**Arkansas Department of Human Services**

**Division of Aging Adult and Behavioral Health Services**

**2020 CARES ACT Funding Application**

**Title:** Supports for Arkansas Veterans with Behavioral Health needs during the COVID-19 Pandemic

**Background:** In response to the COVID-19 Pandemic, Governor Asa Hutchinson created the Arkansas Coronavirus Aid, Relief, and Economic Security (CARES) Act Steering Committee to make recommendations to the Governor on the “best uses of the CARES Act funding” under Section 601 of PL116-136, the “Coronavirus Relief Fund.” This funding opportunity is offered to support Arkansas veterans with behavioral health needs that may be exacerbated by the current health emergency.

**Overview**: The Arkansas Department of Human Services (DHS) requests applications for funds available through the CARES Act to provide funding to non-profit veteran service organizations to address crisis interventions with Arkansas Veterans affected by behavioral health issues during the COVID-19 pandemic. All funding must be expended by December 30, 2020.

**Eligible Providers:** In order to be eligible for this funding opportunity, applicants must be a Non-Profit Veteran Service Organization.

**Non-Profit Veteran Service Organizations**

Funding is available to support non-profit veteran service organizations with qualified expenditures for equipment and services to support veterans experiencing behavioral health needs.

These organizations must meet the following **minimum eligibility requirements:**

1. A mission and vision that aligns with addressing the needs of Arkansas veterans;
2. A demonstrated history of service to Arkansas veterans;
3. Leadership and staff that are representative of Arkansas veterans;
4. A history of demonstrating clear strategies for engagement with Arkansas veterans; and
5. Been in operation since March 1, 2019.

In order to be eligible for reimbursement, expenses must be specifically related to services provided to veterans. Eligible reimbursement expenses may include:

* First Aid / Trauma Supplies
* Personal Protective Equipment
* Naloxone
* Training and Professional Development
* Seminars/Support Groups
* Food and Nutrition Assistance for Veterans/Families
* Shelter Expense for Homeless Veterans
* Outreach/Information Campaigns
* Information Technology

**Application Guidelines:** Organizations applying for Coronavirus Relief Funding must submit a completed application to DHS detailing their requested needs and proposed budget for expenses and any other information DHS requests of applicants in order to select funding awardees. Eligible organizations may submit proposals based on the following funding levels:

* Organizations with 0 to 4 employees may submit for up to $15,000
* Organizations with 5 to 15 employees may submit for up to $30,000
* Organizations with 15 to 30 employees may submit for up to $60,000
* Organizations with 30 or more employees may submit for up to $100,000

Proposals for funding should include information regarding the population served, the proposed timeline for activities, types of activities, and proposed budget for each activity. In addition, proposals must include information detailing how the organization meets the minimum requirements for eligibility (items 1-5 listed above).

**Award Information:** Applications will be reviewed in the order received and awarded upon review and final approval. Review and approval processes will begin as soon as applications are received. Those submitted after Nov. 18 will not be accepted. Total funds awarded cannot exceed the amount approved for this section. Any funds not awarded will be returned to DHS within fourteen (14) days of the application deadline for ultimate return to DFA. Funds must be used or distributed based on the organization’s plan by December 30, 2020. Funds are for eligible costs, as detailed above, incurred through the end of calendar year 2020 and require documentation detailing expenditures, including required financial reports or receipts.

**Application Deadline**: November 18, 2020, 4:30 p.m.

**Submission**: Please submit completed applications to the following email address: [DHS.caresfundingact.veterans@dhs.arkansas.gov](mailto:DHS.caresfundingact.veterans@dhs.arkansas.gov)

**2020 CARES ACT Funding Application**

**Application Organization Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Owner’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**County:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note:** When entering the assistance provided to the client also enter the funding you are requesting.

|  |  |
| --- | --- |
| **Assistance Provided to Clients** | **Requested Funding** |
|  |  |
|  |  |
|  |  |
|  |  |

**Application Checklist**

Organizations applying for this funding opportunity must complete this application and provide a proposal and budget detailing the following:

* Detail on organization’s adherence to the minimum eligibility requirements stated on page 1.
* Indicate the population to be served through the grant
* The activities to be performed
* The timeframe for the activities
* The proposed budget for each activity
* Attest that these are necessary expenditures due to public health emergency with respect to COVID-19 and that these funds are not used to offset other expenditures (See attestation form, page 4).

**The documents should be assembled and scanned into a PDF file. No paper copies will be accepted.**

**All submissions must be emailed to the DHS mailbox address in the submission section above.**

**Please contact the staff below for any questions or clarifications.**

**Tammy Alexander: PHONE: 501-396-6310 EMAIL:** [**TAMMY.ALEXANDER@dhs.arkansas.gov**](mailto:TAMMY.ALEXANDER@dhs.arkansas.gov)

**Scottie Leslie: PHONE: 501-686-9594 EMAIL:** [**Scottie.Leslie@dhs.arkansas.gov**](mailto:Scottie.Leslie@dhs.arkansas.gov)

**Application Information**

The applicant must fill out each field in this Section.

1. Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Federal Tax ID Number (TIN): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Physical City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Physical Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Mailing City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailing Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Please enter the counties that this proposal will serve: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name of Responsible Party (RP): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. RP Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. RP Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. RP Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Name of the Primary Person (PP): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. PP Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. PP Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. PP Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. **Responsible Party**

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“I hereby acknowledge that the submission of the CARES Action Funding Application has been approved by me and if necessary, the Board of Directors

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ATTESTATION**

I, [Responsible Party] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby attest:

[Organization Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, attest that these are necessary expenditures due to the public health emergency with respect to COVID-19 and that none of these funds are used to:

* duplicate or supplant funding from any other federal or state program. Payments or other reimbursement for direct client care is not included as funding from a federal or state program;
* offset loss of revenue;
* provide “retention” or retainer payments;
* pay bonuses;
* pay any increase in management fees to administrative personnel.
* reimburse donors for donated items or services, previously donated; this includes reimbursement for items purchased by the non-profit with funds specifically donated and designated for the response to COVID-19
* pay any expense not related to the current COVID-19 public health emergency; or
* pay for general economic development or capital improvement projects that are not necessary expenditures due to the COVID-19 public health emergency

[Organization Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, shall retain records sufficient to support each and every payment claimed herein, for so long as may be deemed necessary, but in no case less than seven (7) years;

[Organization Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, shall make such records available to the Arkansas Department of Human Services and/or any other lawful authority, upon request; and

upon penalty of perjury, all facts contained in the foregoing application are true and correct to the best of my knowledge, information, and belief.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date