

File Number: _____
(Provided by Clerk of Board of Supervisors)

Grant Resolution Information Form
(Effective July 2011)

Purpose: Accompanies proposed Board of Supervisors resolutions authorizing a Department to accept and expend grant funds.

The following describes the grant referred to in the accompanying resolution:

1. Grant Title: **HB MH1921 HMM104 Hummingbird Place – Tipping Point**
2. Department: **Department of Public Health**
3. Contact Person: **Kelly Hiramoto** Telephone: **415-206-4168**
4. Grant Approval Status (check one):
 Approved by funding agency Not yet approved
5. Amount of Grant Funding Approved or Applied for: **\$3,000,000**
- 6a. Matching Funds Required: **\$0**
b. Source(s) of matching funds (if applicable):
- 7a. Grant Source Agency: **Tipping Point Community**
b. Grant Pass-Through Agency (if applicable):
8. Proposed Grant Project Summary: **The creation of a new “Hummingbird Place” Behavioral Health respite center site in San Francisco**
9. Grant Project Schedule, as allowed in approval documents, or as proposed:
Start-Date: **1/16/2020** End-Date: **1/15/2022**
- 10a. Amount budgeted for contractual services: **\$3,000,000**
b. Will contractual services be put out to bid? **No**
c. If so, will contract services help to further the goals of the Department’s Local Business Enterprise (LBE) requirements? **N/A**
d. Is this likely to be a one-time or ongoing request for contracting out? One-time
- 11a. Does the budget include indirect costs? Yes No
b1. If yes, how much? \$
b2. How was the amount calculated?
c1. If no, why are indirect costs not included?
 Not allowed by granting agency To maximize use of grant funds on direct services
 Other (please explain):

c2. If no indirect costs are included, what would have been the indirect costs? **25% of Salaries and fringe benefits.**

12. Any other significant grant requirements or comments:

We respectfully request for approval to accept and expend these funds retroactive to Jan 16, 2020. The Department received the grant award letter on December 19, 2019,

This grant does not require an ASO amendment. No position to be funded by the grant.

Proposal ID: **CTR00001593**

Version ID: **V101**

Project ID: **10035627**

Activity ID: **0001**

Fund ID: **11580**

Dept ID: **251984**

****Disability Access Checklist***(Department must forward a copy of all completed Grant Information Forms to the Mayor's Office of Disability)**

13. This Grant is intended for activities at (check all that apply):

- | | | |
|--|---|---|
| <input checked="" type="checkbox"/> Existing Site(s) | <input type="checkbox"/> Existing Structure(s) | <input checked="" type="checkbox"/> Existing Program(s) or Service(s) |
| <input type="checkbox"/> Rehabilitated Site(s) | <input type="checkbox"/> Rehabilitated Structure(s) | <input type="checkbox"/> New Program(s) or Service(s) |
| <input type="checkbox"/> New Site(s) | <input type="checkbox"/> New Structure(s) | |

14. The Departmental ADA Coordinator or the Mayor's Office on Disability have reviewed the proposal and concluded that the project as proposed will be in compliance with the Americans with Disabilities Act and all other Federal, State and local disability rights laws and regulations and will allow the full inclusion of persons with disabilities. These requirements include, but are not limited to:

1. Having staff trained in how to provide reasonable modifications in policies, practices and procedures;
2. Having auxiliary aids and services available in a timely manner in order to ensure communication access;
3. Ensuring that any service areas and related facilities open to the public are architecturally accessible and have been inspected and approved by the DPW Access Compliance Officer or the Mayor's Office on Disability Compliance Officers.

If such access would be technically infeasible, this is described in the comments section below:

Comments:

Departmental ADA Coordinator or Mayor's Office of Disability Reviewer:

Toni Rucker, PhD
(Name)

DPH ADA Coordinator
(Title)

Date Reviewed: 12-11-19



(Signature Required)

Department Head or Designee Approval of Grant Information Form:

Dr. Grant Colfax
(Name)

Director of Health
(Title)

Date Reviewed: 12/13/19


(Signature Required)