Subrecipient | As needed |
| Mental Health Services                 | Partner      | As needed |
| Outpatient Health Services             | Partner      | As needed |
| Outreach Services                      | Subrecipient | As needed |
| Substance Abuse Treatment Services     | Subrecipient | As needed |
| Transportation                         | Subrecipient | As needed |
| Utility Deposits                       |              |           |

**2. Please identify whether the project includes the following activities:**

**2a. Transportation assistance to clients to attend mainstream benefit appointments, employment training, or jobs?** Yes

**2b. Use of a single application form for four or more mainstream programs?** Yes

**2c. At least annual follow-ups with participants to ensure mainstream benefits** Yes

**are received and renewed?**

**3. Do project participants have access to SSI/SSDI technical assistance provided by the applicant, a subrecipient, or partner agency?** Yes

**3a. Has the staff person providing the technical assistance completed SOAR training in the past 24 months.** Yes

## 4B. Housing Type and Location

This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.

The following list summarizes each housing site in the project. To add a housing site to the list, select the icon. To view or update a housing site already listed, select the icon.

**Total Units:** 114

**Total Beds:** 123

**Total Dedicated CH Beds:** 0

| Housing Type                    | Units | Beds |
|---------------------------------|-------|------|
| Scattered-site apartments (...) | 114   | 123  |

## 4B. Housing Type and Location Detail

**1. Housing Type:** Scattered-site apartments (including efficiencies)

**2. Indicate the maximum number of units and beds available for project participants at the selected housing site.**

**a. Units:** 114

**b. Beds:** 123

**3. How many beds of the total beds in "2b. Beds" are dedicated to the chronically homeless?** 0

**This includes both the "dedicated" and "prioritized" beds from previous competitions.**

**4. Address:**

**Street 1:** 112 East Post Road

**Street 2:** 4th Floor

**City:** White Plains

**State:** New York

**ZIP Code:** 10601

**5. Select the geographic area(s) associated with the address:  
(for multiple selections hold CTRL Key)**

369119 Westchester County

## 5A. Project Participants - Households

**This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.**

| Households                        | Households with at Least One Adult and One Child | Adult Households without Children | Households with Only Children | Total |
|-----------------------------------|--|-----------------------------------|-------------------------------|-------|
| <b>Total Number of Households</b> | 8  | 106                               | 0                             | 114   |

| Characteristics                            | Persons in Households with at Least One Adult and One Child | Adult Persons in Households without Children | Persons in Households with Only Children | Total |
|--|---|--|--|-------|
| <b>Adults over age 24</b>                  | 8   | 102  |  | 110   |
| <b>Adults ages 18-24</b>                   | 0   | 4  |  | 4     |
| <b>Accompanied Children under age 18</b>   | 9   |  | 0  | 9     |
| <b>Unaccompanied Children under age 18</b> |   |  | 0  | 0     |
| <b>Total Persons</b>                       | 17  | 106  | 0  | 123   |

**Click Save to automatically calculate totals**

## 5B. Project Participants - Subpopulations

This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.

### Persons in Households with at Least One Adult and One Child

| Characteristics       | Chronically Homeless Non-Veterans | Chronically Homeless Veterans | Non-Chronically Homeless Veterans | Chronic Substance Abuse | Persons with HIV/AIDS | Severely Mentally Ill | Victims of Domestic Violence | Physical Disability | Developmental Disability | Persons not represented by listed subpopulations |
|-----------------------|-----------------------------------|-------------------------------|-----------------------------------|-------------------------|-----------------------|-----------------------|------------------------------|---------------------|--------------------------|--|
| Adults over age 24    | 8                                 |                               |                                   | 3                       |                       | 6                     | 1                            |                     |                          |  |
| Adults ages 18-24     |                                   |                               |                                   |                         |                       |                       |                              |                     |                          |  |
| Children under age 18 | 9                                 |                               |                                   |                         |                       |                       | 1                            |                     |                          |  |
| <b>Total Persons</b>  | <b>17</b>                         | <b>0</b>                      | <b>0</b>                          | <b>3</b>                | <b>0</b>              | <b>6</b>              | <b>2</b>                     | <b>0</b>            | <b>0</b>                 | <b>0</b>   |

Click Save to automatically calculate totals

### Persons in Households without Children

| Characteristics      | Chronically Homeless Non-Veterans | Chronically Homeless Veterans | Non-Chronically Homeless Veterans | Chronic Substance Abuse | Persons with HIV/AIDS | Severely Mentally Ill | Victims of Domestic Violence | Physical Disability | Developmental Disability | Persons not represented by listed subpopulations |
|----------------------|-----------------------------------|-------------------------------|-----------------------------------|-------------------------|-----------------------|-----------------------|------------------------------|---------------------|--------------------------|--|
| Adults over age 24   | 80                                | 3                             |                                   | 46                      |                       | 72                    |                              | 10                  |                          |  |
| Adults ages 18-24    | 4                                 |                               |                                   | 2                       |                       | 3                     |                              |                     |                          |  |
| <b>Total Persons</b> | <b>84</b>                         | <b>3</b>                      | <b>0</b>                          | <b>48</b>               | <b>0</b>              | <b>75</b>             | <b>0</b>                     | <b>10</b>           | <b>0</b>                 | <b>0</b>   |

Click Save to automatically calculate totals

### Persons in Households with Only Children

| Characteristics                   | Chronically Homeless Non-Veterans | Chronically Homeless Veterans | Non-Chronically Homeless Veterans | Chronic Substance Abuse | Persons with HIV/AIDS | Severely Mentally Ill | Victims of Domestic Violence | Physical Disability | Developmental Disability | Persons not represented by listed subpopulations |
|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------------|-------------------------|-----------------------|-----------------------|------------------------------|---------------------|--------------------------|--|
| Accompanied Children under age 18 |                                   |                               |                                   |                         |                       |                       |                              |                     |                          |  |

|                                     |   |  |  |   |   |   |   |   |   |   |
|-------------------------------------|---|--|--|---|---|---|---|---|---|---|
| Unaccompanied Children under age 18 |   |  |  |   |   |   |   |   |   |   |
| <b>Total Persons</b>                | 0 |  |  | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## 5C. Outreach for Participants

**This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.**

**1. Enter the percentage of project participants that will be coming from each of the following locations.**

|      |   |
|------|---|
| 5%   | Directly from the street or other locations not meant for human habitation.                                 |
| 95%  | Directly from emergency shelters.   |
|      | Directly from safe havens.  |
| 0%   | Persons fleeing domestic violence.  |
|      | Directly from transitional housing eliminated in the FY 2017 CoC Program Competition.                       |
|      | Directly from the TH Portion of a Joint TH and PH-RRH Component project.                                    |
|      | Persons receiving services through a Department of Veterans Affairs(VA)-funded homeless assistance program. |
| 100% | Total of above percentages  |



## 6A. Funding Request

**This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.**

**1. Do any of the properties in this project have an active restrictive covenant?** No

**2. Was the original project awarded as either a Samaritan Bonus or Permanent Housing Bonus project?** Yes

**3. Does this project propose to allocate funds according to an indirect cost rate?** Yes

**Indirect cost rate proposals should be submitted as soon as the applicant is notified of a conditional award. Conditional award recipients will be asked to submit the proposal rate during the e-snaps post-award process.**

**Applicants with an approved indirect cost rate must submit a copy of the approval with this application.**

**a. Please complete the indirect cost rate schedule below:**

| Administering Department/Agency                      | Indirect Cost Rate | Direct Cost Base |
|--|--------------------|------------------|
| Not applicable - we will use the 10% de minimis rate | 10%                | \$965,552        |
|  |                    |                  |
|  |                    |                  |
|  |                    |                  |
|  |                    |                  |

**b. Has this rate been approved by your cognizant agency?** No

**c. Do you plan to use the 10% de minimis rate?** Yes

**4. Renewal Grant Term:** 1 Year

**5. Select the costs for which funding is being**

**requested:**

|                            |                                     |
|----------------------------|-------------------------------------|
| <b>Leased Units</b>        | <input checked="" type="checkbox"/> |
| <b>Leased Structures</b>   | <input type="checkbox"/>            |
| <b>Rental Assistance</b>   | <input type="checkbox"/>            |
| <b>Supportive Services</b> | <input checked="" type="checkbox"/> |
| <b>Operating</b>           | <input checked="" type="checkbox"/> |
| <b>HMIS</b>                | <input type="checkbox"/>            |

## 6B. Leased Units Budget

**This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.**

**The following list summarizes the funds being requested for one or more units leased for operating the projects. To add information to the list, select the icon. To view or update information already listed, select the icon.**

| <b>Total Annual Assistance Requested:</b> |                       | \$1,733,206                   |                        |
|---|-----------------------|-------------------------------|------------------------|
| <b>Grant Term:</b>                        |                       | 1 Year                        |                        |
| <b>Total Request for Grant Term:</b>      |                       | \$1,733,206                   |                        |
| <b>Total Units:</b>                       |                       | 114                           |                        |
| FMR Area                                  | Total Units Requested | Total Annual Budget Requested | Total Budget Requested |
| NY - Westchester ...                      | 114                   | \$1,733,206                   | \$1,733,206            |

## Leased Units Budget Detail

Enter the appropriate values in the "Number of Units" AND "Total Request" fields.

