CITY OF NORWICH
CORONAVIRUS AID RELIEF & ECONOMIC SECURITY (CARES ACT) FUNDING
COMMUNITY DEVELOPMENT BLOCK GRANT – CDBG-CV
APPLICATION FOR FUNDING - PUBLIC SERVICE -
AMENDED PROGRAM YEAR 2019-2020 (PY 45)

Agency:
Norwich Human Services, Rose City Senior Center

Program:
Overcoming Covid-related Disparities with Accessible Medical Care & Education for Norwich Seniors

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DUE: MARCH 17, 2023 4:00 PM IN OFFICE OF COMMUNITY DEVELOPMENT

Office of Community Development
23 Union Street, 2nd floor •Tel (860) 823-3770 • Fax (860) 823-3715
E-mail addresses:
sphelps@cityofnorwich.org (Sydney Phelps, Community Development Director)
tcurtis@cityofnorwich.org (Tianne Curtis, Program Assistant)

PART I: GENERAL INFORMATION

AGENCY: Norwich Human Services Department, Rose City Senior Center
LEGAL NAME (If different from Agency) _____

ADDRESS: 8 Mahan Drive, Norwich CT 06360

E-MAIL: kmilde@cityofnorwich.org

EXECUTIVE DIRECTOR: Katherine Milde, MS

CONTACT NAME & TITLE: Katherine Milde, Director of Human Services & Mike Wolak, Senior Division Head

TELEPHONE: 860-823-3700 x3481 EMAIL: kmilde@cityofnorwich.org

AGENCY FISCAL YEAR: 07/01/2022 (Begin) 06/30/2023 (End)

PROJECT NAME: Overcoming Covid-related Disparities with Accessible Medical Care & Education for Norwich Seniors

CDBG REQUEST & AWARD AMOUNTS:

	REQUEST	AWARD
THIS REQUEST CV FUNDING	$ **$170,000**	$
PRIOR YEAR CV FUNDING	$ **60,000**	$ **60,000**

The information contained herein and attached as exhibits hereto is, to the best of our knowledge and belief, true, correct, and complete, and the City of Norwich can rely upon these statements in determining whether to fund this project. We certify that the Agency Board of Directors has approved this application.

EXECUTIVE DIRECTOR/DEPT. HEAD (SIGN)

Katherine Milde
PRINT NAME

DATE: 3/15/2023

PRESIDENT, BOARD OF DIRECTORS (SIGN)

John Salomone
PRINT NAME

DATE: 3/15/23

FROM: CITY OF NORWICH COMMUNITY DEVELOPMENT OFFICE

TO: CDBG-CV APPLICANTS

SUBJECT: SPECIAL INSTRUCTIONS FOR CDBG-CV FUNDING APPLICATIONS FOR BOTH PUBLIC AND NON-PUBLIC SERVICES APPLICANTS

SPECIAL INSTRUCTIONS FOR CDBG-CV FUNDING APPLICATIONS

In response to the Coronavirus Pandemic (COVID-19) the U.S. Department of Housing and Urban Development Community Development Block Grant program has notified the City of Norwich that they will receive a formula allocation from the first round of CDBG-CV funding to be used **specifically for the prevention of, preparation for, and response to the Coronavirus.**

The Community Development Office is accepting applications from qualifying candidates to help in the prevention of, preparation for, and response to the Coronavirus throughout the City of Norwich. All applications that meet a National Objective, Eligible Activity, AND prevent, prepare for, or respond to the Coronavirus will be reviewed.

PART II: PROJECT INFORMATION

A. INTRODUCTION/AGENCY INFORMATION

A1. Brief history:
Norwich Human Services is a department of the City of Norwich and is comprised of three divisions: Adult & Family Services; the Youth, Family, & Recreation Division; and the Rose City Senior Center. The mission of the Department is to enhance the quality of life for all Norwich residents by providing opportunities and services that promote health, social and emotional well-being, and economic empowerment. We recognize that people must have their basic needs met, gainful employment, social and recreational activities, and mental health supports to achieve optimal health and a sustainable level of independence. Our three Divisions collaborate to assist individuals and families in reaching their maximum potential.

