

**OPERATION SUPPORT AND  
CAPITAL EQUIPMENT  
GRANT APPLICATION**



Long Island Cares Inc., The Harry Chapin Food Bank  
10 Davids Dr.  
Hauppauge, NY 11788  
[www.licares.org](http://www.licares.org)

As a recipient of Hunger Prevention and Nutrition Assistance Program (HPNAP), funds made available for the period of July 1, 2008 through June 30, 2009 and as the duly authorized representative of

\_\_\_\_\_ I certify the following:  
(Name of Organization)

- ◆ That my public or private organization has the capability to provide emergency food and/or shelter services;
- ◆ Will provide services as described in the HPNAP 2008-2009 application;
- ◆ Is not-for-profit organization; and has a Section 501 (C) (3) status certificate from the Internal Revenue Service;
- ◆ Does not require persons identifying themselves as homeless and destitute to document this condition;
- ◆ Does not refuse to give food to any person on the basis of gender, ethnicity, religious affiliation, handicapping condition or other personal characteristic. Will provide food to homeless or destitute persons free of charge or obligation;
- ◆ Will provide all required reports to the Long Island Cares Inc., The Harry Chapin Food Bank;
- ◆ Will submit Interim and Final report which will include documentation of all Operation support expenditures (cancelled checks, invoice, receipts, time sheets, photo id if applicable)
- ◆ Organization maintains a checking account for HPNAP award payments and expenditures;
- ◆ Checking account has more than one authorized signature;
- ◆ Will expend monies only on eligible program costs as described on the approved budget, and keep complete documentation (copies of cancelled checks, invoices, receipts, etc.) for a minimum of seven years;
- ◆ Will spend all allocated HPNAP funds by dates noted on application and return any unused money to Long Island Cares Inc., The Harry Chapin Food Bank.

\_\_\_\_\_  
**SIGNATURE**

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

\_\_\_\_\_  
**TITLE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**NAME OF ORGANIZATION**

\_\_\_\_\_  
**ADDRESS**

\_\_\_\_\_  
**CITY/STATE**

\_\_\_\_\_  
**ZIP**

\_\_\_\_\_  
**HPNAP ID**

\_\_\_\_\_  
**TELEPHONE NUMBER**

\_\_\_\_\_  
**AGENCY ID NUMBER**

**New York State Department of Health  
Hunger Prevention and Nutrition Assistance Program**

**OPERATIONS SUPPORT BUDGET PROPOSAL: STAFF  
USE ADDITIONAL PAGES AS NECESSARY TO ANSWER THESE QUESTIONS.**

Amount requested \$ \_\_\_\_\_

Title of Staff Position: \_\_\_\_\_

List the specific duties this staff person performs. If operation of the food assistance program is only part of the position, list only those tasks related to food assistance, **or**, attach the job description, highlighting the relevant duties.

Approximately how many hours per day or week does the staff person work on food assistance?

What is the wage rate? (Reminder, the wage rate must be at least \$7.15, minimum wage) \_\_\_\_\_

Did your program receive HPNAP (SNAP) OS Staff funding in 2006-07? \_\_\_\_\_ No \_\_\_\_\_ Yes  
If yes, How much? \$ \_\_\_\_\_

Please list the sources and approximate amounts of any other funding source(s) currently which contribute to funding this position.

Check which form(s) of documentation your program can provide to verify the use of the grant funds:

- \_\_\_\_\_ Copies of the payroll register.
- \_\_\_\_\_ Copies of time cards or time sheets showing days and hours worked, and copies of the cancelled pay checks.
- \_\_\_\_\_ Copies of 1099 or W-2 forms.

How would the requested grant funds support or improve your program's ability to provide food assistance to needy people? Please be specific. List your program's goals to maintain or improve the quality and/or quantity of food assistance during the 2008-2009 grant year.

**New York State Department of Health  
Hunger Prevention and Nutrition Assistance Program**

**OPERATIONS SUPPORT BUDGET PROPOSAL: UTILITIES** (Heat, Electric, Water, Cooking Fuel ONLY)  
**USE ADDITIONAL PAGES AS NECESSARY TO ANSWER THESE QUESTIONS.**

Amount requested \$ \_\_\_\_\_

Explain clearly how this amount was estimated. (For example, was it based on expenses in the past, or did you use estimates of how much it costs to operate a freezer or other equipment?)