**Metropolitan or non-metropolitan fair market rent area:** NY - Westchester County, NY Statutory Exception Area (3611999999)

### Leased Units Annual Budget

| Size of Units                                      | # of Units (Applicant) | Total Request (Applicant) |
|--|------------------------|---------------------------|
| SRO  |                        |                           |
| 0 Bedroom  |                        |                           |
| 1 Bedroom  | 106                    |                           |
| 2 Bedroom  | 7                      |                           |
| 3 Bedroom  | 1                      |                           |
| 4 Bedroom  |                        |                           |
| 5 Bedroom  |                        |                           |
| 6 Bedroom  |                        |                           |
| 7 Bedroom  |                        |                           |
| 8 Bedroom  |                        |                           |
| 9 Bedroom  |                        |                           |
| <b>Total Units and Annual Assistance Requested</b> | 114                    | \$1,733,206               |
| <b>Grant Term</b>                                  |                        | 1 Year                    |
| <b>Total Request for Grant Term</b>                |                        | \$1,733,206               |

**Click the 'Save' button to automatically calculate totals.**

## 6D. Sources of Match

The following list summarizes the funds that will be used as Match for the project. To add a Matching source to the list, select the  icon. To view or update a Matching source already listed, select the  icon.

### Summary for Match

|                                     |           |
|-------------------------------------|-----------|
| Total Value of Cash Commitments:    | \$151,388 |
| Total Value of In-Kind Commitments: | \$90,000  |
| Total Value of All Commitments:     | \$241,388 |

**1. Does this project generate program income** Yes  
 as described in 24 CFR 578.97 that will be  
 used as Match for this grant?

**1a. Briefly describe the source of the program income:**

Occupancy charges collected from program participants per 24 CFR 578.77.

**1b. Estimate the amount of program income** \$50,616  
 that will be used as Match for this project:

**Before grant execution, services to be provided by a third party must be documented by a memorandum of understanding (MOU) between the recipient or subrecipient and the third party that will provide the services.**

| Match | Type    | Source     | Contributor          | Date of Commitment | Value of Commitments |
|-------|---------|------------|----------------------|--------------------|----------------------|
| Yes   | Cash    | Government | Westchester Count... | 07/25/2017         | \$72,287             |
| Yes   | In-Kind | Private    | St. Vincent's/ St... | 08/01/2017         | \$15,000             |
| Yes   | In-Kind | Private    | Family Services O... | 08/09/2017         | \$15,000             |
| Yes   | In-Kind | Private    | Montefiore Mount ... | 08/11/2017         | \$15,000             |
| Yes   | In-Kind | Private    | Rockland Psychiat... | 08/08/2017         | \$15,000             |
| Yes   | In-Kind | Private    | St. Johns Riversi... | 07/26/2017         | \$15,000             |
| Yes   | Cash    | Private    | Family Service So... | 07/25/2017         | \$4,884              |
| Yes   | Cash    | Private    | Caring for the Ho... | 08/02/2017         | \$4,884              |
| Yes   | Cash    | Private    | Guidance Center O... | 07/25/2017         | \$10,212             |
| Yes   | Cash    | Private    | Lifting Up Westch... | 07/25/2017         | \$10,212             |

|     |         |         |                         |            |          |
|-----|---------|---------|-------------------------|------------|----------|
| Yes | Cash    | Private | Westhab Program<br>I... | 07/25/2017 | \$20,424 |
| Yes | Cash    | Private | Guidance Center<br>O... | 07/25/2017 | \$28,485 |
| Yes | In-Kind | Private | Westchester<br>Medic... | 08/01/2017 | \$15,000 |

## Sources of Match Detail

- 1. Will this commitment be used towards Match? Yes
- 2. Type of Commitment: Cash
- 3. Type of Source: Government
- 4. Name the Source of the Commitment: Westchester County Department of Social Services  
(Be as specific as possible and include the office or grant program as applicable)
- 5. Date of Written Commitment: 07/25/2017
- 6. Value of Written Commitment: \$72,287

## Sources of Match Detail

- 1. Will this commitment be used towards Match? Yes
- 2. Type of Commitment: In-Kind
- 3. Type of Source: Private
- 4. Name the Source of the Commitment: St. Vincent's/ St. Joseph's Hospital Medicaid paid Substance Abuse, Mental Health, and Outpatient Medical Treatment services  
(Be as specific as possible and include the office or grant program as applicable)
- 5. Date of Written Commitment: 08/01/2017
- 6. Value of Written Commitment: \$15,000

**Before grant execution, services to be provided by a third party must be documented by a memorandum of understanding (MOU) between the recipient or subrecipient and the third party that will provide the services.**

## Sources of Match Detail

- 1. Will this commitment be used towards Match? Yes
- 2. Type of Commitment: In-Kind

**3. Type of Source:** Private

**4. Name the Source of the Commitment:** Family Services of Westchester case management, mental health, and vocational services  
**(Be as specific as possible and include the office or grant program as applicable)**

**5. Date of Written Commitment:** 08/09/2017

**6. Value of Written Commitment:** \$15,000

**Before grant execution, services to be provided by a third party must be documented by a memorandum of understanding (MOU) between the recipient or subrecipient and the third party that will provide the services.**

## Sources of Match Detail

**1. Will this commitment be used towards Match?** Yes

**2. Type of Commitment:** In-Kind

**3. Type of Source:** Private

**4. Name the Source of the Commitment:** Montefiore Mount Vernon/ New Rochelle Hospitals outpatient health services  
**(Be as specific as possible and include the office or grant program as applicable)**

**5. Date of Written Commitment:** 08/11/2017

**6. Value of Written Commitment:** \$15,000

**Before grant execution, services to be provided by a third party must be documented by a memorandum of understanding (MOU) between the recipient or subrecipient and the third party that will provide the services.**

## Sources of Match Detail

**1. Will this commitment be used towards Match?** Yes

**2. Type of Commitment:** In-Kind

**3. Type of Source:** Private

**4. Name the Source of the Commitment:** Rockland Psychiatric Center mental health treatment services  
**(Be as specific as possible and include the office or grant program as applicable)**

**5. Date of Written Commitment:** 08/08/2017



**6. Value of Written Commitment:** \$15,000

**Before grant execution, services to be provided by a third party must be documented by a memorandum of understanding (MOU) between the recipient or subrecipient and the third party that will provide the services.**

## Sources of Match Detail

**1. Will this commitment be used towards Match?** Yes

**2. Type of Commitment:** In-Kind

**3. Type of Source:** Private

**4. Name the Source of the Commitment:** St. Johns Riverside Hospital substance abuse, mental health, and outpatient health services  
**(Be as specific as possible and include the office or grant program as applicable)**

**5. Date of Written Commitment:** 07/26/2017

**6. Value of Written Commitment:** \$15,000

**Before grant execution, services to be provided by a third party must be documented by a memorandum of understanding (MOU) between the recipient or subrecipient and the third party that will provide the services.**

## Sources of Match Detail

**1. Will this commitment be used towards Match?** Yes

**2. Type of Commitment:** Cash

**3. Type of Source:** Private

**4. Name the Source of the Commitment:** Family Service Society of Yonkers Program  
**(Be as specific as possible and include the office or grant program as applicable)** Income - Occupancy Charges