A2. Hours of Operation:
Our hours for the Rose City Senior Center are 8:00a–4:00p, Monday through Friday.

A3. Number of Staff:
There are 22 full-time staff throughout the Human Services Department, and 7 full-time staff in the Senior Division.

A4. Contact for Nondiscrimination Compliance:
Brigid Marks, Director of Human Resources for the City of Norwich. 860-823-3786.

A5. Recipient of Federal Funding exceeding $500,000?
Yes.

B. STATEMENT OF NEED

B1. Identifying Need:
The Covid 19 pandemic greatly affected all community populations regardless of age group, gender, ethnicity, or economic status. However, due to systemic and historical issues of access, we observed that our underserved and most vulnerable populations were most affected by Covid 19 and continue to experience greater challenges accessing healthcare services and factual, culturally-relevant information even as the pandemic begins to subside.

A particularly vulnerable population throughout the pandemic was our seniors. Research has shown that Covid 19 was far more deadly and devastating in this age group and resulted in many seniors going years without proper healthcare services, whether for preventative measures or more complicated and emergent needs. The traditional methods of accessing care and services either from the health care system or community organizations have also changed due to the pandemic. Seniors have not been educated about these new processes, technologies, or benefits that are available to them.

Studies[1] have also shown that seniors suffered greatly from a lack of resources due to not only fear but the recommendation that they isolate themselves from the community to reduce transmission rates and protect themselves; these barriers to engaging with healthcare providers still exist among our seniors:

> "The changes many countries have seen come into place since the start of the COVID-19 pandemic extend far beyond the loss of socialization and increased depression. ... As hospitals have filled with COVID-19 patients, access to regular healthcare for non-COVID-related disorders has been interrupted[2]. Those who do not seek care for non-COVID-related disorders may be at higher risk of

[1] Martins Van Jaarsveld G (2020) The Effects of COVID-19 Among the Elderly Population: A Case for Closing the Digital Divide. Front. Psychiatry 11:577427. doi: 10.3389/fpsyt.2020.577427

[2] https://www.frontiersin.org/articles/10.3389/fpsyt.2020.577427/full#B50

> illness and fatality during this period.[3]. This risk is likely to disproportionately affect the elderly, who have higher rates of health problems than younger populations and are more likely to be encouraged to avoid areas where they could contract the disease... Telehealth, or the act of providing healthcare digitally, and remotely, has become commonplace in many countries..[4] However... A recent study showed that about 40% of elderly individuals were unprepared to use telehealth resources, predominantly due to a lack of skills to effectively make use of the technology.[5]... Although there have been some recent efforts to create virtual geriatric clinics to support the elderly during the pandemic, research has shown these have had varying success, and have been met with a variety of problems related to difficulties with technology use."

The recently-updated ALICE report[6] by the United Way details several alarming indicators for cities across Connecticut and, in particular, Norwich. This report, which was updated in 2018, states that Norwich has a poverty rate of 14%. Additionally, 40% of Norwich households qualify as ALICE households; ALICE stands for Asset Limited Income Constrained and Employed. These are households that do not earn sufficient income to afford to fully pay their monthly expenses. Individuals experiencing financial insecurity do not prioritize their health; eliminating barriers to access to care will mitigate the comorbidities they endure.

B2. Program Uniqueness:

Yes, the services we are attempting to provide are offered by other organizations, but the uniqueness of our program lies in these healthcare services being offered right at the Rose City Senior Center and in the community (senior housing complexes, food pantries, and churches). While NHS is the primary applicant, we intend to utilize these funds to acquire a package from HHC, detailed below, that we co-crafted and will ensure Norwich Seniors are receiving a continuum of care they would not get in a typical healthcare setting. By using these trusted and familiar locations, HHC can supplement our existing services with socialization aspects and social influencers of health (SIOH) like transportation, case management, education, and exercise options which are offered at the Senior Center.

