November 13, 2025 - HOME ARP 2025 2H RFP Supportive Services Supplement - this supplement replaces the Development Budget and Operating Proforma ONLY in the current HOME ARP RFP and ONLY for Supportive Services Requests

Mayor Christopher P. Scanlon

I. Instructions:

Only complete this form BURA HOME-ARP Application if your organization is requesting resources for a HOME-ARP Supportive Services Project.

Project Name:
Address:
Federal Tax ID Number:
Applicant Status: ____ Non-profit _____Private Corporation _____ Other: Describe: _____

Chief official of applicant
Name
Title
Mailing Address
City, State, Zip
Email
Phone
Fax

Designated contact person for this application
Name
Title
Mailing Address
City, State, Zip
Email
Phone
Fax

I HEREBY SUBMIT THIS PROPOSAL FOR THE CONSIDERATION OF FINANCIAL ASSISTANCE IN SUPPORT OF THE PROJECT HEREWITHIN DESCRIBED. I CERTIFY THAT ALL INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IF SELECTED FOR FUNDING, I WILL COOPERATE FULLY WITH THE CITY OF BUFFALO TO COMPLY WITH FEDERAL HOME INVESTMENT PARTNERSHIPS PROGRAM REGULATIONS AS APPLICABLE.

The undersigned certifies that to his/her/their knowledge as of the date hereof, no principal, officer, board member, employee responsible for managing finances, consultant or contractor acting as a fiscal agent of or to the Applicant, has been convicted of a local, state or federal criminal offense involving moral terpitude or dishonesty in the last 10 years or, if sooner, since the age of eighteen (18). (if the Applicant cannot certify to this statement, please submit a signed statement explaining the related facts and circumstances). To the extent required by BURA, the undersigned agrees to reaffirm this certification on prior written notice from BURA.

Authorized Signature: _____ Date: _____

Printed Name: _____ Title: _____

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II. Proposal Summary:

HOME-ARP Request

$ - *Prefilled from Request below.*

General Information

Below are the Eligible Costs under HOME-ARP Supportive Services. For additional details and complete definitions, please refer to 24 CFR 578 (e) and CPD Notice 21-10

Child care	*Substance abuse treatment services*
Education services	*Transportation*
Employment assistance and job training	*Case management*
Food	*Mediation*
Housing search and counseling services	*Credit repair*
Legal services	*Landlord/Tenants Liaison*
Life skills training	*Services for special populations*
Mental health services	*Financial assistance costs*
Outpatient health services	*Short-term and medium-term financial assistance for rent*
Outreach services	

Agency Type

Check all that apply.

_____ Day Shelter
_____ Emergency Shelter - 90 days or less
_____ Homeless Services Provider (Homeless Prevention or Rapid Re-Housing)
_____ Street Outreach
_____ Victim Service Provider
_____ Other (Provide Description in box below)

Other Partners

Are there other agencies/entities you will be collaborating with to implement this program? If yes, please describe below:

III. Activities:

Proposed Grant Period Start Date: _____

Proposed Grant Period End Date: _____

What eligible activities will be provided under each funding category? Place an "X" in the appropriate box indicating your plan to provide the eligbile service.

Activity*	McKinney-Vento Supportive Services	Homeless Prevention Services	Housing Counseling Services
Child Care			N/A
Education Services			N/A
Employment Assistance/job training			N/A
Food			N/A
Housing Search and counseling services (does not meet definition of Housing Counseling, as defined in 24 CFR 578.53)			N/A
Legal services			N/A
Life Skills Training			N/A
Mental Health Services			N/A
Outpatient health services			N/A
Outreach services			N/A
Substance abuse treatment services			N/A
Transportation			N/A
Case Management			N/A
Mediation			N/A
Credit Repair			N/A
Landlord/Tenant Liaison			N/A
Financial assistance costs (application fee, deposit, utility payment, moving cost, first and last month's rent, rent arrears)			N/A
Short-term and medium-term rent payments			N/A
Housing Counseling Services as defined in 24 CFR 5.100	N/A	N/A	

*For complete definitions for each of the activities, refer to HUD CPD Notice 21-10.

IV. Budget:

Enter the estimated budget amount for each activity and provide a brief description of the activity.

If the applicant uses a row labeled "Other," please delete "Other" and describe the activity identified. ***Be specific.***

McKinney-Vento Supportive Services		
Activity	**Amount**	**Detail**
Staff Salaries/ Personnel Costs	$ -	
Services	$ -	
Travel/ Transportation	$ -	
Emergency Financial Assistance	$ -	
Short-Term and Medium-Term Rent	$ -	
Supplies/Materials	$ -	
Other	$ -	
Other	$ -	
Other	$ -	
Total	**$ -**	

Homeless Prevention Services		
Activity	**Amount**	**Detail**
Staff Salaries/ Personnel Costs	$ -	
Services	$ -	
Travel/ Transportation	$ -	
Emergency Financial Assistance	$ -	
Short-Term and Medium-Term Rent	$ -	
Supplies/Materials	$ -	
Other	$ -	
Other	$ -	
Other	$ -	
Total	**$ -**	

Housing Counseling Services		
Activity	**Amount**	**Detail**
Staff Salaries	$ -	
Overhead Costs of HUD-Certified Housing Couseling Agency	$ -	
Development of Housing Counseling Workplans	$ -	
Marketing and Outreach	$ -	
Financial and Housing Affordability Analysis	$ -	
Other	$ -	
Other	$ -	
Other	$ -	
Total	**$ -**	

Activities	Supportive Services Requested Expense
McKinney-Vento Supportive Services	$ -
Homeless Prevention (24 CFR Part 576)	$ -
Housing Counseling Services	$ -
Victim Services	$ -
Total	**$ -**

Rental and NCS Projects

Is the applicant requesting HOME-ARP Rental or NCS funds?
If yes, complete the remainder of this section.

Supportive Services Request $ - *Prefilled from Budget above.*

Describe how much of the above request will be dedicated to providing Supportive Services to the Rental or NCS project. Provide exact amounts* and be specific. OHFA understands these numbers are subject to change.

Describe how much of the above request will be dedicated to providing Supportive Services to the general public (individuals and families not residing in the Rental or NCS project). Provide exact amounts* and be specific. OHFA understands these numbers are subject to change.

***The numbers contemplated in these two narratives should total the Supportive Services request.**

V. Agency Details:

Other Partners

Are there other agencies/entities you will be collaborating with to implement this program? If yes, please describe below:

Agency Capacity

Is your organization an active member of any of the following? Check all that apply.

Continuum of Care _____

Regional/Local Planning Meetings _____

State/Local Consolidated Plan Process _____

Regional/Local Homeless Committees _____

How do agency staff participate in these meetings/groups? Please describe the level of involvement.

Describe how your proposed project will collaborate with the Continuum of Care.

How will the applicant ensure services and activities are not duplicated by other programs or funding sources?

Proposed Accomplishments

During the timeframe of the applicant's proposed Supportive Services program, what is the:
Total number of households to be served: _____
Total unduplicated individuals to be served: _____
Indicate the number of unduplicated adults to be served: _____
Indicate the number of unduplicated children to be served: _____