**5. Date of Written Commitment:** 07/25/2017

**6. Value of Written Commitment:** \$4,884

## Sources of Match Detail

- 1. Will this commitment be used towards Match?** Yes
- 2. Type of Commitment:** Cash
- 3. Type of Source:** Private
- 4. Name the Source of the Commitment:** Caring for the Homeless of Peekskill Program  
**(Be as specific as possible and include the office or grant program as applicable)** Income - Occupancy Charges
- 5. Date of Written Commitment:** 08/02/2017
- 6. Value of Written Commitment:** \$4,884

### Sources of Match Detail

- 1. Will this commitment be used towards Match?** Yes
- 2. Type of Commitment:** Cash
- 3. Type of Source:** Private
- 4. Name the Source of the Commitment:** Guidance Center of Westchester Program  
**(Be as specific as possible and include the office or grant program as applicable)** Income - Occupancy Charges
- 5. Date of Written Commitment:** 07/25/2017
- 6. Value of Written Commitment:** \$10,212

### Sources of Match Detail

- 1. Will this commitment be used towards Match?** Yes
- 2. Type of Commitment:** Cash
- 3. Type of Source:** Private
- 4. Name the Source of the Commitment:** Lifting Up Westchester Program Income -  
**(Be as specific as possible and include the office or grant program as applicable)** Occupancy Charges

- 5. Date of Written Commitment:** 07/25/2017
- 6. Value of Written Commitment:** \$10,212

### Sources of Match Detail

- 1. Will this commitment be used towards Match?** Yes
- 2. Type of Commitment:** Cash
- 3. Type of Source:** Private
- 4. Name the Source of the Commitment:** Westhab Program Income - Occupancy Charges  
**(Be as specific as possible and include the office or grant program as applicable)**
- 5. Date of Written Commitment:** 07/25/2017
- 6. Value of Written Commitment:** \$20,424

### Sources of Match Detail

- 1. Will this commitment be used towards Match?** Yes
- 2. Type of Commitment:** Cash
- 3. Type of Source:** Private
- 4. Name the Source of the Commitment:** Guidance Center of Westchester substance abuse and mental health treatment services  
**(Be as specific as possible and include the office or grant program as applicable)**
- 5. Date of Written Commitment:** 07/25/2017
- 6. Value of Written Commitment:** \$28,485

### Sources of Match Detail

- 1. Will this commitment be used towards Match?** Yes

**2. Type of Commitment:** In-Kind

**3. Type of Source:** Private

**4. Name the Source of the Commitment:** Westchester Medical Center substance abuse, mental health, and outpatient health services  
**(Be as specific as possible and include the office or grant program as applicable)**

**5. Date of Written Commitment:** 08/01/2017

**6. Value of Written Commitment:** \$15,000

**Before grant execution, services to be provided by a third party must be documented by a memorandum of understanding (MOU) between the recipient or subrecipient and the third party that will provide the services.**

## 6E. Summary Budget

**This screen is currently read only and only includes data from the previous grant. To make changes to this information, navigate to the Submission without Changes screen, select "Make Changes" in response to Question 2, and then check the box next each screen that requires a change to match the current grant agreement, as amended, or to account for a reallocation of funds.**

**The following information summarizes the funding request for the total term of the project. Budget amounts from the Leased Units, Rental Assistance, and Match screens have been automatically imported and cannot be edited. However, applicants must confirm and correct, if necessary, the total budget amounts for Leased Structures, Supportive Services, Operating, HMIS, and Admin. Budget amounts must reflect the most accurate project information according to the most recent project grant agreement or project grant agreement amendment, the CoC's final HUD-approved FY 2017 GIW or the project budget as reduced due to CoC reallocation. Please note that, new for FY 2017, there are no detailed budget screens for Leased Structures, Supportive Services, Operating, or HMIS costs. HUD expects the original details of past approved budgets for these costs to be the basis for future expenses. However, any reasonable and eligible costs within each CoC cost category can be expended and will be verified during a HUD monitoring.**

| Eligible Costs                           | Total Assistance Requested for 1 year Grant Term (Applicant) |
|--|--|
| 1a. Leased Units                         | \$1,733,206  |
| 1b. Leased Structures                    | \$0  |
| 2. Rental Assistance                     | \$0  |
| 3. Supportive Services                   | \$657,248  |
| 4. Operating                             | \$131,750  |
| 5. HMIS                                  | \$0  |
| 6. Sub-total Costs Requested             | \$2,522,204  |
| 7. Admin (Up to 10%)                     | \$176,554  |
| 8. Total Assistance plus Admin Requested | \$2,698,758  |
| 9. Cash Match                            | \$151,388  |
| 10. In-Kind Match                        | \$90,000   |
| 11. Total Match                          | \$241,388  |
| 12. Total Budget                         | \$2,940,146  |

## 7A. Attachment(s)

| Document Type                           | Required? | Document Description | Date Attached |
|---|-----------|----------------------|---------------|
| 1) Subrecipient Nonprofit Documentation | No        | Turning Point Sub... | 10/18/2015    |
| 2) Other Attachmenbt                    | No        |                      |               |
| 3) Other Attachment                     | No        |                      |               |

## **Attachment Details**

**Document Description:** Turning Point Subrecipient Nonprofit Documentation

## **Attachment Details**

**Document Description:**

## **Attachment Details**

**Document Description:**

## 7A. In-Kind Match MOU Attachment

| Document Type     | Required? | Document Description | Date Attached |
|-------------------|-----------|----------------------|---------------|
| In-Kind Match MOU | No        | In-Kind Match MOU... | 08/17/2017    |



## Attachment Details

**Document Description:** In-Kind Match MOUs for FY2017 Turning Point

## 7B. Certification

### A. For all projects:

#### Fair Housing and Equal Opportunity

It will comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000(d)) and regulations pursuant thereto (Title 24 CFR part I), which state that no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the applicant receives Federal financial assistance, and will immediately take any measures necessary to effectuate this agreement. With reference to the real property and structure(s) thereon which are provided or improved with the aid of Federal financial assistance extended to the applicant, this assurance shall obligate the applicant, or in the case of any transfer, transferee, for the period during which the real property and structure(s) are used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits.

It will comply with the Fair Housing Act (42 U.S.C. 3601-19), as amended, and with implementing regulations at 24 CFR part 100, which prohibit discrimination in housing on the basis of race, color, religion, sex, disability, familial status or national origin.

It will comply with Executive Order 11063 on Equal Opportunity in Housing and with implementing regulations at 24 CFR Part 107 which prohibit discrimination because of race, color, creed, sex or national origin in housing and related facilities provided with Federal financial assistance.

It will comply with Executive Order 11246 and all regulations pursuant thereto (41 CFR Chapter 60-1), which state that no person shall be discriminated against on the basis of race, color, religion, sex or national origin in all phases of employment during the performance of Federal contracts and shall take affirmative action to ensure equal employment opportunity. The applicant will incorporate, or cause to be incorporated, into any contract for construction work as defined in Section 130.5 of HUD regulations the equal opportunity clause required by Section 130.15(b) of the HUD regulations.

It will comply with Section 3 of the Housing and Urban Development Act of 1968, as amended (12 U.S.C. 1701(u)), and regulations pursuant thereto (24 CFR Part 135), which require that to the greatest extent feasible opportunities for training and employment be given to lower-income residents of the project and contracts for work in connection with the project be awarded in substantial part to persons residing in the area of the project.

It will comply with Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), as amended, and with implementing regulations at 24 CFR Part 8, which prohibit discrimination based on disability in Federally-assisted and conducted programs and activities.

It will comply with the Age Discrimination Act of 1975 (42 U.S.C. 6101-07), as amended, and implementing regulations at 24 CFR Part 146, which prohibit discrimination because of age in projects and activities receiving Federal financial assistance.

It will comply with Executive Orders 11625, 12432, and 12138, which state that program participants shall take affirmative action to encourage participation by businesses owned and operated by members of minority groups and women.

If persons of any particular race, color, religion, sex, age, national origin, familial status, or disability who may qualify for assistance are unlikely to be reached, it will establish additional procedures to ensure that interested persons can obtain information concerning the assistance.

It will comply with the reasonable modification and accommodation requirements and, as appropriate, the accessibility requirements of the Fair Housing Act and section 504 of the Rehabilitation Act of 1973, as amended.