Currently, the local State-Licensed Health Clinic at RCSC has a podiatrist offering foot care (1x a month for 5-6 hours) and an RN who provides foot care for non-diabetic seniors and ear flushing 1x per week for 4 hours. It is our goal to continue these services in conjunction with ours while we expand the menu of services offered and increase the types and number of available educational opportunities.

B3. Addressing Community Needs:

According to the Connecticut General Assembly, seniors (individuals 65 years of age and older), make up over 18% of the state's population. This specific age group faces many challenges when it comes to health care and social determinants of health. These challenges greatly increase when a senior is also part of a low-income, underserved, and diverse population. Healthcare is often confusing, intimidating, and expensive and many seniors are not aware of whom to turn to when they have medical questions. Many seniors also lack disease-specific education to help to manage and advocate for their diagnosis. Transportation, as well as access, are also major issues surrounding a senior's healthcare. Seniors often find it difficult to access healthcare services and are not aware of or have difficulty applying for community-based services.

By having a preventive health center and going directly to where seniors are in our community, we will be able to provide better access to screenings seniors need to detect chronic diseases and monitor chronic conditions. We will be able to provide disease-specific education and programming to help seniors manage their conditions and advocate for their healthcare. By connecting seniors to healthcare and community resources, we will be able to affect access issues and transportation/technological limitations prevalent in this population.

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[3] https://www.frontiersin.org/articles/10.3389/fpsyt.2020.577427/full#B51
[4] https://www.frontiersin.org/articles/10.3389/fpsyt.2020.577427/full#B28
[5] https://www.frontiersin.org/articles/10.3389/fpsyt.2020.577427/full#B52
[6] ALICE Report, http://www.unitedwayalice.org/reports.php, CT 2016 update

B4. Waiting List?
No; our program does not have a waiting list.

C. PROGRAM DESCRIPTION

C1. General Description:
Norwich Human Services and Hartford Health Care co-crafted this program to ensure our clients are receiving a continuum of care they would not get in a typical healthcare setting and to address the seemingly insurmountable barriers that are technology and a lack of education and transportation. NHS intends to acquire this program package from HHC to meet the needs of our seniors. As a part of this package, Hartford Health Care would like to hire a community health nurse to bring our Preventative Health services to the Rose City Senior Center. Services and program administration would be provided 5 days a week from 2 on-site and 3 in the community and/or at an HHC site if needed, and would provide preventative screenings and disease-specific education, and offer coordination of care to Norwich seniors. An individual would have the opportunity to schedule a visit on-site.

During a typical visit, an individual would be required to provide demographics such as (age, DOB, Address, etc.), along with any other necessary intake paperwork. A Social Determinants of Health (SDOH) Assessment would be conducted to screen the individual for any specific needs and identify eligibility for specific community programs. The LPN would also measure an individual vitals which include BP/Temp/O2/Heart rate/respirations/Pain, and weight. Different types of Point of Care testing would be made available. Tests such as Blood sugar, A1C, cholesterol, waist circumference, Hepatitis C, HIV, and Hemoglobin would be conducted and any irregular results would be shared with the individual's Primary Care physician. The center is focused on screenings and referrals only and will not provide any active treatment. Vaccines and immunizations may also be made available. We plan to provide Covid 19 vaccines and will distribute Covid 19 take-home test kits to mitigate the loss of community-based testing stations.

The LPN would be available to do medication reconciliation and it is our goal to designate specific times during the month for medication fills as we know this is a particularly time-consuming and difficult process for some seniors. The medication reconciliation can be done through our electronic health record or we may ask the patient to bring their meds or med list with them and the nurse can call their pharmacy to confirm.

HHC would work closely with their Federally Qualified Health Center (FQHC) partners to provide wrap-around care when appropriate. For example, if an individual did not have a primary care physician we would be able to use the FQHCs as a resource. The LPN would work in concert with the Social worker from the senior center to connect individuals to services they may qualify for such as rental and utility assistance, SNAP, Insurance, food pantries, meals on wheels, etc.

