

STATE OF UTAH
DEPARTMENT OF COMMUNITY AND CULTURE
DIVISION OF HOUSING AND COMMUNITY
DEVELOPMENT

EMERGENCY FOOD NETWORK PROGRAM
POLICY AND PROCEDURES



EMERGENCY FOOD NETWORK PROGRAM POLICY AND PROCEDURES

REV. MAY 2010

TABLE OF CONTENTS:

| | |
|--|---|
| PROGRAM DESCRIPTION & OBJECTIVES | 1 |
| REQUIRED CRITERIA..... | 1 |
| PROGRAM MONITORING | 2 |
| PROGRAM REPORTING..... | 2 |
| PROGRAM DEFINITIONS..... | 3 |

APPENDIX:

SAMPLE EFN WEBGRANTS APPLICATION – (3 pages)

DEFINITION OF SERVICES CHART – ATTACHMENT A

DEPARTMENT OF HHS 2009 POVERTY GUIDELINES

SAMPLE – CLIENT INTAKE APPLICATION

PROGRAM MONITORING CHECKLIST

EMERGENCY FOOD NETWORK PROGRAM POLICY AND PROCEDURES

Emergency Food Network Program Objectives:

Emergency Food Network program funding provides grants to non-profit 501(c)(3) entities that operate pantries to help ease some of the burden and meet the basic nutritional needs of low-income and working poor Utahns.

The following categories are allocated under EFN funding:

- *Mass Food Purchase*
- *Other/Foods*
- *Operations-Food Pantry*
- *Transportation*
- *Supplies/Equipment*
- *Technical Assistance*
- *Meals*
- *Other*

Program Procedures:

The Emergency Food Pantry program funds organizations that can demonstrate a need for specific pantry services in helping meet the nutritional needs of low-income individuals in the state of Utah. Requests for State funding proposals are advertised statewide for interested parties each year in the month of May. Information in obtaining applications for funding are described in the program advertisement and Housing and Community Development (HCD), State Community Services Office (SCSO) website address - www.housing.utah.gov/scso/programs.html

All applications received by the deadline indicated are reviewed and rated by staff and available funds will be awarded to current agencies within the Emergency Food Network, and award notifications are mailed within the following month.

Please refer to program definitions when preparing your application (**Program Definitions - ATTACHMENT A**).

Accountability and Program Requirements:

Grantee must abide by Health and Human Services 150% program eligibility standards within the range established by law, which is based on the most current census data. The authorization provides that an eligible household's income must not exceed the 150% program eligibility standards. (**Program Poverty Guidelines - ATTACHMENT B**)

Required Criteria:

Grantee shall create program service measures that are designed to address the most vulnerable low-income/homeless persons that are eligible for assistance. Listed below are a few recommendations for information on client receiving services:

- Intake application designed to obtain information for eligible client program services. Program Example of Client In-take Application – (**Sample Program In-take Application ATTACHMENT C**)

- Documentation of income eligibility must be obtained and kept in a secure locked file.
- Grantee must conduct outreach activities designed to assure that eligible households are made aware of the available assistance.
- Grantee must coordinate services with similar and related programs in their county.
- Grantee must have referral resources of other related services. It is recommended to have this information available for clients to help them continue to work towards self-sufficiency.
- Grantee must be able to show coordination of other funding resources that are directly related to program activities, for example: in-kind services, volunteers' service hours, or donations of other similar funding sources.
- A 501(c)(3) tax rebate on donated food must be on file with the Tax Commission.
- Grantees may use funds for administration use that are directly related to the pantry program.
- Grantees must submit an Outcome Measurement Report of project activities based on their contract scope of work for this funding on a **quarterly** basis. A program reporting schedule will be located in an EFN contract agreement. The reports are due on **October 15th, January 15th, April 15th and July 15th** and possibly a cumulative year-end report.

Program Reporting must show quantifiable project objectives and accomplishments, per contract scope of work.

Contractor Reimbursements:

SCSO can support two methods of submitting claims for reimbursements. The first and preferred method is Request for Funds Lite (RFF-Lite). The second is to submit full backup documentation. For more information on the RFF-Lite WebGrants program, please refer to the power point presentation found on SCSO's website at www.housing.utah.gov/scso/programs.html.

Program Monitoring Requirements:

Grantees will be monitored at least once a year by an on-site visit or desktop review for programmatic and fiscal compliance.