**Additional for Rental Assistance Projects:**

If applicant has established a preference for targeted populations of disabled persons pursuant to 24 CFR 582.330(a), it will comply with this section's nondiscrimination requirements within the designated population.

**B. For non-Rental Assistance Projects Only.**

**20-Year Operation Rule.**

For applicants receiving assistance for acquisition, rehabilitation or new construction: The project will be operated for no less than 20 years from the date of initial occupancy or the date of initial service provision for the purpose specified in the application.

**1-Year Operation Rule.**

For applicants receiving assistance for supportive services, leasing, or operating costs but not receiving assistance for acquisition, rehabilitation, or new construction: The project will be operated for the purpose specified in the application for any year for which such assistance is provided.

**C. Explanation.**

Where the applicant is unable to certify to any of the statements in this certification, such applicant shall provide an explanation.

**Name of Authorized Certifying Official** Kevin McGuire

**Date:** 08/18/2017

**Title:** Commissioner

**Applicant Organization:** Westchester County Dept. of Social Services

**PHA Number (For PHA Applicants Only):**

**I certify that I have been duly authorized by the applicant to submit this Applicant**

X

**Certification and to ensure compliance. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties . (U.S. Code, Title 218, Section 1001).**

## Submission Without Changes

**1. Are the requested renewal funds reduced from the previous award as a result of reallocation?** No

**2. Do you wish to submit this application without making changes? Please refer to the guidelines below to inform you of the requirements.** Make changes

**3. Specify which screens require changes by clicking the checkbox next to the name and then clicking the Save button.**

|   |                                     |
|---|-------------------------------------|
| <b>Part 2- Recipient and Subrecipient Information</b> |                                     |
| 2A. Subrecipients                                     | <input type="checkbox"/>            |
| 2B. Recipient Performance                             | <input type="checkbox"/>            |
| <b>Part 3 - Project Information</b>                   |                                     |
| 3A. Project Detail                                    | <input checked="" type="checkbox"/> |
| 3B. Description                                       | <input type="checkbox"/>            |
| 3C. Dedicated Plus                                    | <input checked="" type="checkbox"/> |
| <b>Part 4 - Housing Services and HMIS</b>             |                                     |
| 4A. Services  | <input type="checkbox"/>            |
| 4B. Housing Type                                      | <input type="checkbox"/>            |
| <b>Part 5 - Participants and Outreach Information</b> |                                     |
| 5A. Households  | <input type="checkbox"/>            |
| 5B. Subpopulations                                    | <input type="checkbox"/>            |
| 5C. Outreach  | <input type="checkbox"/>            |
| <b>Part 6 - Budget Information</b>                    |                                     |
| 6A. Funding Request                                   | <input type="checkbox"/>            |

|   |                                     |
|---|-------------------------------------|
| 6B. Leased Units                                  | <input type="checkbox"/>            |
| 6D. Match   | <input checked="" type="checkbox"/> |
| 6E. Summary Budget                                | <input type="checkbox"/>            |
| <b>Part 7 - Attachment(s) &amp; Certification</b> |                                     |
| 7A. Attachment(s)                                 | <input checked="" type="checkbox"/> |
| 7A. In-Kind Match MOU Attachment                  | <input checked="" type="checkbox"/> |
| 7B. Certification                                 | <input checked="" type="checkbox"/> |

**The applicant has selected "Make Changes" to Question 2 above. Please provide a brief description of the changes that will be made to the project information screens (bullets are appropriate):**

- \* 2A - Update subawards to reflect consolidation with NY0750L2T041607 during FY2016 grant
- \* 2B - Update recipient performance based on most recent expired operating period
- \* 3B, 4B, 5A, 5B, 5C - Update to reflect consolidation with NY0750L2T041607 during FY2016 grant and conversion to DedicatedPLUS
- \* 6A – Update to reflect budget amendment to FY2016 grant and change answers to question #3 Indirect Cost Rate
- \* 6B, 6E - Update to reflect consolidation with NY0750L2T041607 during FY2016 grant

**The applicant has selected "Make Changes". Once this screen is saved, the applicant will be prohibited from "unchecking" any box that has been checked regardless of whether a change to data on the corresponding screen will be made.**

## 8B Submission Summary

| Page                                  | Last Updated      |
|---------------------------------------|-------------------|
| <b>1A. SF-424 Application Type</b>    | 08/17/2017        |
| <b>1B. SF-424 Legal Applicant</b>     | No Input Required |
| <b>1C. SF-424 Application Details</b> | No Input Required |

|                                    |         |            |
|------------------------------------|---------|------------|
| Renewal Project Application FY2017 | Page 63 | 08/18/2017 |
|------------------------------------|---------|------------|

|   |                   |
|---|-------------------|
| <b>1D. SF-424 Congressional District(s)</b> | 08/17/2017        |
| <b>1E. SF-424 Compliance</b>                | 08/17/2017        |
| <b>1F. SF-424 Declaration</b>               | 08/17/2017        |
| <b>1G. HUD-2880</b>                         | 08/17/2017        |
| <b>1H. HUD-50070</b>                        | 08/17/2017        |
| <b>1I. Cert. Lobbying</b>                   | 08/17/2017        |
| <b>1J. SF-LLL</b>                           | 08/17/2017        |
| <b>2A. Subrecipients</b>                    | 08/17/2017        |
| <b>2B. Recipient Performance</b>            | 08/17/2017        |
| <b>3A. Project Detail</b>                   | 08/17/2017        |
| <b>3B. Description</b>                      | 08/17/2017        |
| <b>3C. Dedicated Plus</b>                   | 08/17/2017        |
| <b>4A. Services</b>                         | 08/17/2017        |
| <b>4B. Housing Type</b>                     | 08/17/2017        |
| <b>5A. Households</b>                       | 08/17/2017        |
| <b>5B. Subpopulations</b>                   | No Input Required |
| <b>5C. Outreach</b>                         | 08/17/2017        |
| <b>6A. Funding Request</b>                  | 08/17/2017        |
| <b>6B. Leased Units</b>                     | 08/17/2017        |
| <b>6D. Match</b>                            | 08/17/2017        |
| <b>6E. Summary Budget</b>                   | No Input Required |
| <b>7A. Attachment(s)</b>                    | 08/17/2017        |
| <b>7A. In-Kind Match MOU Attachment</b>     | 08/17/2017        |
| <b>7B. Certification</b>                    | 08/17/2017        |
| <b>Submission Without Changes</b>           | 08/17/2017        |



Internal Revenue Service  
District Director

Department of the Treasury

P. O. Box 2508  
Cincinnati, OH 45201

Date: May 17, 1999

Person to Contact:  
Cheryl Skaggs 31-04010  
Customer Service Representative  
Telephone Number:  
877-829-5500  
Fax Number:  
513-684-5936  
Federal Identification Number:  
13-3437332

Caring for the Homeless of  
Peekskill, Inc.  
200 N. Water St.  
Peekskill, NY 10566-2024

Dear Sir or Madam:

This letter is in response to your telephone request on May 13, 1999, for copy of your organization's determination letter. This letter will take the place of the copy you requested.

Our records indicate that a determination letter issued in April 1993, granted your organization exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. That letter is still in effect.

Based on information subsequently submitted, we classified your organization as one that is not a private foundation within the meaning of section 509(a) of the Code because it is an organization described in sections 509(a)(1) and 170(b)(1)(A)(vi).

This classification was based on the assumption that your organization's operations would continue as stated in the application. If your organization's sources of support, or its character, method of operations, or purposes have changed, please let us know so we can consider the effect of the change on the exempt status and foundation status of your organization.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, only if its gross receipts each year are normally more than \$25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of \$20 a day, up to a maximum of \$10,000, when a return is filed late, unless there is reasonable cause for the delay.

All exempt organizations (unless specifically excluded) are liable for taxes under the Federal Insurance Contributions Act (social security taxes on remuneration of \$100 or more paid to each employee during a calendar year. Your organization is not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, these organizations are not automatically exempt from other federal excise taxes.

Donors may deduct contributions to your organization as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to your organization or for its use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

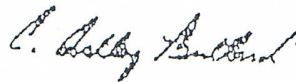
Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Code. If your organization is subject to this tax, it must file an income tax return on the Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your organization's present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

Because this letter could help resolve any questions about your organization's exempt status and foundation status, you should keep it with the organization's permanent records.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

This letter affirms your organization's exempt status.

