Ohio Mental Health & Addiction Services (OhioMHAS)
Community Capital
PROJECT WORK SHEET for FY19-20
(Each project uses a separate worksheet)

1. **Board Name:** Hamilton County Mental Health and Recovery Services Board
2. **Board Contact Person** LaNora Godfrey
   E-Mail lanorag@hcmhrsb.org
   Phone 513-946-8625

3. **Type of project (check all that apply):**

☐ Permanent Supportive Housing with Supportive Services Available	# of unit(s)	# persons/unit(s)
☐ Permanent Supportive Housing with Supportive Services on site	# of unit(s)	# persons/unit(s)
☐Community Residence (not a standard lease)	# of unit(s)	# persons/unit(s)
☐ Consumer Operated Recovery Center	# served per year	
☐ Residential Facility MH - Adults	# of beds	# persons served/per year
☐ Residential Facility AOD - Adults	# of beds	# persons served/per year
☐ Residential Facility - Children/Youth	# of beds	# persons served/per year
☐ Program Space: Mental Health Center	# served per year	
☐ Program Space: AOD	# served per year	
☐ Program Space: Vocational	# served per year	
☐ Program Space: Crisis	# served per year	
☐ Program Space: Children's Service Agency	# served per year	

Demographic to be served:

- ☐ Children
- ☐ Adults
- ☐ Families
- ☐ Transition Aged Youth

4. **Proposed Owner of Property and Project (the Applicant):**

5. **Proposed Service Provider(s):**

6. **Project Description:**

- ☐New Construction
- ☐Purchase/Renovation
- ☐Addition to Existing
- ☐Renovation only
- ☐Purchase only

Estimated Project Cost:

Purchase Cost	$
Construction	$
Miscellaneous	$
Equip./Furnish	$
Architect	$
Fees	$
Total Cost	$

7. **Funding for Capital Project**:

a. OhioMHAS Assistance Required (up to 50% of total cost up to a maximum of $500,000) $

b. Amount of Non-OhioMHAS Funds (minimum of 50% of total cost): $

c. Source of Non-OMHAS Funds*: select all that apply*

☐Ohio Housing Finance Agency - Amount
(describe):
☐Federal Home Loan Bank - Amount
☐Community Foundation - Amount
☐HOME Funds - Amount
☐ADAMH Board Funds - Amount
☐Other - Amount
(describe) :

d. Source(s) of Operating Costs: *select all that apply*

☐CoC or HUD Funds
☐SHP or HCRP Funds
☐ADAMH Board Funds
☐Other (describe):
☐Other (describe):
☐Other (describe):

e. Annual Total Operating Costs: $

8. **Has match funding already been awarded**? ☐Yes ☐ No

If yes, describe funding source and when project was awarded:

If no, describe when funding will be applied, include award notification dates, etc.:

9. **How did consumers, family members and providers participate in the planning of this project?**

10. **Describe how this project will fill a gap in the local continuum of care:**

11. **Can the project be developed by March 2020**? ☐Yes ☐No
If no, please provide a project development timeline.

12. **Provide description (no more than one page single spaced, at least font size 11) of the proposed Capital Project. In addition to the type of project, the description should indicate the targeted population/sub-population (e.g., persons with severe mental illness who are homeless, homeless veterans, criminal justice, transition-aged youth, persons recovering from addiction), service/services to be provided, and should address the roles of key players to the project.**

Please return completed form and project description to dianeb@hcmhrsb.org by September 15, 2017