The following items will be reviewed and discussed during the monitoring visit:

- ✓ Most recent application for Emergency Food Network program (EFN) in file
- ✓ Award EFN notification & copy of executed EFN contract agreement in file.
- ✓ Copies of all EFN Requests for Funds per FY recorded in file
- ✓ Provide proof of 501(c)(3) status
- ✓ Financial reports related to funding in file.
- ✓ Provide state tax ID number
- ✓ Provide Federal EIS number
- ✓ Records pertaining to previous monitoring reviews (if applicable).
- ✓ Most recent IRS Form 990 in file.

DEFINITIONS OF EMERGENCY FOOD NETWORK PROGRAM SERVICES

Capacity Building (note – some of these items may be considered part of the supplies/equipment category):

To improve the existing pantries operations or services

- Purchase of Commercial Freezer/Refrigerator
- Storage Bins
- Pallet Racking
- Shelving
- Purchase of Fork Lift* (*with restrictions and approval only*)
- Delivery Truck* (*with restrictions and approval only*)
 - *must have other funding sources for maintenance
 - *required approval based upon pantry need and reasonable cost
 - *for trucks, collaboration of food delivery services of various pantries within designated county is expected
- Other – Innovative pantry projects. (**No duplication of Existing Emergency Network Food Funding.**) For example: Meals, Mass Food Purchases, Other/Food, Technical Assistance and Transportation Cost

Meal Food Purchase:

Pantries are to obtain more nonperishable food items for nutritionally balanced meals serving.

- Nutritional Non-perishable Food Items
- Hot Meal Service to Eligible Clients
- Aggregate Meals to Senior Citizens Program
- Food items that are usually not donated

Operations – Food Pantry:

This category represents pantry operations costs.

- Utility Operation Costs
- Pantry General Repairs
- Vehicle Minor Maintenance Repair Costs
- Salary costs of pantry staff person(s) who work directly in the pantry

Transportation:

To assist with the cost of transporting various food items to pantries statewide.

- Transportation cost to transport food to other Food Pantries

Supplies/Equipment:

To assist with one time purchases of pantry supplies and equipment that are pantry related.

- Pantry Operation Supply Upgrade
- Pantry Operation Minor Equipment
- Capacity building equipment (as outlined above)

Technical Assistance:

A food security approach to help bring together a variety of community groups that include farmers, youth groups, schools and local leaders. Funds will provide a match to competitive federal grants to help low-income individuals to continue to work towards self-sufficiency.

- Agriculture Community Support
- Gardening Classes to community groups in collaboration with a master gardening program
- Outreach and education about federal nutrition programs
- Conducting a general statewide survey of emergency food providers and federal nutrition programs. (Note: **this grantee will be responsible to write and compile annual reports**)

DEPARTMENT OF HOUSING & COMMUNITY DEVELOPMENT
STATE COMMUNITY SERVICES OFFICE

EMERGENCY FOOD NETWORK (EFN)
“SAMPLE” EFN APPLICATION FORM

(see website for current year EFN form)

www.housing.utah.gov/scso/programs.html

This funding is intended to provide services within the intent of the program. Funds are to be used on an ongoing basis to supplement and extend food services, not to substitute for other program funds or start new programs. Funds are *not* to be held or reserved but spent on an as needed basis to supplement and extend services.

AGENCY INFORMATION:

Agency Name: _____
Name of Executive Director: _____ email: _____
Pantry Contract Person Name: _____ email: _____
Address: _____ City/Zip _____
Phone No: _____ Fax No.: _____

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a nonprofit organization? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you an agency of the government? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an accounting system? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you conduct an annual audit? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you practice nondiscrimination? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an active board? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you charge a fee for services paid with these monies? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this an existing program? |

Note: Please attach an organizational chart, agency’s most current bylaws, updated board list and Mission Statement.

APPLICATIONS WILL BE DUE GENERALLY THE END OF MAY OF EACH FY

Please submit (1) copy of the application w/(1) copy of the attachments to:
Clayton Fulton, Program Specialist
State Community Services Office (SCSO)
324 South State, 5th Floor
Salt Lake City, UT 84111

If you have any questions, please call Stephanie Bourdeaux at 801-538-8870

1. **Explain how your agency’s program aligns with any/all of the above identified program goals and objectives.**

2. **If awarded funds, explain exactly how you would use them.**

3. **Describe the outcomes you expect to achieve as a result of your programs.**

4. **Describe the coordination and linkage the food pantry has with other service providers to help clients with other needed services.**

5. **Is this a new Program? If not, how has your program service improved from last year?**

6. **Number of Program Staff Positions**

| #of Pantries | #of Full Time Staff | #of Part Time Staff | #of Volunteers Hours |
|--------------|---------------------|---------------------|----------------------|
| | | | |

EFN PROGRAM BUDGET

Agency Name: _____

| EFN FINANCIAL INFORMATION | Previous July thru June | Current July thru June | Projected July thru June |
|--|----------------------------|---------------------------|-----------------------------|
| EXPENDITURES: (EFN Money Only) | | | |
| Expenditures | | | |
| Total Agency Budget | \$ | \$ | \$ |
| Total Program Budget | \$ | \$ | \$ |
| EFN Funds Only | | | |
| Food Purchases | \$ | | |
| Operational Costs (utilities, rent, etc.) | \$ | \$ | \$ |
| Transportation | \$ | \$ | \$ |
| Supplies/Equipment | \$ | \$ | \$ |
| Technical Assistance | \$ | \$ | \$ |
| Meals | \$ | \$ | \$ |
| Other | \$ | \$ | \$ |
| Other | \$ | \$ | \$ |
| Other | \$ | \$ | \$ |
| | | | |
| | | | |
| TOTAL PROGRAM EXPENSES | \$ | \$ | \$ |

ATTACHMENT A

| Emergency Food Network Program DEFINITION OF SERVICES, OUTCOME AND SERVICE UNITS | | |
|---|--|---|
| SERVICE | OUTCOME | SERVICE UNIT |
| Mass Food Purchase | To help with additional pantry food items. | 1 pantry food purchase |
| Operations-Food Pantry | To help with pantry operations. | 1 pantry operation supported |
| Transportation | To help with the cost of transporting needed food items to various pantries. | 1 pantry cost of delivery of food. |
| Supplies/Equipment | To assist with one time purchases of pantry supplies and equipment that are pantry related. | 1 pantry purchase |
| Technical Assistance | Compelling Food Pantry Collaborative Projects. | 1 pantry project |
| Meals | To accommodate with additional needed food items (non-perishables), food shortage items etc. | 1 meal served |
| Capacity Building | To improve the existing pantries operations and capacity. | 1 pantry capacity or operation improvement |
| Other | Contractor defines measurable service unit (contact SCSO for acceptability) | Fill gaps in emergency food needs for clientele |

ATTACHMENT B

| DEPARTMENT OF HEALTH AND HUMAN SERVICES 2009 POVERTY GUIDELINES | | | |
|--|---|--------------------|--------------------|
| Person in Family or Households | Federal Register, Vol. 74, No. 14 January 23, 2009 | | |
| | 100% of Poverty | 125% of Poverty | 150% of Poverty |
| 1 | \$10,830 | \$13,538 | \$16,245 |
| 2 | \$14,570 | \$18,213 | \$21,855 |
| 3 | \$18,310 | \$22,888 | \$26,465 |
| 4 | \$22,050 | \$27,563 | \$33,075 |
| 5 | \$25,790 | \$32,238 | \$38,685 |
| 6 | \$29,530 | \$36,913 | \$44,295 |
| 7 | \$33,270 | \$41,588 | \$49,905 |
| 8 | \$37,010 | \$46,263 | \$55,515 |
| *families with more than 8 persons - | (100% add \$3,740) | (125% add \$4,675) | (150% add \$5,610) |

HHS Website for obtaining program fiscal year poverty guidelines is located at <http://aspe.hhs.gov/poverty/index.shtml>. This website is updated by HHS each FY. Applicants should check this website prior to submitting their application(s).

Note: The poverty guideline figures listed on HHS website normally are calculated at 100%. Provided is the HHS chart that has been calculated to meet the 100%, 125% and 150%.

When computing the percentage of poverty guidelines that are required for your program client eligibility, remember HHS charts are always at 100% of poverty. Agency will need to multiply the % of the threshold by your set program eligibility of poverty guidelines.