Sincerely,



C. Ashley Bullard  
District Director



Internal Revenue Service

Department of the Treasury

District  
Director

P.O. Box 1680, GPO Brooklyn, N.Y. 11202

Date: JAN 25 1989

Family Service Society of Yonkers Inc.  
213 Palisades Avenue  
Yonkers, NY 10703  
Attn: John Augistin

Person to Contact: C. Jones

Contact Telephone Number:

1 (718) 780-6681

Re: 13-1739956

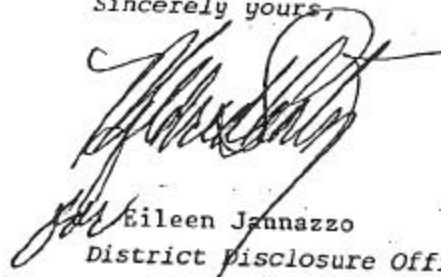
Dear Sir or Madam:

Reference is made to your request for verification of the tax exempt status of Family Services Society of Yonkers Inc.

A determination or ruling letter issued to an organization granting exemption under the Internal Revenue Code of 1954 or under a prior or subsequent Revenue Act remains in effect until exempt status has been terminated, revoked or modified.

Our records indicate that exemption was granted as shown below.

Sincerely yours,



Eileen Jannazzo  
District Disclosure Officer

Name of Organization: Family Services Society of Yonkers Inc.

Date of Exemption Letter: December, 1934

Exemption granted pursuant to 1954 Code section 501(c) ( 3) or its predecessor Code Section.

Foundation Classification ( If Applicable ): Not a private foundation as you are an organization described in sections 509(a)(1) & 170(b)(1)(A)(vi) of the Internal Revenue Code.

**Internal Revenue Service**

**Department of the Treasury**

District  
Director

10 Metro Tech Center  
625 Fulton Street  
Brooklyn, NY 11201

▷

Date: DEC 01 1995

Grace Church  
Community Center, Inc.  
171 E Post Road Suite 219  
White Plains, NY 10601-4901

Person to Contact:  
Patricia Holub  
Contact Telephone Number:  
(718) 488-2333  
EIN: 13-3121606

Dear Sir or Madam:

Reference is made to your request for verification of the tax exempt status of Grace Church Community Center, Inc.

A determination or ruling letter issued to an organization granting exemption under the Internal Revenue Code remains in effect until the tax exempt status has been terminated, revoked or modified.

Our records indicate that exemption was granted as shown below.

Sincerely yours,

Patricia Holub  
Manager, Customer  
Service Unit

Name of Organization: Grace Church Community Center, Inc.

Date of Exemption Letter: October 1982

Exemption granted pursuant to section 501(c)(3) of the Internal Revenue Code.

Foundation Classification (if applicable): Not a private foundation as you are an organization described in section 509(a)(2) of the Internal Revenue Code.

**Internal Revenue Service**

**Date:** September 28, 2007

THE GUIDANCE CENTER INC  
70 GRAND ST  
NEW ROCHELLE NY 10801-5606

**Department of the Treasury**  
**P. O. Box 2508**  
**Cincinnati, OH 45201**

**Person to Contact:**

Miss Csinsi 17-56980  
Customer Service Representative

**Toll Free Telephone Number:**  
877-829-5500

**Federal Identification Number:**  
13-1839684

Dear Sir or Madam:

This is in response to your request of September 28, 2007, regarding your organization's tax-exempt status.

In April 1942 we issued a determination letter that recognized your organization as exempt from federal income tax. Our records indicate that your organization is currently exempt under section 501(c)(3) of the Internal Revenue Code.

Our records indicate that your organization is also classified as a public charity under section 509(a)(2) of the Internal Revenue Code.

Our records indicate that contributions to your organization are deductible under section 170 of the Code, and that you are qualified to receive tax deductible bequests, devises, transfers or gifts under section 2055, 2106 or 2522 of the Internal Revenue Code.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely,



Michele M. Sullivan, Oper. Mgr.  
Accounts Management Operations 1

INTERNAL REVENUE SERVICE  
DISTRICT DIRECTOR  
P.O. BOX 1680  
BROOKLYN, NY 11202

DEPARTMENT OF THE TREASURY

Date: MAR 06 1995

WESTHAB, INC.  
35 EXECUTIVE BLVD.  
ELMSFORD, NY 10523-1326

Employer Identification Number:  
06-1064281  
Case Number:  
114357005  
Contact Person:  
FRANCES E MCKENNA  
Contact Telephone Number:  
(718) 488-2318  
Our Letter Dated:  
March 12, 1991  
Addendum Applies:  
Yes

Dear Applicant:

This modifies our letter of the above date in which we stated that you would be treated as an organization that is not a private foundation until the expiration of your advance ruling period.

Your exempt status under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3) is still in effect. Based on the information you submitted, we have determined that you are not a private foundation within the meaning of section 509(a) of the Code because you are an organization of the type described in section 509(a)(1) and 170(b)(1)(A)(vi).

Grantors and contributors may rely on this determination unless the Internal Revenue Service publishes notice to the contrary. However, if you lose your section 509(a)(1) status, a grantor or contributor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act, or the substantial or material change on the part of the organization that resulted in your loss of such status, or if he or she acquired knowledge that the Internal Revenue Service had given notice that you would no longer be classified as a section 509(a)(1) organization.

As of January 1, 1984, you are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of \$100 or more you pay to each of your employees during a calendar year. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

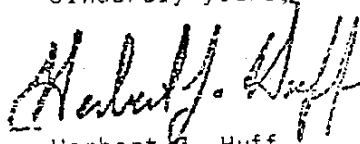
If we have indicated in the heading of this letter that an addendum applies, the addendum enclosed is an integral part of this letter.

Because this letter could help resolve any questions about your private foundation status, please keep it in your permanent records.

WESTHAB INC

If you have any questions, please contact the person whose name and telephone number are shown above.

Sincerely yours,



Herbert G. Huff  
District Director

Enclosure:  
Addendum

BESTHAB INC

As per Income Tax Regulations 1.509(a)-6, if an organization is described in section 509(a)(1) and also in another paragraph of section 509 it will be treated as a 509(a)(1) organization.

Although you were treated as an organization described in section 509(a)(2) during your advance ruling period, you now qualify under sections 509(a)(1) and 170(b)(1)(A)(vi) of the Internal Revenue Code and therefore, you have reclassified accordingly.





Robert P. Astorino  
County Executive

Department of Social Services

Kevin McGuire  
Commissioner

**MEMORANDUM OF UNDERSTANDING  
BETWEEN  
WESTCHESTER COUNTY DEPARTMENT OF SOCIAL SERVICES,  
AND  
FAMILY SERVICES OF WESTCHESTER**

**HUD Project:** Turning Point

**Grant Number:** NY0988L2T041703

**Grant Operating Period/MOU Term:** 8/1/18-7/31/19

**Recipient:** Westchester County Department of Social Services

**Contact:** Craig Wong

Program Administrator-Homeless Services

85 Court Street 5<sup>th</sup> Floor

White Plains, NY 10601

914-995-1014

[cqw1@westchestergov.com](mailto:cqw1@westchestergov.com)

**Service Provider:** Family Services of Westchester

**Contact:** Polly Kerrigan

Senior Vice President Program Operations

One Gateway Plaza, 4th floor

Port Chester, NY 10573

(914) 738-1728

[pkerrigan@fsw.org](mailto:pkerrigan@fsw.org)

**Total clients receiving service over grant term:** 15

**Estimated value of services provided:** \$15,000

### **1. Background**

The Westchester County Department of Social Services Turning Point project is funded by a grant from the United States Department of Housing and Urban Development (HUD). The Project is designed to provide both affordable housing and a full range of services to chronic homeless individuals and chronic homeless families.

### **2. Purpose of Memorandum of Understanding**

The purpose of this Memorandum of Understanding (MOU) is to clearly identify the services to be provided and the responsibilities of the Family Services Of Westchester, an identified service provider ("Provider"); and the responsibilities of the Westchester County Department of Social Services ("WC DSS") in relation to the project stated above. By signing this MOU, Provider is making an unconditional commitment to provide the services specified below.