The LPN would sit under the Community Health Department of Backus Hospital. This department would also provide Dietary education services with a licensed registered Dietician as additional programming for qualifying individuals. As part of the community health Improvement Plan Backus Hospital Departments and institutes are engaged in providing additional specialty screenings to members of the community. As part of this grant, the Community Health Department could make additional specialty screenings available through the LPN at the senior center.

For days and times the LPN would not be facilitating the health center at the Rose City senior center he/she would be engaged in community outreach activities and programming for seniors within the Norwich community. Examples of this type of activity would be stand-up screenings like (A1c, blood pressure, etc.) at Norwich-based senior housing facilities, participation in the Mobile Health Hubs (urgent care and community benefit resource events through the Eastern CT Health Collaborative) when the site is reflective of a senior population (St Vincent de Paul Place, East wood court) Additionally the LPN would work with TVCCA (community action agency) to provide health education and screenings at congregate meals sites when appropriate.

C1a. Consolidated Plan Alignment:
This program is in alignment with Public Services objectives in the Consolidated Plan, specifically the "provision of necessary public services in a comprehensive and coordinated manner particularly services associated with… the elderly..." It also aligns with the plan by providing activities that address quality of life and improving collaborations.

Priority 2 of the Plan Needs Assessment Overview notes we should, "Create a suitable living environment that includes programs that focus on self-sufficiency, health, and safety. These objectives include proving funding for … outreach, access to benefits, removing barriers around transportation related to medical/health [needs]." Senior services and health care services, in addition to community health care facilities, were identified as high-need.

C1b. Collaborations/Partnerships:
With this program, we would be working alongside RCSC's health center, as they have a Podiatrist and RN with limited availability currently placed in the health center. We would also be working directly with UCFS and Generations for primary care referrals, connection to services, and follow-ups. The community health department is closely connected to community benefit agencies in our area and can assist and connect individuals to resources in the community when appropriate, starting with Norwich Human Service's three Divisions: Seniors, Social Services, and Youth & Recreation.

We would also be leveraging our relationships within Hartford Health Care for further specialty screenings and education; Oncology, Men's Health, Digestive Health, Heart and Vascular, Bone and Joint, and Ayer Neuroscience institutes would be invited to hold screenings as well as educational events at the RCSC. We would also be connecting individuals to the Center for Healthy Aging which connects seniors to all types of resources to help them age independently at home; provides resource coordination, transitional care nurses as well as dementia specialists. We would leverage HHC's Community Education Department to provide educational topics (opioid awareness, orthopedic surgeries, chronic disease management, healthy eating, active living, etc.) to patrons of the senior center. As previously mentioned in the last paragraph of C1 we would engage with the mobile health hubs from the Eastern Connecticut Health Collaborative. We would also be interested in working with the Thames Valley Community Action Agency to provide health education and screenings at their congregate meal events in the Norwich area.

C1c. Link with Local and Regional Plans:
Along with this program aligning with Norwich's 5-year Consolidated Plan, it also aligns with the Norwich Health Equity Committee (HEC) goals, created by City Council per a Resolution. Two of these HEC directives include, "Focus on access to prevention and treatment that is culturally and linguistically competent and meets communities where they are to counter the inequities that exist in health care;" and, "Develop direct service programs and services to address the negative impact that these inequities have had on specific populations as well as programs that empower communities to tackle these systemic barriers."

HHC/Backus Hospital's 2023-2024 Community Health Needs Assessment (CHNA).[7] data points and Community Health Improvement Plan (CHIP) also reflect a linkage to the proposed programming:

- 53% of adults in the Backus Hospital HSA say they are in excellent or very good health as compared to 59% State of CT
- Diabetes prevalence by race ages 50-64: white 11%, Black 32%, Latino 22%
- Asthma prevalence by race ages 18-34: White 16%, Black 29%, Latino 23%
- Hypertension Prevalence by race ages 65 and older: white 59%, Black 59%, Latino 42%
- 39.5% of respondents identified "healthcare for seniors" as a "much-needed concern"

Integrated medical and mental health services for seniors were found to be a top-five need in Norwich. HHC partnered with the Uncas Department of Health on our CHNA so our findings reflect

[7] Backus CHNA 2022, Data Haven Health Equity Profile 2022

the goals of the local health district; it's not only health care system data, but data collected and aggregated by the health district.