(For example: a family of 3 multiply the income limit \$18,310 by 1.25 for 125% and 1.50 for 150%)

“SAMPLE”

CSBG INTAKE APPLICATION
Please print when completing application

CLINT NTAKE APPLICATION

EMERGENCY FOOD

DATE: _____

MAIN SITE: BEAVER DIXIE ESCALANTE IRON
 KANE MILFORD PANGUITCH

UNEMPLOYMENT GRANT/FINANCIAL AID OTHER

SOCIAL SECURITY NUMBER: _____ - _____ - _____

DATE OF BIRTH: _____ / _____ / _____
MONTH DAY YEAR

LAST NAME INITIAL **FIRST NAME**

GENDER MALE FEMALE
DISABILITY YES NO
VETERAN YES NO

STREET

ETHNICITY:
 ASIAN BLACK HISPANIC NATIVE AMERICAN
 PACIFIC ISLANDER WHITE OTHER

CITY STATE ZIP CODE

()
AREA CODE TELEPHONE

HOUSING: OWN RENT \$
 HOMELESS

HOUSEHOLD TYPE:
 Female/Single Parent Male/Single Parent Two Parent
 Single Couple (no children) Other

EDUCATION: 0-8 GRADE 9-12 GRADE
 HIGH SCHOOL GRAD GED 12+ COLLEGE DEGREE

FOOD STAMPS: YES \$ _____ NO

EMPLOYMENT STATUS: EMPLOYED UN-EMPLOYED

INSURANCE INFORMATION:
HEALTH INSURANCE: YES NO
MEDICAID: YES NO
MEDICARE: YES NO
C.H.I.P.: YES NO

MONTHLY INCOME: \$ _____

SOURCE OF INCOME:
 EMPLOYMENT SOCIAL SECURITY PENSION SSI
 AFDC CHILD SUPPORT GENERAL ASSISTANCE

In this section please provide information on spouse or other:

LAST NAME **FIRST NAME** **INITIAL**

RELATIONSHIP: SPOUSE ROOM MATE OTHER

EDUCATION: 0-8 GRADE 9-12 GRADE
 HIGH SCHOOL GRAD GED 12+ COLLEGE DEGREE

EMPLOYMENT STATUS: EMPLOYED UN-EMPLOYED

MONTHLY INCOME: \$ _____

OTHER SOURCE OF INCOME:

EMPLOYMENT SOCIAL SECURITY PENSION SSI AFDC CHILD SUPPORT GENERAL ASSISTANCE
 UNEMPLOYMENT GRANT/FINANCIAL AID OTHER

SOCIAL SECURITY NUMBER: _____ - _____ - _____ **OF BIRTH:** _____ /
 / _____ MONTH DAY YEAR

GENDER **DISABILITY** **VETERAN**
 MALE YES YES
 FEMALE NO NO

ETHNICITY:

ASIAN BLACK HISPANIC NATIVE AMERICAN
 PACIFIC ISLANDER WHITE OTHER

INSURANCE INFORMATION:

HEALTH INSURANCE: YES NO
 MEDICAID: YES NO
 MEDICARE: YES NO
 C.H.I.P.: YES NO

In this section please include additional members of household (Please attach second sheet if additional space is needed):

| LAST NAME | FIRST NAME | BIRTH DATE |
|-----------|------------|----------------|
| _____ | _____ | ____/____/____ |
| _____ | _____ | ____/____/____ |
| _____ | _____ | ____/____/____ |
| _____ | _____ | ____/____/____ |

I certify that the information submitted on this form is accurate:

Client's Signature _____ Date _____

| SOC SEC # | GENDER | DISABILITY | RELATIONSHIP | INSURANCE |
|----------------|--------|------------|--------------|-----------|
| ____-____-____ | M F | YES NO | _____ | YES NO |
| ____-____-____ | M F | YES NO | _____ | YES NO |
| ____-____-____ | M F | YES NO | _____ | YES NO |
| ____-____-____ | M F | YES NO | _____ | YES NO |