### **3. Scope of Services**

Building upon our existing referral relationship, provider shall render the following services for the WC DSS HUD Turning Point project:

| Description of Services to be Provided     | Profession of Person Providing Service | Hourly Cost of Service to be Provided |
|--|--|---------------------------------------|
| <input type="checkbox"/> Medical           |  |                                       |
| <input type="checkbox"/> Case Management   | MSW, LMSW, LCSW, Psychologist          | \$43.44                               |
| <input type="checkbox"/> Educational       |  |                                       |
| <input type="checkbox"/> Transportation    |  |                                       |
| <input type="checkbox"/> Clothing          |  |                                       |
| <input type="checkbox"/> Mental Health     | MSW, LMSW, LCSW, Psychologist          | \$46.78                               |
| <input type="checkbox"/> Substance Use     |  |                                       |
| <input type="checkbox"/> Life Skills       | Vocational counselor, MSW, LMSW, LCSW  | \$30.07                               |
| <input type="checkbox"/> Legal Services    |  |                                       |
| <input type="checkbox"/> Housing Placement |  |                                       |
| <input type="checkbox"/> Child Care        |  |                                       |

The WC DSS, with sub-recipients Lifting Up Westchester, The Guidance Center of Westchester, Family Service Society of Yonkers, Caring for the Homeless of Peekskill, and Westhab ("Sub-Recipients"), shall administer all grant requirements, including oversight and monitoring activities, administer rental assistance to eligible participants, coordinate participant intake, referral, and service delivery, and coordinate services between housing providers and service providers, deliver technical assistance and training to providers as needed.

**4. Documentation of Services**

The Provider will be required, upon request and with participant consent, to submit on a monthly basis documentation to support services rendered to rental assistance recipients. This information shall be submitted to the Sub-Recipient(s) for filing in each individual participant's chart. This information shall include the date, the type of service, the profession of the individual providing the service and the reimbursement/hourly rate/value for the service.

The WC DSS shall make a good faith effort to seek and secure the information related to this service delivery in alternate ways in order to limit the burden on the Provider's and Sub-Recipients' staff. WC DSS will also make efforts to seek additional financial and in-kind resources in support of Turning Point project related activities. WC DSS staff will communicate any changes to requirements to Sub-Recipient and Provider as information becomes available.

**By signing below all parties agree to all aspects of this Memorandum of Understanding and will perform functions as listed.**

**Westchester County Dept. of Social Services**

Kevin M. McGuire Commissioner  
 Name Title

[Signature] 8/14/17  
 Signature Date

**Family Services Of Westchester**

Polly Kerrigan Senior Vice President

Polly Kerrigan 8/19/17





Robert P. Astorino  
County Executive

Department of Social Services

Kevin McGuire  
Commissioner

**MEMORANDUM OF UNDERSTANDING  
BETWEEN  
WESTCHESTER COUNTY DEPARTMENT OF SOCIAL SERVICES,  
AND  
WESTCHESTER MEDICAL CENTER, INC.**

**HUD Project:** Turning Point

**Grant Number:** NY0988L2T041703

**Grant Operating Period/MOU Term:** 8/1/18-7/31/19

**Recipient:** Westchester County Department of Social Services

**Contact:** Craig Wong

Program Administrator-Homeless Services

85 Court Street 5<sup>th</sup> Floor

White Plains, NY 10601

914-995-1014

[cqw1@westchestergov.com](mailto:cqw1@westchestergov.com)

**Service Provider:** Westchester Medical Center, Inc.

**Contact:** Eric Amoh

Vice President, Behavioral Health Services

Westchester Medical Center

100 Woods Avenue

Valhalla, NY 10595

(914) 493-1906

[amohe@wcmc.com](mailto:amohe@wcmc.com)

**Total clients receiving service over grant term:** 15

**Estimated value of services provided:** \$15,000

### **1. Background**

The Westchester County Department of Social Services Turning Point project is funded by a grant from the United States Department of Housing and Urban Development (HUD). The Project is designed to provide both affordable housing and a full range of services to chronic homeless individuals and chronic homeless families.

### **2. Purpose of Memorandum of Understanding**

The purpose of this Memorandum of Understanding (MOU) is to clearly identify the services to be provided and the responsibilities of the Westchester Medical Center, an identified service provider ("Provider"); and the responsibilities of the Westchester County Department of Social Services ("WC DSS") in relation to the project stated above. By signing this MOU, Provider is making an unconditional commitment to provide the services specified below.

### **3. Scope of Services**

Building upon our existing referral relationship, provider shall render the following services for the WC DSS HUD Turning Point project:

| Description of Services to be Provided     | Profession of Person Providing Service | Hourly Cost of Service to be Provided |
|--|--|---------------------------------------|
| <input type="checkbox"/> Medical           | MD/RN                                  | \$95.35/\$85.08 respectively          |
| <input type="checkbox"/> Case Management   | MSW, LMSW, LCSW, Psychologist          | \$43.44                               |
| <input type="checkbox"/> Educational       |  |                                       |
| <input type="checkbox"/> Transportation    |  |                                       |
| <input type="checkbox"/> Clothing          |  |                                       |
| <input type="checkbox"/> Mental Health     | MSW, LMSW, LCSW, Psychologist          | \$46.78                               |
| <input type="checkbox"/> Substance Use     | MSW, LMSW, CASAC                       |                                       |
| <input type="checkbox"/> Life Skills       | Vocational counselor, MSW, LMSW, LCSW  | \$30.07                               |
| <input type="checkbox"/> Legal Services    |  |                                       |
| <input type="checkbox"/> Housing Placement |  |                                       |
| <input type="checkbox"/> Child Care        |  |                                       |

The WC DSS, with sub-recipients Lifting Up Westchester, The Guidance Center of Westchester, Family Service Society of Yonkers, Caring for the Homeless of Peekskill, and Westhab ("Sub-Recipients"), shall administer all grant requirements, including oversight and monitoring activities, administer rental assistance to eligible participants, coordinate participant intake, referral, and service delivery, and coordinate services between housing providers and service providers, deliver technical assistance and training to providers as needed.

**4. Documentation of Services**

The Provider will be required, upon request and with participant consent, to submit on a monthly basis documentation to support services rendered to rental assistance recipients. This information shall be submitted to the Sub-Recipient(s) for filing in each individual participant's chart. This information shall include the date, the type of service, the profession of the individual providing the service and the reimbursement/hourly rate/value for the service.

The WC DSS shall make a good faith effort to seek and secure the information related to this service delivery in alternate ways in order to limit the burden on the Provider's and Sub-Recipients' staff. WC DSS will also make efforts to seek additional financial and in-kind resources in support of Turning Point project related activities. WC DSS staff will communicate any changes to requirements to Sub-Recipient and Provider as information becomes available.

**By signing below all parties agree to all aspects of this Memorandum of Understanding and will perform functions as listed.**

**Westchester County Dept. of Social Services**

Kevin M. McGuire Commissioner  
 Name Title

[Signature] 8/1/17  
 Signature Date

**Westchester Medical Center**

Eric Amoh SVP-Clinical Services  
 Name Title

[Signature] 8/1/17  
 Signature Date





Robert P. Astorino  
County Executive

Department of Social Services

Kevin McGuire  
Commissioner

**MEMORANDUM OF UNDERSTANDING  
BETWEEN  
WESTCHESTER COUNTY DEPARTMENT OF SOCIAL SERVICES,  
AND  
ST. JOSEPH'S MEDICAL CENTER and its ST. VINCENT'S HOSPITAL – WESTCHESTER  
DIVISION**

**HUD Project:** Turning Point

**Grant Number:** NY0988L2T041703

**Grant Operating Period/MOU Term:** 8/1/18-7/31/19

**Recipient:** Westchester County Department of Social Services

**Contact:** Craig Wong

Program Administrator-Homeless Services

85 Court Street 5<sup>th</sup> Floor

White Plains, NY 10601

914-995-1014

[cqw1@westchestergov.com](mailto:cqw1@westchestergov.com)

**Service Provider:** St. Joseph's Medical Center and its St. Vincent's Hospital – Westchester Division

**Contact:** Bernadette Kingham-Bez

Executive Director

275 North Street

Harrison, NY 10528

[bkingham@svwsjmc.org](mailto:bkingham@svwsjmc.org)

**Total clients receiving service over grant term:** 15

**Estimated value of services provided:** \$15,000

### **1. Background**

The Westchester County Department of Social Services Turning Point project is funded by a grant from the United States Department of Housing and Urban Development (HUD). The Project is designed to provide both affordable housing and a full range of services to chronic homeless individuals and chronic homeless families.