If only a proportion of a utility bill will be charged to the Operations Support grant, explain what percentage of the bill will be charged, and why. (For example, does the food pantry occupy a percentage of the space to be heated?)

Did your program receive HPNAP (SNAP) OS Utilities funding in 2006-07? \_\_\_\_No \_\_\_\_Yes  
If yes, how much? \$ \_\_\_\_\_

If any other funding source(s) currently contribute to funding this expense, please list the sources:

How would the requested grant funds support or improve your program's ability to provide food assistance to needy people? Please be specific. List your program's goals to maintain or improve the quality and/or quantity of food assistance during the 2008-2009 grant year.

**New York State Department of Health  
Hunger Prevention and Nutrition Assistance Program**

**OPERATIONS SUPPORT BUDGET PROPOSAL: SPACE  
USE ADDITIONAL PAGES AS NECESSARY TO ANSWER THESE QUESTIONS.**

Amount requested \$\_\_\_\_\_

NOTE: You must include a copy of the rental agreement or a letter stating the rent/user fee from the organization that provides the space. Include this information, even if you previously received an Operations Support grant.

If only a proportion of your rent will be charged to the Operations Support grant, please give a clear explanation for what percentage of your rent will be paid by the OS grant.

Did your program receive HPNAP (SNAP) OS funding for space in 2006-07? \_\_\_\_No \_\_\_\_Yes

If yes, how much? \$\_\_\_\_\_

If any other funding source(s) currently contribute to funding the cost, please list the source(s).

How will the requested grant funds support or improve your program's ability to provide food assistance to needy people? Please be specific. List your program's goals to maintain or improve the quality and/or quantity of food assistance during the 2008-2009 grant year.

**New York State Department of Health  
Hunger Prevention and Nutrition Assistance Program**

**OPERATIONS SUPPORT BUDGET PROPOSAL: DISPOSABLES (Does not include Food Safety and Sanitation items available from HPNAP)**

**USE ADDITIONAL PAGES AS NECESSARY TO ANSWER THESE QUESTIONS.**

Amount requested \$\_\_\_\_\_

List the specific disposable items you plan to buy, the amount of each, and the estimated price per case.

(Please attach another sheet if you need more room.)

Did your program receive HPNAP (SNAP) OS funding for disposables in 2006-07?

\_\_\_\_No \_\_\_\_Yes If yes, How much \$\_\_\_\_\_

If any other source(s) currently contribute to funding the disposables needed for your program, please list the sources and amounts from each.

How will the requested grant funds support or improve your program's ability to provide food assistance to needy people? List your program's goals to maintain or improve the quality and/or quantity of food assistance during the 2008-2009 grant year.

## Hunger Prevention and Nutrition Assistance Program

**OPERATIONS SUPPORT BUDGET PROPOSAL: FOOD SERVICE EQUIPMENT. PLEASE OBTAIN PRICES ON YOUR OWN. YOU DO NOT HAVE TO ATTACH A BID TO THE APPLICATION.**

**USE ADDITIONAL PAGES AS NECESSARY TO ANSWER THESE QUESTIONS.**

1. Was the Capital Equipment recommended during a Long Island Cares Site Visit?  
  
Date of Site Visit?  
  
Long Island Cares staff member name: \_\_\_\_\_
2. List the equipment item(s) requested.
3. Describe why HPNAP monies should be used to purchase each item requested. If replacing equipment, explain why the current equipment needs to be replaced. If purchasing additional equipment, explain why the equipment will allow your program to serve more people and/or enable the program to provide better quality service or a greater variety of foods. This includes a start of or an expansion of Client Choice Pantry Models. (Attach additional pages if more space is needed.)
4. Explain how your agency will cover any costs for installing, operating, maintaining and securing the requested equipment. If capital improvements become necessary because of the equipment selected, the applicant must explain how these costs will be covered with other than HPNAP funds (for example, any costs of plumbing, electricity, or building alterations).
5. If the applicant has received HPNAP (formerly SNAP)-funded equipment in the past, please list the equipment and year purchased with previous HPNAP/SNAP awards. Add a separate sheet if necessary.