



Dear Partner,

Foodlink is pleased to make available Hunger Prevention and Nutrition Assistance Program (HPNAP) Food and Operating Support (OS) funding to its member agencies.

We updated the applications to streamline the information and provide you with an opportunity to express how your program contributes to our mission: **to leverage the power of food to end hunger and build healthier communities.**

When applying for Food or OS funding we urge you to think strategically about what is needed to **increase capacity, distribute more nutritious food, and sustain your program for the long-term.**

Please remember that the HPNAP calendar has changed to a November through October fiscal year. We expect to allocate these HPNAP dollars by the end of October so that you have no gap in funding. In addition, we will send out two additional applications in the coming months:

- Holiday Distributions: August
- Seed Grants: October

We truly appreciate your partnership and remain committed to providing you with the resources you need to be effective and successful in meeting the needs of our communities.

In Partnership,

A handwritten signature in black ink that reads "Julia Tedesco". The signature is written in a cursive, flowing style.

Julia Tedesco  
President & CEO

**Applications must be received by 4 pm  
on Friday August 24, 2018**

# Hunger Prevention and Nutrition Assistance Program Application (HPNAP) Application | 2018-2019

November 1 2018-October 31 2019

*Applications are reviewed by small committees consisting of Foodlink staff and external stakeholders. Please ensure all information is clear, complete, and legible. HPNAP funds are designed to supplement and/or match a program's own efforts. Funds should not be viewed as a sole means of support.*

## General Instructions

- Send five (5) printed, completed, signed applications. Each should be collated and stapled.
- Agencies with more than one program ID must submit a separate, complete application for **each** program.
- Do not include blank pages in your completed application.
- Submit **only** pages that are relevant to your application.
- An incomplete application may disqualify the agency's request.
- *Hot Meal Programs: Please send a copy of a valid facility department of health inspection certificate.*

## Operation Support Instructions

- Include **D. Operation Support application** with overall application (5 copies).
- New this grant year, funding categories now have request caps.
  - Capital Equipment requests are capped at **\$6,000**
  - Staff, Utilities, Space, Transportation, FSPS and Pest Control requests are capped at **\$2,500**
- Programs applying for Operation Support must complete appropriate budget proposals and provide documentation as described in application guidelines. Please be sure to read the Operation Support Guidelines document for further instructions.

***Send Completed Applications to:***  
**Foodlink**  
**1999 Mt Read Blvd**  
**Rochester, NY 14615**  
**Attention: Member Services**

### Questions:

Morgan McKenzie <a href="mailto:mmckenzie@foodlinkny.org">mmckenzie@foodlinkny.org</a> (585) 413-4069	Moses Ulom <a href="mailto:mulom@foodlinkny.org">mulom@foodlinkny.org</a> (585) 413-4057
Sheila Williams <a href="mailto:swilliams@foodlinkny.org">swilliams@foodlinkny.org</a> (585) 413-4083	Emily Diaz <a href="mailto:ediaz@foodlinkny.org">ediaz@foodlinkny.org</a> (585) 413-4054

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# Hunger Prevention and Nutrition Assistance Program Application (HPNAP) Application | 2018-2019

**Program Name:**

**Foodlink ID:**

**HPNAP ID:**

**County:**

**This application is a request for:**

Food Line of Credit grant only

Operation Support grant only

Both Food Line of Credit and Operations Support grants

**Please select the type of emergency program:**

Soup Kitchen or Hot Meal

Food Pantry

Shelter

## A. Application Agreement

*Submission of this application does not guarantee receipt of grant funding. Agencies should not include Operations Support requests in their annual budget. Food Line of Credit and Operation Support requests are contingent on available funds. The NYS Department of Health and Foodlink, Inc. reserve the right to adjust or reject funding requests based on responses submitted.*

**Person submitting application:**

**Phone:**

**Email:**

I verify that the information provided in this application is true to the best of my knowledge. The agency I represent understands that submission of this application does not guarantee receipt of an award and will not include requests in its annual budget.

**Signature:**

**Date:**

Please note that Foodlink may share information submitted in this application in order to assist your program with building capacity. All information that you have provided to Foodlink will be kept confidential.