### **2. Purpose of Memorandum of Understanding**

The purpose of this Memorandum of Understanding (MOU) is to clearly identify the services to be provided and the responsibilities of St. Joseph's Medical Center and its St. Vincent's Hospital – Westchester Division, an identified service provider ("Provider"); and the responsibilities of the Westchester County Department of Social Services ("WC DSS") in relation to the project stated above. By signing this MOU, Provider is making an unconditional commitment to provide the services specified below.

### **3. Scope of Services**

Building upon our existing referral relationship, provider shall render the following services for the WC DSS HUD Turning Point project:

| Description of Services to be Provided     | Profession of Person Providing Service             | Hourly Cost of Service to be Provided |
|--|--|---------------------------------------|
| <input type="checkbox"/> Medical           | Physician, Nurse, Physician Assistant, Nurses Aide | \$230 - \$325                         |
| <input type="checkbox"/> Case Management   | Case Manager, Social Worker                        | \$100 - \$150                         |
| <input type="checkbox"/> Educational       |  |                                       |
| <input type="checkbox"/> Transportation    |  |                                       |
| <input type="checkbox"/> Clothing          |  |                                       |
| <input type="checkbox"/> Mental Health     | Psychiatrist, Social Worker, Psychologist, Nurse   | \$121 - \$190                         |
| <input type="checkbox"/> Substance Use     | CASAC, Social Worker, Psychiatrist, Nurse          | \$80 - \$100                          |
| <input type="checkbox"/> Life Skills       |  |                                       |
| <input type="checkbox"/> Legal Services    |  |                                       |
| <input type="checkbox"/> Housing Placement |  |                                       |
| <input type="checkbox"/> Child Care        |  |                                       |

The WC DSS, with sub-recipients Lifting Up Westchester, The Guidance Center of Westchester, Family Service Society of Yonkers, Caring for the Homeless of Peekskill, and Westhab ("Sub-Recipients"), shall administer all grant requirements, including oversight and monitoring activities, administer rental assistance to eligible participants, coordinate participant intake, referral, and service delivery, and coordinate services between housing providers and service providers, deliver technical assistance and training to providers as needed.

#### 4. Documentation of Services

The Provider will be required, upon request and with participant consent, to submit on a monthly basis documentation to support services rendered to rental assistance recipients. This information shall be submitted to the Sub-Recipient(s) for filing in each individual participant's chart. This information shall include the date, the type of service, the profession of the individual providing the service and the reimbursement/hourly rate/value for the service.

The WC DSS shall make a good faith effort to seek and secure the information related to this service delivery in alternate ways in order to limit the burden on the Provider's and Sub-Recipients' staff. WC DSS will also make efforts to seek additional financial and in-kind resources in support of Turning Point project related activities. WC DSS staff will communicate any changes to requirements to Sub-Recipient and Provider as information becomes available.

By signing below all parties agree to all aspects of this Memorandum of Understanding and will perform functions as listed.

Westchester County Dept. of Social Services

Kevin M. McGuire Commissioner  
Name Title

[Signature] 8/14/17  
Signature Date

St. Joseph's Medical Center and its St. Vincent's Hospital – Westchester Division

Bernadette Kingham-Bez Executive Director  
Name Title

[Signature] 8-1-17  
Signature Date



Robert P. Astorino  
County Executive

Department of Social Services

Kevin McGuire  
Commissioner

**MEMORANDUM OF UNDERSTANDING  
BETWEEN  
WESTCHESTER COUNTY DEPARTMENT OF SOCIAL SERVICES,  
AND  
ST. JOHN'S RIVERSIDE HOSPITAL, INC.**

**HUD Project:** Turning Point

**Grant Number:** NY0988L2T041703

**Grant Operating Period/MOU Term:** 8/1/18-7/31/19

**Recipient:** Westchester County Department of Social Services

**Contact:** Craig Wong

Program Administrator-Homeless Services

85 Court Street 5<sup>th</sup> Floor

White Plains, NY 10601

914-995-1014

[cqw1@westchestergov.com](mailto:cqw1@westchestergov.com)

**Service Provider:** St. John's Riverside Hospital

**Contact:** Brian Kaley

Vice President, Behavioral Health Services

Riverside Health – St. John's Riverside Hospital

967 North Broadway

Yonkers, NY 10701

[bkaley@riversidehealth.org](mailto:bkaley@riversidehealth.org)

**Total clients receiving service over grant term:** 16

**Estimated value of services provided:** \$30,000

### **1. Background**

The Westchester County Department of Social Services Turning Point project is funded by a grant from the United States Department of Housing and Urban Development (HUD). The Project is designed to provide both affordable housing and a full range of services to chronic homeless individuals and chronic homeless families.

### **2. Purpose of Memorandum of Understanding**

The purpose of this Memorandum of Understanding (MOU) is to clearly identify the services to be provided and the responsibilities of St. John's Riverside Hospital, Inc., an identified service provider ("Provider"); and the responsibilities of the Westchester County Department of Social Services ("WC DSS") in relation to the project stated above. By signing this MOU, Provider is making an unconditional commitment to provide the services specified below.

### **3. Scope of Services**

Building upon our existing referral relationship, provider shall render the following services for the WC DSS HUD Turning Point project:

| Description of Services to be Provided | Profession of Person Providing Service  | Hourly Cost of Service to be Provided |
|--|---|---------------------------------------|
| Medical                                | Physicians, mid-level practitioners, RN | \$164                                 |
| Case Management                        |   |                                       |
| Educational                            |   |                                       |
| Transportation                         |   |                                       |
| Clothing                               |   |                                       |
| Mental Health                          |   |                                       |
| Substance Use                          | Social Worker, CASAC                    | \$91.12                               |
| Life Skills                            |   |                                       |
| Legal Services                         |   |                                       |
| Housing Placement                      |   |                                       |
| Child Care                             |   |                                       |

The WC DSS, with sub-recipients Lifting Up Westchester, The Guidance Center of Westchester, Family Service Society of Yonkers, Caring for the Homeless of Peekskill, and Westhab ("Sub-Recipients"), shall administer all grant requirements, including oversight and monitoring activities, administer rental assistance to eligible participants, coordinate participant intake, referral, and service delivery, and coordinate services between housing providers and service providers, deliver technical assistance and training to providers as needed.

**4. Documentation of Services**

The Provider will be required, upon request and with participant consent, to submit on a monthly basis documentation to support services rendered to rental assistance recipients. This information shall be submitted to the Sub-Recipient(s) for filing in each individual participant's chart. This information shall include the date, the type of service, the profession of the individual providing the service and the reimbursement/hourly rate/value for the service.

The WC DSS shall make a good faith effort to seek and secure the information related to this service delivery in alternate ways in order to limit the burden on the Provider's and Sub-Recipients' staff. WC DSS will also make efforts to seek additional financial and in-kind resources in support of Turning Point project related activities. WC DSS staff will communicate any changes to requirements to Sub-Recipient and Provider as information becomes available.

**By signing below all parties agree to all aspects of this Memorandum of Understanding and will perform functions as listed.**

**Westchester County Dept. of Social Services**

Kevin M McGuire Commissioner  
 Name Title

[Signature] 8/15/17  
 Signature Date

**St. John's Riverside Hospital, Inc.**

Brian Kaley Vice President  
 Name Title Deborah Halby

[Signature] 7/26/17  
 Signature Date



Robert P. Astorino  
County Executive

Department of Social Services

Kevin McGuire  
Commissioner

**MEMORANDUM OF UNDERSTANDING  
BETWEEN  
WESTCHESTER COUNTY DEPARTMENT OF SOCIAL SERVICES,  
AND  
ROCKLAND PSYCHIATRIC CENTER**

**HUD Project:** Turning Point **Grant Number:** NY0988L2T041703

**Grant Operating Period/MOU Term:** 8/1/18-7/31/19

**Recipient:** Westchester County Department of Social Services

**Contact:** Craig Wong  
Program Administrator-Homeless Services  
85 Court Street 5<sup>th</sup> Floor  
White Plains, NY 10601  
914-995-1014  
[cqwl@westchestergov.com](mailto:cqwl@westchestergov.com)

**Service Provider:** Rockland Psychiatric Center  
**Contact:** Janet Monroe  
Executive Director  
140 Old Orangeburg Road - Building 57, 8<sup>th</sup> Floor  
Orangeburg, NY 10962  
[janet.monroe@omh.state.ny.us](mailto:janet.monroe@omh.state.ny.us)

**Total clients receiving service over grant term:** 15

**Estimated value of services provided:** \$15,000

**1. Background**

The Westchester County Department of Social Services Turning Point project is funded by a grant from the United States Department of Housing and Urban Development (HUD). The Project is designed to provide both affordable housing and a full range of services to chronic homeless individuals and chronic homeless families.

