

**BERKSHIRE COUNTY**  
**EMERGENCY FOOD AND SHELTER PROGRAM-PHASE CARES (FY20)**  
**STATE SET ASIDE FUNDS APPLICATION**

*Emergency Food and Shelter Program (EFSP) funds from the Federal Emergency Management Agency (FEMA) are intended to help people with non disaster-related economic emergencies. Awards will be based on an agency's ability to supplement and expand ongoing efforts to provide shelter and food for those in economic crisis. Funding is available through competitive bid to all organizations helping hungry and homeless people. EFSP funds must be used to provide direct services toward feeding, sheltering, rent/mortgage and utility assistance efforts only; this does not cover overhead expenses.*

**Instructions: Applicants must send this this completed application as a pdf by July 2nd to: [ccollier@nbunitedway.org](mailto:ccollier@nbunitedway.org) You will receive a verification response by a separate email. All responses must be typed on this application form. Applicants must also email a copy of their most recent financial audit.**

**If you have application questions please email: [ccollier@nbunitedway.org](mailto:ccollier@nbunitedway.org)**

**EFSP Agency Profile**

Legal Name of Applicant Organization: \_\_\_\_\_

Physical Address of Organization: \_\_\_\_\_  
Street Name and Number City/State ZIP Code

Mailing Address of Organization: \_\_\_\_\_  
Street Name and Number City/State ZIP Code

Agency Executive Director/CEO Name: \_\_\_\_\_

Contact Person for EFSP application: \_\_\_\_\_ Position: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ \*E-mail: \_\_\_\_\_  
\*Must be main contact for EFSP notifications

Federal Employer Identification Number (FEIN): \_\_\_\_\_

**EFSP Agency Eligibility Criteria**

**YES   NO**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Is your organization a non-profit or an agency of government?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the organization have an accounting system <u>and</u> conduct an independent annual audit? | <input type="checkbox"/> | <input type="checkbox"/> |

3. Does the organization practice non-discrimination (i.e. age, race, sex, religion, national origin, disability, economic status or sexual orientation)? [ ] [ ]
4. Is this a religious organization? [ ] [ ]  
 If "Yes", do you agree not to refuse services to an applicant based upon religion; requiring attendance at religious services; and engaging in any religious proselytizing in any program receiving EFSP funds? [ ] [ ]
5. Is this a private voluntary organization? [ ] [ ]  
 If "Yes", does it have a voluntary board? [ ] [ ]
6. Is your agency handicapped accessible? [ ] [ ]

**EFSP Program Funding Application Information Please answer each question in 2000 words or less.**

**Program Name:**

1. Briefly describe your organization's mission and how your program will utilize EFSP assistance (describe the intake assessments, eligibility process and forms)
2. Define and discern an "emergency" situation for individuals and families.
3. Why is the requested amount of EFSP assistance crucial to the clients you serve? What impact does the EFSP assistance have on your clients?
4. Are there other organizations providing the same or similar services? How do you collaborate to avoid duplication?
5. Without EFSP assistance, what gaps or unmet needs will there be in services?

6. Is there anything else you would like us to know about your organization/program and the COVID-19 pandemic as it relates to this funding?

**Total Amount Requested from EFSP: \$\_\_\_\_\_ (\$500 minimum. Whole \$\$ only)**

**Service Area**

**Please list regions of the county served by your organization and the numbers served in the last year/spending period.**

<b>Geography</b>	<b><u>Total Numbers Served by Agency</u></b>	<b><u>Total Numbers Served with EFSP Assistance</u></b>
Northern Berkshire County		
Central Berkshire County		
Southern Berkshire County		
Other County		
<b>TOTAL</b>		

**Please indicate whether your program serves the populations listed below:**

<b>Population</b>	<b>Yes</b>	<b>No</b>
Elderly		
Families with Children		
Veterans		
People with Mental or Physical Disabilities		

**Funding Request and Estimated Numbers to be Served by Category**

1. If you received EFSP funds during the past year/spending period (July – June), how many individuals and/or families were covered for the first time with EFSP funds?

2. Please complete the chart below on projected program outcomes for EFSP funding you are requesting. (Note: The \$ amount must equal the # of meals/nights/bills times the cost/unit)

A. Served Meals \$\_\_\_\_\_ # of Meals: \_\_\_\_\_ Cost/Unit: \_\_\_\_\_ # Unduplicated Persons Served \_\_\_\_\_  
Is this program part of the Food Bank of Western Massachusetts USDA program? Yes or No

B. Other Food \$\_\_\_\_\_ # of Meals: \_\_\_\_\_ Cost/Unit: \_\_\_\_\_ # Unduplicated Persons Served \_\_\_\_\_  
Is this program part of the Food Bank of Western Massachusetts USDA program? Yes or No

C. Mass Shelter \$\_\_\_\_\_ # of Nights: \_\_\_\_\_ Cost/Unit: \_\_\_\_\_ # Unduplicated Persons Served \_\_\_\_\_

D. Other Shelter \$\_\_\_\_\_ # of Nights: \_\_\_\_\_ Cost/Unit: \_\_\_\_\_ # Unduplicated Persons Served \_\_\_\_\_

E. Rent/Mortgage \$\_\_\_\_\_ # of Bills: \_\_\_\_\_ Cost/Unit: \_\_\_\_\_ # Unduplicated Persons Served \_\_\_\_\_

F. Utilities \$\_\_\_\_\_ # of Bills: \_\_\_\_\_ Cost/Unit: \_\_\_\_\_ # Unduplicated Persons Served \_\_\_\_\_

G. Personal Protective Equipment: \$\_\_\_\_\_

(not to exceed more than 10% of total request).

**FINANCIALS:**

Please complete the entire row:

<b>EFSP Program Dollar Amount Requested</b>	<b>Agency's Total Annual Program Budget</b>	<b>Agency's Total Annual Operating Budget</b>

NOTE: Further financial information may be requested and required by the Review Committee

**Please email a copy of your most recent financial audit with your application.**