C1d. Resulting Partnerships:
Norwich Human Services would create a partnership not only with Hartford Health Care but would enhance the work to be done by the City's Health Equity Committee Members.

C1e. New CDBG Program?
Yes; this is a new CDBG Program. These types of services exist but do not have the same type of focus or robust nature of the programs proposed in this application.

C2. Service Location Details:
Preventive Health Center
C2a. Location of Services: Rose City Senior Center
C2b. Frequency of Services: 2 days a week on-site, 3 days in the community
C2c. Hours of Operation: 8 am-1 pm
C2d. Number of Norwich Residents to be Served: 10-20 people per week

Community Screenings
C2a. Location of Services: Senior Housing Complexes, Food Distribution Centers, Faith-based Locations, and other accessible Norwich locations which serve seniors
C2b. Frequency of Services: 3-4 times a month
C2c. Hours of Operation: 10 am-2 pm; will vary
C2d. Number of Norwich Residents to be Served: 10-20 per event

C3. Percentage of Grant Funds used for Administration and Salaries:
1 LPN hired within HHC Package = 76% of the requested funding

C4. Program Continuum:
Inputs
1 Full-time Licensed Practical Nurse (LPN) will be required to administer health care screenings and chronic disease education to approximately 700 Norwich Seniors annually as a part of the HHC program package. IT equipment is necessary to adequately serve patients and communicate with patients' primary care offices as well as with social services agencies. Hartford Health Care will share 50% of the cost of the point-of-care testing supplies. Any other inputs to support the Hartford Health Care program package are in-kind and will include involvement from the East Region Director of Community Health, the East Region Community Health RN, the East Region Chief Hospitalist who will serve as medical director, and the Director of Norwich Human Services. NHS will also be providing in-kind facilities, resources, and IT equipment as needed.

Activities
Health Screenings:
Social Determinants of Health (SDOH) Assessment, Vitals (BP/Temp/O2/Heart rate/respirations/Pain, and weight). Point of Care Testing (POCT) Blood sugar, A1C, cholesterol, waist circumference, Hepatitis C, HIV, and Hemoglobin would be conducted and any irregular results would be shared with the individual's Primary Care physician. During testing, participants will be given education regarding the disease that they have been screened for and how to achieve a "normal" range. The center is focused on screenings referrals only and will not provide any active treatment. Vaccines and immunizations including Covid 19 vaccines and Covid 19 testing.

Outreach Efforts:
Stand-up screenings like (A1c, blood pressure, etc.) at Norwich-based senior housing facilities, participation in the Mobile Health Hubs (urgent care and community benefit resource events through the Eastern CT Health Collaborative) when the site is reflective of a senior population (St

Vincent de Paul Place, East Wood Court, etc.) Additionally, the LPN would work with TVCCA (community action agency) to provide health education and screenings at congregate meal sites when appropriate.

Addressing Barriers to Health:
We will provide access and education for individuals to monitor and manage chronic disease. Examples include: providing blood pressure cuffs, educating on usage and evaluating results. Providing screenings and educational resources to individuals where they live and frequently visit will address the barrier of transportation for seniors. HHC's mobile "CareVans" visit and operate daytime health clinics several times a month at specifically chosen locations. They offer a variety of health services including screenings, mental health counseling, medical referrals, education, and support. Neighborhood Health was developed in collaboration with trusted community partners throughout the state. These groups and individuals help determine the health needs and priorities of their residents and communities. These innovative health clinics are adaptable, flexible, and open to feedback to ensure access to needed services and programs. Currently, Neighborhood Health functions under the Mobile health Hub model from the Eastern Connecticut Health Collaborative. Within this model "Anchor Agencies" host mobile services and invite collaborative partners to attend thus providing wrap-around services (food and nutrition resources, energy assistance, primary care, insurance, legal assistance, etc.) for individuals in the community.