Contact for this Grant (If different than above):

Name	Phone	Email

## B. Program Information Sheet

### Average Number of Meals/People Served Per Month:

Place an X in the corresponding box indicating the average number of meals or people you serve per month. Please be sure to place it under the correct program type.

Use your Agency Monthly Meal Stat Reports from January 1 2017- December 31 2017 to complete this section. These are available on PWW. For agencies that recently became members, please use all available reports and divide by total number of months.

	<b>SHELTER MEALS/MONTH</b>
	3000 and above
	2000 - 2999
	700 - 1999
	300 - 699
	1 - 299

### Days /Hours of Operation:

Please indicate the number of hours/days that your program is open for service per month.

	Open year round (24/7)
	Open year round (not 24/7)
	Seasonal (24/7)
	Seasonal (not 24/7)

Does your program have weekend and/or evening hours?

Yes                      No

## C. General Application

1. Program EIN (Employer Identification Number):

2. Please list all zip codes your agency serves.

3. Based on projected service to meet your agency's needs for the upcoming fiscal year, what do you project for your program's total food budget for 2018-2019?

\$

### Impact and Uniqueness Section (Questions 4-6) (10 points):

4. Please describe the service(s) your organization provides that you are most proud of, and that best demonstrate your impact/uniqueness. This may include a specific element of your food distribution, or be something completely separate.

5. Please describe any special features of your program. (For example, do you serve special populations, offer wrap around services, etc.)

6. What has your organization done to share or learn about best practices with other organizations in your area?

**Health and Wellness Section (Questions 7-9) (10 points):**

7. What percentage of the time do you distribute fresh produce (please place an X in the corresponding box)?

Never      25%      50%      75% or more

8. What challenges do you face in providing fresh produce more often? Please be specific.

9. Describe your organizations effort to provide nutrition education in the past year. What programs have you worked with? What information have you distributed? What challenges do you face in providing more nutrition education to your clients? Please be specific.



## C. Program Specific Application | SHELTER

3. For each day of the week list the hours that your doors are open to actively distribute food to guests

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

4. Does your program receive CACFP funding?      Yes                  No

***Does your Shelter prepare meals and serve them directly to guests? If Yes, please answer question 5. If guests prepare their own meals on site please move on to question 6.***

5. How are you enhancing people’s access to and use of nutritious foods?

**Place an “x” by all that apply. (10 points- Impact and Uniqueness)**

	Use fresh fruits and vegetables in some meals or snacks		Provide 1% or skim milk and other low-fat dairy foods on a regular basis		Use whole grains in some meals
	Cook food by steaming, baking, or stir-frying rather than boiling and frying		Work with a dietitian or nutritionist to look over menus		Use lean proteins such as beans, 90% lean ground beef and fish
	Provide foods that are compatible with special dietary needs (diabetes, hypertension, food allergies, gluten or dairy intolerance)		Seek out healthy recipes to utilize for meals		Plan menus in advance to ensure healthy and varied options

6. How are you enhancing people’s access to and use of nutritious foods?

**Place an “x” by all that apply. (10 points- Impact and Uniqueness)**

	Provide fresh fruits and vegetables for some meals or snacks		Provide 1% or skim milk and other low-fat dairy foods on a regular basis		Provide whole grains for some meals
	Encourage clients to cook food by steaming, baking, or stir-frying rather than boiling and frying		Work with a dietitian or nutritionist to look over clients’ menus or create opportunity for clients to work with dietitian or nutritionist		Provide lean proteins such as beans, 90% lean ground beef and fish for some meals
	Provide foods that are compatible with special dietary needs (diabetes, hypertension, food allergies, gluten or dairy intolerance)		Provide healthy recipes for clients to utilize for meals or encourage clients to find healthy recipes		Encourage clients to plan menus in advance to increase healthy and varied options

11. Please **attach** a current copy of your Shelter’s certificate from the Department of Health.

## D. Operation Support

### Grant Request Summary

You may apply for up to 2 categories of Operation Support funding. You must rank your requests either (1) highest priority or (2) lower priority. Unranked requests will not be considered. When applying for Operation Support, please thoroughly review the criteria and allowable/non-allowable funding requests. This document is available separately. Requests that do not meet guideline criteria will not be considered.

