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

**Program Year: 2016-17**

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 Department of Community Development.

***For Period Ending:***

| | |
|---|---|
| ☐December 31 | **Quarterly Report is Due No Later than January 15, 2017** |
| ☐March 31 | **Quarterly Report is Due No Later than April 15, 2017** |
| ☐June 30 | **Quarterly Report is Due No Later than July 15, 2017** |
| ☐September 30 | **Quarterly Report is Due No Later than October 15, 2017** |

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 _____

Company Logo

Company Name _____ PHONE NUMBER _____
Company Address _____
City, State, Zip Code _____

**CUSTOMER:** City of North Miami
Community Planning & Development Dept.
776 N.E. 125th Street
North Miami, FL 33161
(305) 893-6511

**DATE:** _____

**INVOICE #** _____

**PURCHASE ORDER #** _____

| Spec # | Description | Total Amount Per Contract | Previous Draw Request | Amount This Draw | Percent Completed |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | **TOTAL CONTRACT AMOUNT** | | | | |
| | **TOTAL REQUESTED** | | | | |
| | **BALANCE DUE** | | | | |

CONTRACTOR

The undersigned Agency certifies that the above, services have been completed in accordance with the program specifications and all supporting documents are attached.

*Signature* _____

Date: _____

Amount Approved _____

Date: _____

**CITY OF NORTH MIAMI**

**Goal Progress Report**

**Contract FY 2016 - 2017**

**Reporting Period: _____**

**Provider: _____**

| Unit of Services | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter |
|---|---|---|---|---|
| Goal #1 | | | | |
| % of goal | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

Previous Balance $_____
Amount Requested $_____
Account Balance $_____

| **Agency** | **Project Name** |
|---|---|

| **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 <u>CANCELLED</u> checks**.

**Signature: _____** Date:_____

FOR OFFICE USE ONLY PO#:_____
Adjustment Code Explanations
NCB – Not currently Budgeted Reviewed by:_____
I – Ineligible
A – Approved for reimbursement Date:_____

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

**Provider:** _____ **Project Name:** _____
**Report Period:** _____ **Date Submitted:** _____
**Person Submitting Report:** _____ **Date Submitted:** _____
**Signature:** _____ **Title:** _____

**I. Narrative Report**

_____
_____

**II. Client Profile Report**

| | Clients | | Income Range | | | Ethnicity | | | | | | | | | | | | | Female | Special Needs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Month | 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 | HOH | |
| Oct. | | | | | | | | | | | | | | | | | | | | |
| Nov. | | | | | | | | | | | | | | | | | | | | |
| Dec. | | | | | | | | | | | | | | | | | | | | |
| Jan. | | | | | | | | | | | | | | | | | | | | |
| Feb. | | | | | | | | | | | | | | | | | | | | |
| Mar. | | | | | | | | | | | | | | | | | | | | |
| April | | | | | | | | | | | | | | | | | | | | |
| May | | | | | | | | | | | | | | | | | | | | |
| June | | | | | | | | | | | | | | | | | | | | |
| July. | | | | | | | | | | | | | | | | | | | | |
| Aug. | | | | | | | | | | | | | | | | | | | | |
| Sept. | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Total | | | | | | | | | | | | | | | | | | | | |

## MAXIMUM HOUSEHOLD INCOME LIMITS – 2015

| Household Size/ Income Group | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| 30% - LMI | $14,950 | $17,050 | $20,160 | $24,300 | $28,440 | $32,580 | $36,730 | $40,890 |
| Extremely Low | | | | | | | | |
| 50%-LMI | $24,850 | $28,400 | $31,950 | $35,500 | $38,350 | $41,200 | $44,050 | $46,900 |
| Very Low | | | | | | | | |
| 80%-LMI | $39,800 | $45,450 | $51,150 | $56,800 | $61,350 | $65,900 | $70,450 | $75,000 |
| 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 Time Sheet

**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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Total Hours for the Week | | | | | | |

**Employee Signature:**_____ **Date:**_____
**Supervisor Signature:**_____ **Date:**_____

**Deductions:**

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

***Please make sure the above information is corrected.**

# Monthly Payroll Summary

**Project:** **Sub-recipient:**
**Executive Director:** **Report Prepared by:**
**Reporting Period:** **Funding Source:**

| Employee Name & Title | SSN | Hourly Rate | Hours Worked | Gross Pay | W/H Tax | FICA | Other Deduct. | Net Pay | Check No. | Payroll Period End |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |