

KOVAR

KNIGHTS OF VIRGINIA ASSISTANCE FOR THE INTELLECTUALLY DISABLED
APPLICATION FOR NON-INTEREST LOAN PROGRAM
FOR FINANCING GROUP HOMES FOR CITIZENS WITH INTELLECTUAL DISABILITIES

1. Project Mortgagor (sponsor/borrower):

(Name of Organization)	
(Address)	
, Virginia	
(City/Town)	(Zip Code)
(Contact Person)	(Telephone)
(Alternate Person)	(Telephone)

B. Mortgagor is: non-profit 501(c) (3) _____; Governmental Agency _____.

(Yes/No) (Name)

(Please explain)

2. Community Service Board (CSB) providing support:

(Name)	
(Address)	
, Virginia	
(City/Town)	(Zip Code)
(Contact Person)	(Telephone)
(Alternate Person)	(Telephone)

NOTE: If additional space is needed, use additional sheets showing number and paragraph of question.

A Knights of Columbus Charity

b. CSB will provide mortgagor with funds to support project mortgage and related Housing expenses?

Yes ____ No ____ Other _____

(explain)

If the answer to Question 2b is yes, CSB is to complete parts 12 and 13.

c. If this loan application is granted, will the facility operated on the property upon which the loan is made be open to all intellectually disabled persons without regard to race, color, creed or national origin?

Yes ____ No ____ Other _____

(Explain)

3. Project:

a. _____
(Property Location Address)

(City/Town/County) Virginia (Zip Code)

b. Site control by mortgagor corporation: (check only one)

owns property has option to buy
 has a sales agreement has lease with option to buy
 other _____
(Explain)

(Options and agreements to purchase should have a life of at least 120 days with provision to extend for an additional 30 days from date of application submission to KOVAR.)

7. Description of the residential service to be offered in the facility: (check only one):

a. Group home

b. Supervised apartment

8. Client Population to be Served:

a. Primary Disability Identification

Intellectual Disability

b. Age: (check all that apply)

Children/Adolescents (0-18)

Adults (19-64)

Elderly (65+)

c. Sex:

Female

Male

Both

d. Level of Disability:

Intellectual Disability

Mild

Severe

Moderate Profound

e. Information for Government Monitoring Purposes:

American Indian, Alaskan Native

Black Hispanic White

Asian, Pacific Islander

Other (specify):

f. Number of Intellectually Disabled clients: (enter figures in both spaces)

Number of clients who will be served on an annual basis once the facility's program is fully operational.

Number of clients who will be served during the first fiscal year of operation (normally smaller than the first figure due to start-up/phase-in of the program).

9. Description of Program of Services to be Offered Through the Residential Facility:

a. Static Capacity: (enter figures in both spaces)

_____ Number of beds for which the facility will be approved and staffed once it is fully operational.

_____ Number of beds available during the first fiscal year of operation (normally smaller than the first figure due to start-up/phase-in of the program).

b. Briefly describe the service model which will be used to deliver the type of residential Service checked in item # 7, above. The description should explain how the particular service needs of the client population described in item # 8 will be addressed. (Please use additional sheets if necessary).

c. Licensure: Will this facility be required to be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), or other governmental agency, in order to operate?
 _____ Yes _____ No

If yes, have you discussed the applicability/suitability of the facility with the Licensure Office? _____ Yes _____ No

Name of Licensure Staff member contacted: _____.

Date of Contact: _____ Telephone Number: _____.

d. Staffing: Complete the following table showing each of the direct service staff projected to be employed in this facility (give job titles, not names):

Position/Title	FTE	Sun	Mon	Tue	Wed	Thur	Fri	Sat
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

e. Implementation: Enter projected schedule or status for all of the following items that apply.

- Application date plus number of weeks or estimated dates
- Zoning approval
- Consultation with DMHMRSAS Licensure Office
- Loan closing
- Health Department inspections completed
- Fire Marshall's certificate
- Building inspection approval
- Occupancy certificate obtained
- Staff hired
- Clients screened
- Clients occupy facility

f. Project Manager Name:

Address: _____

_____ Virginia _____

Telephone: _____

10. Project Operating Budget: Enter all applicable items in both columns for the budget of the program that will deliver services in the facility

	First Year FY _____	Annualized Oper. Budget FY
a. Revenues:		
1. MH/MR General Funds	_____	_____.
2. Other	_____	_____.
3. TOTAL STATE FUNDS (1+2)	_____	_____.
4. Local Gov't Appropriations	_____	_____.
5. Other Local Match	_____	_____.
6. TOTAL LOCAL MATCHING FUNDS (4+5)	_____	_____.
7. Direct Client Fees	_____	_____.
8. Parent Fees	_____	_____.
9. Insurance Fees/Medicaid	_____	_____.
10. Other Fees (Auxiliary Grants)	_____	_____.
11. TOTAL FEE REVENUES (7+10)	_____	_____.
12. Gov't Rent Subsidies	_____	_____.
13. Other Federal Funds	_____	_____.
14. TOTAL FEDERAL FUNDS (12+13)	_____	_____.
15. TOTAL REVENUES (3+6+11+14)	_____	_____.
b. Expenses:		
1. Personnel Costs	_____	_____.
2. Staff Development Costs (training)	_____	_____.
3. Mortgage	_____	_____.
4. Property Taxes	_____	_____.
5. Utilities: Heat/Water/Electricity	_____	_____.
6. Telephone	_____	_____.
7. Facility Maintenance	_____	_____.
8. Facility Insurance	_____	_____.
9. Other: _____	_____	_____.
10. Equipment (other than furniture)	_____	_____.
11. Furniture/Furnishings	_____	_____.
12. Equipment Maintenance	_____	_____.
13. Facility Supplies	_____	_____.
14. Food/Drugs/Medical Supplies	_____	_____.
15. Transportation Equipment	_____	_____.
16. Transportation Services - Insurance	_____	_____.
17. Consultants	_____	_____.
18. Liability Insurance	_____	_____.
19. Other: _____	_____	_____.
20. TOTAL EXPENSES (1-19)	_____	_____.

11. Chief Executive Officer of the Mortgagor Corporation:

_____	_____
Signature	Title
_____	_____
Name (Typed)	Date

12. Program Services:

a. Name of Program/Service in the CSB's FY 20__ Program Application/Performance Contract which contains the funds necessary to operate this project: _____.

b. Program/Service operated by: (check only one)

____ This CSB directly

____ CSB-established private, non-profit corporation (name: _____)

____ Contract agency (name: _____)

If a contract agency, describe the nature of the contractual relationship (e.g. for the entire program/service, for services for specific individuals, for purchases of identified beds or services:

c. List the other necessary services and the name of the programs(s) which will provide them:

<u>Service</u>	<u>Program</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

13. Certifications by the CSB regarding proposed project located at:

_____	_____
(address)	(City/State/Zip Code)

a. I certify that funds are available in our budget to operate this project, and that other necessary emergency, outpatient, day support, case management and transportation services will be available to residents of this project when the site becomes operational.

b. I further certify that, to the best of my knowledge, the mortgagor has the intent and ability to provide the services deemed necessary for the success of the project; that the proposed location and type of housing are suitable for the contemplated residents and that there exists a need in the area for housing for the intellectually disabled; and that the development is economically feasible to the extent that it is projected to have or to receive funds in an

amount sufficient to pay for debt service and all of the requisite services deemed necessary for the success of the project.

Name of CSB providing assurances and certifications:

Signature of Executive Director or Chairman

Title

Name (Typed)

Date

(Mortgagor)

Signature of Executive Director or Chairman

Title

Name (Typed)

Date