**New this grant year, funding categories now have request caps. Please pay close attention to the table below.**

Funding Category:	Funding Request Cap:
Capital Equipment	\$6,000
Staff, Utilities, Space, FSPS, Transportation, Pest Control	\$2,500

*Operation Support grants are awarded on a competitive basis. Awards are contingent on available funds and scaled based on score of application. Submission of an application does not guarantee receipt of an award.*

Funding Category	Funding Request	Priority (choose either "1" or "2" for selected categories)	Program funding received in grant year 2017-2018
Staff	\$		
Utilities	\$		
Space	\$		
Food Service Paper Products and Other Supplies (FSPS)	\$		
Transportation	\$		
Pest Control	\$		N/A
Capital (Food Service)Equipment	\$		
Total	\$	N/A	

Have you received Operation Support in the past?\*       Yes       No

*\*First time applicants will be subject to an on-site visit conducted for eligibility verification prior to any funds disbursement.*

**D. Operation Support (15 points)**

*(Required questions for Operation Support applicants). Please attach another sheet if you need more room.*

1. Please explain why this request is a priority for your organization?

2. How will this request impact your ability to serve?

3. Please describe how you will sustain your Operation Support request if this grant is not available next year?

## D. Operation Support Budget Proposal | **STAFF**

Please answer every question. Incomplete applications may be disqualified.

**Amount requested:** \$ \_\_\_\_\_

**Priority of this request:** \_\_\_\_\_

Hourly rate must be at or above New York State minimum wage.

<b>Title of Staff Position</b>	<b>Hours per week</b>	<b>Hours per week to be charged to grant</b>	<b>Hourly rate</b>	<b>Number of weeks</b>	<b>Funding Request</b>

<b>Title of Volunteer Position</b>	<b>Approx. total hours 2018-2019</b>	<b>Stipend paid for total hours</b>	<b>% of hours charged to grant</b>	<b>Total Funding request</b>

1. Please enclose a job description **or** provide a description of duties below for the requested position. The description must contain information on the position's specific duties and the approximate percentage of time spent on each duty (ex: receiving, stocking, preparation, distribution, etc).

2. Please list current funding sources and amounts covering this position.

## D. Operation Support Budget Proposal | UTILITIES

*Please answer every question. Incomplete applications may be disqualified.*

**Amount requested \$** \_\_\_\_\_

**Priority of this request:** \_\_\_\_\_

***Food service work or storage area utility costs such as heat, water, and electricity may be funded.***

1. Percentage of bills for which you are requesting funding? \_\_\_\_\_%

2. If your Agency is seeking funding for only a portion of the monthly utilities, clearly explain how this amount was estimated.

3. Please list current funding sources and amounts currently covering utilities:

## D. Operation Support Budget Proposal | **SPACE**

Please answer every question. Incomplete applications may be disqualified.

Amount requested \$ \_\_\_\_\_

Priority of this request: \_\_\_\_\_

Only space used for food service, distribution, or food storage are eligible for funding.

Monthly rental cost	Percentage of rental cost to be charged to grant	Monthly rental cost to be covered by grant	Charge to grant for 12 months
Example: \$500.00	30%	\$150.00	\$1800.00

1. Please list other funding sources currently covering space costs.

2. Please **attach** a copy of the current rental agreement or a letter stating the rent/user fee from the organization that provides the space.

## D. Operation Support Budget Proposal | **FOOD SERVICE PAPER PRODUCTS and OTHER SUPPLIES**

Please answer every question. Incomplete applications may be disqualified.

Amount requested \$ \_\_\_\_\_

Priority of this request: \_\_\_\_\_

1. List the specific items you plan to buy, the amount of each, and the estimated price per case. (Please attach another sheet if you need more room.) Please refer the Operation Support Guidelines document to be sure you are requesting approved items.