Care Plan Development:
Working in conjunction with the Senior Center Social worker, referrals and program education can be coordinated for various community benefits. Examples may include: rental and utility assistance, Meals on Wheels, Medicare CHOICES program, Veterans benefits, companion homemaker, nutritional assistance, and exercise/socialization activities. Coordination with PCPs will occasionally be warranted.

Health Education Program Enrollment:
In addition to the education being provided directly to the individual from the LPN, there will be access to various health education programming. Examples may include: Making the Most of Medicare's Open Enrollment Period; Understanding Parkinson's disease; Understanding Back Pain with Sciatica; Exercise & Healthy Aging; Low back pain: Causes and treatment options; Depression: An introduction to the disorder; Understanding Arthritis; and Building better bones & joints.

Outputs
Consistent chronic disease screening and education provided for local seniors at Rose City Senior Center as well as senior-serving community organizations throughout Norwich. 700 individuals who have received health screenings and/or education throughout the year.

Outcomes
Short Term:
200 people screened – 100% abnormal results shared with Primary Care Physician
Interim Term:
500 Individuals educated about chronic disease management and healthy living techniques. 500 people assisted with education about and/or access to community benefit resources.
Long Term:
Out of 200 people screened we will see a decrease in abnormal results after 1 year.

Measuring Success
In our Quarterly Reports, we will capture the following data points: # of seniors obtaining screenings and # of seniors who attended educational programs; # of services offered; and # of referrals made.

PUBLIC SERVICE CDBG-CV RECAPTURE

OUTCOME: Seniors gain basic health knowledge and better management of chronic conditions, helping to overcome Covid-related health disparities faced by Norwich seniors.				
Long Term Outcome: Decrease elevated results	**2023-2024 Actual**	**Estimated 2023-2024**	**2023 - 2024 Anticipated**	Finish
Total Number of Participants:		200	200	
Total Number of Participants Achieving Outcome:		100	100	
Percent Who Achieved Outcome:		50%	50%	
Interim Outcome: Individuals educated		-	-	
Total Number of Participants:		500	500	
Total Number of Participants Achieving Outcome:		500	500	
Percent Who Achieved Outcome:		100%	100%	
Short Term Outcome: People having access to health screenings		-	-	
Total Number of Participants:		200	200	
Total Number of Participants Achieving Outcome:		150	150	
Percent Who Achieved Outcome:		75%	75%	
Output: Individuals Screened and Educated		-	-	
Total Number of Participants:		700	700	
Total Participants that are Norwich Residents:		100%	100%	
Total Number of Participants Achieving Outcome:		350	350	Start
Percent Who Achieved Outcome:		50%	50%	

D. FUNDING QUESTIONS

D1. Leveraged Funding:
Hartford Health Care / Backus Hospital will share 50% of the cost of the point-of-care tests that will be administered as a part of their program package. Backus Hospital will pay benefits and payroll tax for the hired position. Backus hospital also provides personnel responsible for the supervision of the LPN position as well as the medical director to oversee the health center. Norwich Human Services and the Rose City Senior Center will be providing personnel, space, supplies, and Program oversight.

D2. Project Completion without CDBG Funds:
Without funding from CDBG, we will not be able to hire an LPN to proceed with the program and services. The community health department will continue to provide services to the greater Norwich community but the specific senior population focus as well as the intended volume will be severely decreased.

D3. Items for Elimination:
If the application was only partially funded we could decrease the number of days the health center is open or the types of testing/screenings we would make available.

E. OTHER

E1. Program Uniqueness:
Our program includes on-site, comprehensive, wrap-around services, such as case management, family supports, and basic needs assistance, which eliminate barriers to wellness. While other Healthcare Providers may have similar offerings, they do not offer the plethora of local programming offered by Norwich Human Services. Another aspect that provides uniqueness is the plan to combine efforts to reduce duplication of local programming through this comprehensive, collaborative, and targeted outreach.

E2. CDBG Continuation?
No.

ADDRESSING THE NATIONAL OBJECTIVE

Does your program:

☒ Address the needs of low- and/or moderate-income residents (see income chart below)? AND/OR

☒ Serve seniors; severely disabled adults; homeless persons; battered spouses; abused/neglected children and youth; illiterate adults; migrant farm workers, and persons living with HIV/AIDS.

