



**COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM Quarterly Progress Report**

**Program Year: 2019-20**

1. Name of Sub-recipient: \_\_\_\_\_

2. Name of Project: \_\_\_\_\_

3. Project Year: \_\_\_\_\_

4. Address of Sub-recipient: \_\_\_\_\_

5. Name of Contact Person: \_\_\_\_\_

6. Phone Number of Contact Person: \_\_\_\_\_

7. Period Covered. Please check the quarter this form covers and submit to the Housing & Social Services Department.

***For Period Ending:***

March 31

**Quarterly Report is Due No Later than April 15, 2020**

June 30

**Quarterly Report is Due No Later than July 15, 2020**

September 30

**Quarterly Report is Due No Later than October 15, 2020**

8. The Sub-grantee's authorized official representative certifies that:

(a) This report contains all items identified above.

(b) To the best of his/her knowledge and belief, the data in this report is true and correct as of the date in item.

9. **WARNING:** Section 1001 of Title 18 of the United States Code (Criminal Code and Criminal Procedure) shall apply to the foregoing certification. Title 18 provides, among other things, that whoever, knowingly and willfully makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry, in any matter within the jurisdiction of any department or agency of the United States, shall be fined not more than \$10,000 or imprisoned not more than five years or both.

10. Type the name and title of the authorized official sub-grantee representative:

\_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



Unit of Services	1st Quarter	2nd Quarter	3rd Quarter
Goal #1			
% of goal			

Community Development Block Grant Program  
**Financial Status Report**

Previous Balance \$ \_\_\_\_\_  
 Amount Requested \$ \_\_\_\_\_  
 Account Balance \$ \_\_\_\_\_

<b>Agency</b>	<b>Project Name</b>
---------------	---------------------

Month	Payee/Description	Monthly Amount	YTD Expenses	Adjustments Amount Code	Reimbursed
October					
November					
December					
January					
February					
March					
April					
May					
June					
July					
August					
September					

**Total Requested:** \_\_\_\_\_

**Total Reimbursed:** \_\_\_\_\_

**Certificate**

I certify that this claim is for authorized expenditures incurred pursuant to this grant project and the appropriate documentation is attached. \*I further certify that the financial records, supporting documents, statistics records and all other records pertinent to this grant project shall be retained for a period of three (3) years according to regulations contained in CFR 570.502(B) (3), 24 CFR 85.42, and OMB Circular A-110, Attachment C.

**\*Appropriate supporting documents includes copies of bills/invoices and proof of payment in the form CANCELLED checks.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

Adjustment Code Explanations

NCB – Not currently Budgeted

I – Ineligible

A – Approved for reimbursement

**PO#:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**CITY OF NORTH MIAMI  
COMMUNITY DEVELOPMENT BLOCK GRANT - RECOVERY PROGRAM  
MONTHLY NARRATIVE AND CLIENT REPORT**

**Provider:** \_\_\_\_\_  
**Report Period:** \_\_\_\_\_  
**Person Submitting Report:** \_\_\_\_\_  
**Signature:** \_\_\_\_\_

**Project Name:** \_\_\_\_\_  
**Date Submitted:** \_\_\_\_\_  
**Date Submitted:** \_\_\_\_\_  
**Title:** \_\_\_\_\_

**I. Narrative Report**

**II. Client Profile Report**

Month	Clients		Income Range			Ethnicity														HOH	Special Needs						
	New	YTD	30% VL	50% (L)	80% LM	White	Black	Asian	American Indian/ Alaskan Native	Native Hawaiian/ Other Pacific Islander	American Indian/ Alaskan Native & White	Asian & White	Black/ African American & White	American Indian/Alaskan Native & Black/ African American	Other Multi -Racial	Hispanic White	Hispanic Black	Hispanic Other									
Oct.																											
Nov.																											
Dec.																											
Jan.																											
Feb.																											
Mar.																											
April																											
May																											
June																											
July.																											
Aug.																											
Sept																											
Total																											

**MAXIMUM HOUSEHOLD INCOME LIMITS - 2020**

Household Size/ Income Group	1	2	3	4	5	6	7	8
30% - LMI	\$19,200	\$21,950	\$24,700	\$27,400	\$30,680	\$35,160	\$39,640	\$44,120
Extremely Low								
50%-LMI	\$32,000	\$36,600	\$41,150	\$45,700	\$49,400	\$53,050	\$56,700	\$60,650
Very Low								
80%-LMI	\$51,200	\$58,500	\$65,800	\$73,100	\$78,950	\$84,800	\$90,650	\$96,500
Very Low								

**Note: The income guidelines are updated by HUD annually.  
The agency using this Intake Sheet should update this information accordingly.**

## **NARRATIVE SUMMARY**

Please use this space to describe activities and/or information not documented elsewhere in this report. Please attach additional pages as needed.

### **1. Coordination with Other Agencies and/or Programs:**

Describe coordination efforts; include names of agencies and/or programs.

### **2. Problems or Obstacles Encountered This Quarter:**

Describe any problems staff and/or participants encountered, include any remedies or solutions devised.

### **3. Accomplishments This Quarter:**

Describe positive accomplishments by staff, program, and/or participants, highlight program and/or beneficiaries.

### **4. Results This Quarter:**

Describe any results (benefits) that were achieved this quarter.

## Objectives and Outcomes

**1. Program Objective – Check which program objective applies to your program.**

**Only one program objective can be selected.**

- Create a suitable living environment
- Provide decent affordable housing
- Create economic opportunities

**2. Program Outcome – Check which program outcome applies to your program.**

**Only one program outcome can be selected.**

- Improve the availability and/or accessibility of a service to the public
- Increase the affordability of a program or service
- Assist with the sustainability of a program or service

**3. Check the statements below which apply to your program.**

- Helps prevent homelessness
- Helps the homeless
- Helps those with HIV/AIDS
- Primarily helps persons with disabilities

## Weekly Timesheet

Employee Name: \_\_\_\_\_ Rate of Pay: \_\_\_\_\_  
 Program: \_\_\_\_\_ Status: (Full Time/Part Time/Contract) \_\_\_\_\_  
 Payroll Period: From \_\_\_\_\_ To \_\_\_\_\_

Beginning Payroll Date	Start Time	End Time	Regular Hours	Total Hours*	Rate of Pay	Gross Pay
<b>Total Hours for the Week</b>						

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Deductions:**

Gross Salary	\$	_____	
W/H Tax	\$	_____	
FICA Tax	\$	_____	
Other Deductions	\$	_____	
Net Pay	\$	_____	Check No./Date _____ / _____

\*Please make sure the above information is corrected.