Intake Worker's Signature _____ Date _____

**DEPARTMENT OF HOUSING & COMMUNITY DEVELOPMENT
STATE COMMUNITY SERVICES OFFICE (SCSO)**

**Checklist for On-Site Program Monitoring Review
Emergency Food Network**

Agency: _____

Date Monitoring Conducted: _____

Agency Staff Involved in Monitoring Review: _____

Monitoring Review Conducted By SCSO Program Staff: _____

| Funding Source(s) | Review Items | Yes | No | N/A |
|--------------------------|---|------------|-----------|------------|
| | Have the agency's Board members and/or staff attended or are they planning to attend at least one training session provided by DCC during the grant period? | | | |
| <u>Comments</u> | | | | |
| | Is the agency using the State's Webgrants Program Outcomes Measurement Tool in reporting Service units Goals and Performance Measures? | | | |
| <u>Comments</u> | | | | |
| | Is agency participating in the annual point and time count and tracking and gathering client data for services provided? | | | |
| <u>Comments</u> | | | | |
| | What client tracking program are you currently using? | | | |
| <u>Comments</u> | | | | |
| | Are the quarterly outcome reports being submitted to SCSO/Utahns Against Hunger on or before the listed due dates in your contract agreement? | | | |
| <u>Comments</u> | | | | |
| | Is the agency submitting all appropriate supporting documentation for expenditures claimed on the RFF? | | | |
| <u>Comments</u> | | | | |
| | Are the expenditures reported through the date of the visit in accordance with the project budget? | | | |

| | | | | |
|-----------------|---|--|--|--|
| | If not, did the agency notify SCSO and receive written approval prior to implementing any change in the program budget? | | | |
| <u>Comments</u> | | | | |
| | Can the expenditures reported on the RFF be traced to the agency's general ledger or other financial reports used to compile the amounts reported on the RFF? | | | |
| <u>Comments</u> | | | | |
| | Does the agency maintain a financial and cost accounting system in accordance with generally accepted accounting principles? | | | |
| <u>Comments</u> | | | | |
| | Will the agency expend the funds awarded under this contract within the contract period? | | | |
| <u>Comments</u> | | | | |
| | Will the agency accomplish their stated objectives with respect to this contract? | | | |
| <u>Comments</u> | | | | |
| | Did the agency sub-contract to provide any of the services specified in the contract? | | | |
| <u>Comments</u> | | | | |
| | If subcontractors are used, was a fully executed contract in place for each of the agency's subcontractors? | | | |
| <u>Comments</u> | | | | |
| | If subcontractors are used, does the agency have evidence of monitoring contract compliance by its subcontractor(s)? | | | |
| <u>Comments</u> | | | | |
| | Has or will the agency make any payments for goods, services, facilities, salaries/wages, etc. to related parties? | | | |
| <u>Comments</u> | | | | |

| | | | | |
|-----------------|--|--|--|--|
| | | | | |
| | Did the agency satisfy the Matching Funds requirement stipulated in the contract, if applicable? | | | |
| <u>Comments</u> | | | | |
| | Can the amount of funds released by SCSO be traced to amounts posted in the Cash Receipts Journal and to the agency's general ledger? | | | |
| <u>Comments</u> | | | | |
| | Does the client intake form used for determining eligibility clearly identify all eligibility criteria, and does the agency obtain, verify and maintain documentation regarding eligibility of clients/participants? | | | |
| <u>Comments</u> | | | | |
| | Are the services provided by the agency accessible to persons with disabilities? | | | |
| <u>Comments</u> | | | | |
| | Did agency use funds for Capacity Building projects? (EFN Only) | | | |
| <u>Comments</u> | | | | |
| | Does agency use volunteers to assist with any program services? | | | |
| <u>Comments</u> | | | | |
| | How does your agency assist persons with various language barriers? | | | |
| <u>Comments</u> | | | | |
| | Is the agency's Code of Ethics conspicuously posted at all service locations? | | | |
| <u>Comments</u> | | | | |
| | Does the agency have an established grievance procedure available for your clients? | | | |

| | | | |
|-----------------|---|--|--|
| <u>Comments</u> | | | |
| | Are client records maintained in a secure area with access restricted to staff directly involved in providing program services? | | |
| <u>Comments</u> | | | |
| | Describe your participation in your local Continuum of Care Plan? | | |
| <u>Comments</u> | | | |
| | Has the agency submitted the most current Board Roster to SCSO? | | |
| <u>Comments</u> | | | |
| | Does the agency submit its Board Minutes to SCSO? | | |
| <u>Comments</u> | | | |
| | Has the agency submitted a Board Agenda, including a list of committees and committee members to SCSO? | | |
| <u>Comments</u> | | | |

Additional Comments:

Contract Agreement Information:

| Funding Source(s) | Contract Number(s) | Contract Amount(s) | Contract Period |
|--------------------------|---------------------------|---------------------------|------------------------|
| | | | |