**2. Purpose of Memorandum of Understanding**

The purpose of this Memorandum of Understanding (MOU) is to clearly identify the services to be provided and the responsibilities of the Rockland Psychiatric Center, an identified service provider ("Provider"); and the responsibilities of the Westchester County Department of Social Services ("WC DSS") in relation to the project stated above. By signing this MOU, Provider is making an unconditional commitment to provide the services specified below.

**3. Scope of Services**

Building upon our existing referral relationship, provider shall render the following services for the WC DSS HUD Turning Point project:

| Description of Services to be Provided     | Profession of Person Providing Service | Hourly Cost of Service to be Provided |
|--|--|---------------------------------------|
| <input type="checkbox"/> Medical           | MD, Psychiatrist, RN, Nurse            | \$31.25 - \$205.19                    |
| <input type="checkbox"/> Case Management   | SW, LMSW, RN, Nurse                    | \$71.65                               |
| <input type="checkbox"/> Educational       |  |                                       |
| <input type="checkbox"/> Transportation    |  |                                       |
| <input type="checkbox"/> Clothing          |  |                                       |
| <input type="checkbox"/> Mental Health     | Psychologist, SW, RN, MD               | \$71.65 - \$97.17                     |
| <input type="checkbox"/> Substance Use     | Psychologist, SW, RN                   | \$79.35                               |
| <input type="checkbox"/> Life Skills       | Peer Specialist, Rehab counselor, LMSW | \$79.35                               |
| <input type="checkbox"/> Legal Services    |  |                                       |
| <input type="checkbox"/> Housing Placement |  |                                       |
| <input type="checkbox"/> Child Care        |  |                                       |

The WC DSS, with sub-recipients Lifting Up Westchester, The Guidance Center of Westchester, Family Service Society of Yonkers, Caring for the Homeless of Peekskill, and Westhab ("Sub-Recipients"), shall administer all grant requirements, including oversight and monitoring activities, administer rental assistance to eligible participants, coordinate participant intake, referral, and service delivery, and coordinate services between housing providers and service providers, deliver technical assistance and training to providers as needed.

#### 4. Documentation of Services

The Provider will be required, upon request and with participant consent, to submit on a monthly basis documentation to support services rendered to rental assistance recipients. This information shall be submitted to the Sub-Recipient(s) for filing in each individual participant's chart. This information shall include the date, the type of service, the profession of the individual providing the service and the reimbursement/hourly rate/value for the service.

The WC DSS shall make a good faith effort to seek and secure the information related to this service delivery in alternate ways in order to limit the burden on the Provider's and Sub-Recipients' staff. WC DSS will also make efforts to seek additional financial and in-kind resources in support of Turning Point project related activities. WC DSS staff will communicate any changes to requirements to Sub-Recipient and Provider as information becomes available.

By signing below all parties agree to all aspects of this Memorandum of Understanding and will perform functions as listed.

Westchester County Dept. of Social Services

Karin M McGuire Commissioner  
Name Title

[Signature] 8/15/17  
Signature Date

Rockland Psychiatric Center

Janet Monroe Executive Dir.  
Name Title

[Signature] 8/08/17  
Signature Date

Robert P. Astorino  
County Executive

Department of Social Services

Kevin McGuire  
Commissioner

MEMORANDUM OF UNDERSTANDING  
BETWEEN  
WESTCHESTER COUNTY DEPARTMENT OF SOCIAL SERVICES,  
AND  
MONTEFIORE MOUNT VERNON/MONTEFIORE NEW ROCHELLE

HUD Project: Turning Point Grant Number: NY0988L2T041703  
Grant Operating Period/MOU Term: 8/1/18-7/31/19

Recipient: Westchester County Department of Social Services

Contact: Craig Wong  
Program Administrator-Homeless Services  
85 Court Street 5<sup>th</sup> Floor  
White Plains, NY 10601  
914-995-1014  
[cqw1@westchestergov.com](mailto:cqw1@westchestergov.com)

Service Provider: Montefiore Mount Vernon/Montefiore New Rochelle

Contact: Dr. Claus VonSchorn  
12 North 7<sup>th</sup> Avenue  
Mount Vernon, NY 10550  
914-664-8000  
[cvonschorn@sshsw.org](mailto:cvonschorn@sshsw.org) *cvonscho@montefiore.org*

Total clients receiving service over grant term: 15

Estimated value of services provided: \$15,000

### 1. Background

The Westchester County Department of Social Services Turning Point project is funded by a grant from the United States Department of Housing and Urban Development (HUD). The Project is designed to provide both affordable housing and a full range of services to chronic homeless individuals and chronic homeless families.

### 2. Purpose of Memorandum of Understanding

The purpose of this Memorandum of Understanding (MOU) is to clearly identify the services to be provided and the responsibilities of Montefiore Mount Vernon and Montefiore New Rochelle, an identified service provider ("Provider"); and the responsibilities of the Westchester County Department of Social Services ("WC DSS") in relation to the project stated above. By signing this MOU, Provider is making an unconditional commitment to provide the services specified below.

### 3. Scope of Services

Building upon our existing referral relationship, provider shall render the following services for the WC DSS HUD Turning Point project:



| Description of Services to be Provided     | Profession of Person Providing Service | Hourly Cost of Service to be Provided |
|--|--|---------------------------------------|
| <input type="checkbox"/> Medical           | MD, Psychiatrist                       | \$230 - \$325                         |
| <input type="checkbox"/> Case Management   | SW, CASAC                              | \$100 - \$150                         |
| <input type="checkbox"/> Educational       |  |                                       |
| <input type="checkbox"/> Transportation    |  |                                       |
| <input type="checkbox"/> Clothing          |  |                                       |
| <input type="checkbox"/> Mental Health     | Psychiatrist, SW, CASAC                | \$121 - \$190                         |
| <input type="checkbox"/> Substance Use     | Psychiatrist, SW, CASAC                | \$80 - \$100                          |
| <input type="checkbox"/> Life Skills       |  |                                       |
| <input type="checkbox"/> Legal Services    |  |                                       |
| <input type="checkbox"/> Housing Placement |  |                                       |
| <input type="checkbox"/> Child Care        |  |                                       |

The WC DSS, with sub-recipients Lifting Up Westchester, The Guidance Center of Westchester, Family Service Society of Yonkers, Caring for the Homeless of Peekskill, and Westhab ("Sub-Recipients"), shall administer all grant requirements, including oversight and monitoring activities, administer rental assistance to eligible participants, coordinate participant intake, referral, and service delivery, and coordinate services between housing providers and service providers, deliver technical assistance and training to providers as needed.

#### 4. Documentation of Services

The Provider will be required, upon request and with participant consent, to submit on a monthly basis documentation to support services rendered to rental assistance recipients. This information shall be submitted to the Sub-Recipient(s) for filing in each individual participant's chart. This information shall include the date, the type of service, the profession of the individual providing the service and the reimbursement/hourly rate/value for the service.

The WC DSS shall make a good faith effort to seek and secure the information related to this service delivery in alternate ways in order to limit the burden on the Provider's and Sub-Recipients' staff. WC DSS will also make efforts to seek additional financial and in-kind resources in support of Turning Point project related activities. WC DSS staff will communicate any changes to requirements to Sub-Recipient and Provider as information becomes available.

By signing below all parties agree to all aspects of this Memorandum of Understanding and will perform functions as listed.

Westchester County Dept. of Social Services

Kevin M. McGuire Commissioner [Signature] 8/16/17  
 Name Title Signature Date

Montefiore Mount Vernon/Montefiore New Rochelle  
Claus P. von Schorn MD Chairman Dept of Psychiatry [Signature] 8/11/17  
 Name Title Signature Date