

DEPARTMENT OF HOUSING & COMMUNITY SERVICES

MAILING ADDRESS:

116 HAMPTON ROAD  
SOUTHAMPTON, NY 11968

OFFICE LOCATION:

240 W. MONTAUK HWY  
HAMPTON BAYS, NY 11946



Jay Schneiderman  
TOWN SUPERVISOR

JAMIE BOWDEN  
COMMUNITY SERVICES  
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# GRANT CHECKLIST and APPLICATION

- 2024 HUMAN SERVICES GRANT       2024 CULTURAL ARTS & RECREATION GRANT
- 2024 COMMUNITY GRANT PROGRAM       2024 HAMLET SERVICES GRANT

If you are applying for multiple grants, you must submit separate applications.

1. \_\_\_ CONTACT SHEET
2. \_\_\_ PROGRAM DESCRIPTION
3. \_\_\_ PROGRAM BUDGET
4. \_\_\_ FINANCIAL DATA
5. \_\_\_ **ALL APPLICANTS: submit proof of 501 (C) Status, 990 Filing AND W-9 Form**
6. \_\_\_ **END-of-YEAR PROGRAM SUMMARY AND ACCOUNTING:** Organizations that received a **2023** Town of Southampton grant **must** submit a **grant annual report form which includes an accounting** of how the awarded funds were actually spent.
7. \_\_\_ **INSURANCES:** Insurance requirements *may* include one or more of the following:
  - A. Liability Insurance
  - B. Worker’s Compensation, Form C-105.2 OR U26.3
  - C. Disability Benefits Insurance, Form DB 120.1
  - D. A state-issued, substantiating waiver, available at [www.wcb.ny.gov](http://www.wcb.ny.gov)

**FUNDING WILL NOT BE RELEASED UNTIL ALL REQUIRED CURRENT CERTIFICATES AND DOCUMENTS ARE RECEIVED. ALL FUNDING IS SUBJECT TO THE ADOPTION OF THE 2024 BUDGET**

8. \_\_\_ **RETURN ONE COMPLETED COPY:** by email, mail, or hand deliver the hard copy.

# CONTACT SHEET

AGENCY NAME: \_\_\_\_\_

AGENCY DIRECTOR: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

\_\_\_\_\_

WEB ADDRESS: \_\_\_\_\_

PROGRAM / EVENT TITLE: \_\_\_\_\_

PROGRAM ADDRESS: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_ TITLE: \_\_\_\_\_

CONTACT TELEPHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

TOTAL PROGRAM COSTS: \_\_\_\_\_

TOTAL REQUESTED FROM TOWN: \$ \_\_\_\_\_

**If applicant is a corporation, the signatory hereby acknowledges that he/she executed this application in his/her capacity on behalf of the corporation and that he/she has full authority to bind the corporation to same.**

\_\_\_\_\_  
DULY AUTHORIZED SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
TITLE

# **PROGRAM DESCRIPTION**

**Organization Name:** \_\_\_\_\_

**Program Name:** \_\_\_\_\_

Please answer the following questions. Feel free to attach additional pages.

**1. What is your organization's history?** \_\_\_\_\_

**2. What makes your proposed program unique to Southampton Town?**

**How will the requested funding support a specific program or additional service that would otherwise not occur or be available in Southampton Town?**

\_\_\_\_\_  
\_\_\_\_\_

**3. What issue does this program address and how will the Town of Southampton benefit?**

\_\_\_\_\_  
\_\_\_\_\_

**4. What methods and/or activities will be used to achieve your program objectives?**

\_\_\_\_\_  
\_\_\_\_\_

**5. What target population will this program serve? Do you have a waiting list?**

\_\_\_\_\_  
\_\_\_\_\_

**6. How many participants will be served?** \_\_\_\_\_

**7. How will the program results be evaluated?**

\_\_\_\_\_  
\_\_\_\_\_

**8. Where will the program be held?** \_\_\_\_\_

**9. How will you verify that participants in your proposed program are Southampton Town residents?**

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**10. Describe your agency's service record and fee structure.**

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**11. This grant is not automatically renewable. What provisions will be made if future funding is not available?**

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**12. Do you have other funding sources? If "YES", please list those sources? If "NO" - how will you fund the program if the Town does not award your total request?**

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**13. If the program budget exceeds the amount requested, explain how you will make up that difference.**

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**14. Are you in compliance with the Americans with Disabilities Act? YES  NO**

**15. Are you in compliance with Title VI of the Civil Rights Act of 1964 prohibiting discrimination in hiring or employment opportunities? YES  NO**

# PROGRAM BUDGET

**I. If applicable, include personnel costs for proposed program:**

<u>POSITION</u>	<u>DUTIES</u>	<u>ANNUAL RATE</u>	<u>PROJECT SALARY</u>

Salary Total \$ \_\_\_\_\_

**II. Employee Benefits**

<u>ITEM</u>	<u>PROPOSED EXPENDITURE</u>
Social Security	_____
Health Insurance	_____
Workers Compensation Insurance	_____
Unemployment Insurance	_____
Other (Identify)	_____
Other (Identify)	_____

Benefits Total \$ \_\_\_\_\_

**III. NON-PERSONNEL COSTS**

<u>EXPENDITURES</u>
_____
_____
_____
_____

Non-personnel Total \$ \_\_\_\_\_

**GRAND TOTAL: \$** \_\_\_\_\_

## **FINANCIAL DATA**

**I. List funding other than from Southampton Town received over the past three years:**

<u><b>DATE</b></u>	<u><b>FUNDING SOURCE</b></u>	<u><b>AMOUNT</b></u>	<u><b>ACTIVITY</b></u>

**II. Provide a copy of your organization's latest financial statement or annual report prepared by an independent auditor. Report should not be more than 2 years old.**

**DEADLINE: 4 PM, FRIDAY, NOVEMBER 17, 2023**