Item(s)	Number of Cases	Price per Case	Total Cost
1.			
2.			
3.			
4.			
5.			
6.			
7.			
<b>Total Cost for all items:</b>			

2. If any other source(s) currently contribute to funding the disposables needed for your program, please list the sources and amounts from each.

## D. Operation Support Budget Proposal | **TRANSPORTATION**

*Please answer every question. Incomplete applications may be disqualified.*

**Amount requested \$** \_\_\_\_\_

**Priority of this request:** \_\_\_\_\_

If you are requesting funds to rent a vehicle, please attach the following:

- Two (2) quotes from separate truck rental companies
- A copy of your current contract and payment receipts

*Please be aware that Operation Support DOES NOT cover the cost of mileage or gas when renting a truck.*

If you are requesting funds for mileage reimbursement, please calculate total estimated number of miles traveled in grant year and multiply miles by **.545**. (*Mileage may only be reimbursed for approved travel using personal vehicles. The mileage reimbursement rate is determined by New York State at the beginning of each calendar year.*)

**Total estimated miles traveled in 2018-2019 grant year:** \_\_\_\_\_ **x .545 =** \_\_\_\_\_

1. Please describe how you plan to use the requested funds for transportation. Give specific information about how often, by whom, for what purpose, and total number of miles to be traveled. Note: HPNAP funds cannot be used to deliver food to clients.

2. If any other source(s) currently contribute to funding the food transportation needed for your program, please list the sources and the amounts from each.



## D. Operation Support Budget Proposal | **PEST CONTROL**

*Please answer every question. Incomplete applications may be disqualified.*

**Amount requested \$** \_\_\_\_\_

**Priority of this request:** \_\_\_\_\_

If requesting pest control assistance, please present documentation to support costs (quotes or pest control company invoices) and show that effective pest control results have occurred due to these preventive services. Only licensed pest control operators will be considered.

1. Please justify how you came to the cost associated for pest control (including the percentage of building used for food storage).

a. Percentage of cost \_\_ \_\_\_\_\_%

2. Justification of need:

3. Please describe how billing is established (monthly or per occurrence) and the frequency of pest control application.

4. If any other source(s) currently contribute to funding pest control needed for your program, please list the sources and the amounts from each.

## D. Operation Support Budget Proposal | CAPITAL EQUIPMENT

Please answer every question. Incomplete applications may be disqualified.

Amount requested (lowest quote) \$ \_\_\_\_\_

Priority of this request: \_\_\_\_\_

You may apply for **one** type of capital equipment. Equipment must be between **\$300 - \$6,000**. List the equipment item you are requesting and give a brief description. Include the brand, model number and total cost.

**Attach at least two (2) written quotes from potential vendors for comparable models for each item requested.**

Temporary (sale) price quotes will not be accepted. On-line quotes are accepted.

Capital Equipment warranties are an allowable expense if the warranty is shown to be standard and reasonable for the cost and type of equipment. An extended warranty should be itemized out so that it can be determined if it is reasonable for the piece of equipment.

Reasonable delivery charges can be funded, **if** included in the initial grant request.

**IMPORTANT** – Any equipment bought with HPNAP funds must be NEW. No used or second-hand equipment may be purchased with this grant. All equipment will be 100% owned by the State of New York.

HPNAP prefers to fund commercial and industrial grade equipment due to its durability and longevity. You must provide additional rationale for any non-commercial request (attach additional pages if more space is needed).

**Please indicate what type of equipment you are applying for in the chart below:**

Name & Type of Equipment	Brand & Model # Total Cost (Quote #1-lowest price)	Brand & Model # Total Cost (Quote #2)

1. Will the requested item replace old equipment? YES NO

*If yes, briefly explain **why** current equipment needs to be replaced. If the equipment was previously purchased with HPNAP funding and needs to be disposed please contact Member Services to complete the appropriate paperwork.*

2. Explain how your agency will cover any costs for installing, operating, maintaining and securing the requested equipment. If capital improvements become necessary because of the equipment selected, the applicant must explain how these costs will be covered with non-HPNAP funds (for example, any cost of plumbing, electricity, or building alterations).