FY 2022 Income Limits Summary									
FY 2022 Income Limit Area	FY 2022 Income Limit Category	Persons in Family							
		1	2	3	4	5	6	7	8
Norwich-New London, CT HUD Metro FMR Area	Very Low (50%) Income Limits ($)	$39,450	$45,050	$50,700	$56,300	$60,850	$ 65,350	$ 69,850	$ 74,350
	Extremely Low Income Limits ($)*	$23,700	$27,050	$30,450	$33,800	$36,550	$ 39,250	$ 41,950	$ 46,630
Median Family Income $102,700	Low (80%) Income Limits ($)	$62,600	$71,550	$80,500	$89,400	$96,600	$103,750	$110,900	$118,050

STAFFING RESOURCES:

If you are/will meet Section 3 criteria, it will be mandatory for you to complete the attached Section 3 documentation.

Position/Title	Salary Range	CDBG Portion of Salary	Full-Time or Part-Time?	Hired As a Result of Funding? (Y/N)
LPN (year 1)	$46,000 - 68,000	100% *(Benefits will be in-kind)*	Full-Time	Yes
LPN (year 2)	$46,000 - 68,000	100% *(Benefits will be in-kind)*	Full-Time	Yes
Medical Director	$311,000 - 340,000	(in-kind)	Part-Time	NO
Director Community Health	$100,000 - 150,000	(in-kind)	Full-Time	NO
Community Health RN	$85,000 – 95,000	(in-kind)	Full-Time	NO
Director of Norwich Human Services	$100,000 - 150,000	(in-kind)	Full-Time	NO
Senior Division Head, Norwich Human Services	$90,000-100,000	(in-kind)	Full-Time	NO

PART III: BUDGET INFORMATION

AGENCY FINANCIAL DATA

SUPPORT & REVENUE	Current	Anticipated
	FY 22-23	FY 23-24
Program Fees	$	$
Other Grants including foundations		
Donations		
CDBG (Norwich Works PY48; NWPY49 & Health CV PY45)	$ 60,000	$ 240,000
General Fund	$1,930,703	$1,847,714
State & Federal Grants		
Other Revenue (specify)		
TOTAL REVENUE	$1,990,703	$2,087,714

EXPENSES	Current	Anticipated
	FY 22-23	FY 23-24
Salaries	$1,210,000	$ 1,762,000
Employee Benefits		
Payroll Taxes		
Professional Fees & Services		
Operations/Phones/Postage		
Insurance		
Equipment Rental, Maintenance & Acquisition		
Printing & Publication		
Travel/Conferences/Conventions		
Legal Fees		
Vehicle Lease/Repair		
Other Expenses (specify) Operations, Services	$ 780,703	$ 325,714
TOTAL EXPENSES	$1,990,703	$2,087,714
BALANCE (TOTAL REVENUE LESS EXPENSES)	$0	$0

PROGRAM-SPECIFIC FINANCIAL DATA

SUPPORT & REVENUE	CDBG-Funded Portion	Non-CDBG Funded Portion	% of CDBG Funds used for Program
Program Fees			
Other grants/foundations (non-government)			
Donations			
CDBG	$ 170,000		
General Fund			
State Government			
Federal Government			
Other Revenue (specify)			
Hartford Healthcare In-Kind Contributions		POCT - $7,342.53 Med Director - $20,000 % HHC Comm Health staff time - $60,000 Payroll Tax – $9,945 Employee benefits $39,000	
TOTAL REVENUE	**$170,000**	**$136,287.53**	**55%**
EXPENSES	CDBG-Funded Portion	Non-CDBG Funded Portion	% of CDBG Funds used for Program
Salaries			
Employee Benefits		$39,000	
Payroll Taxes		$9,945	
Professional Services (incl. accounts and attorneys)			
General Operations & Supplies - RCSC (Medical cart, locking cabinet, exam table, computer, scheduling software, sanitary/maintenance needs for treatment space)	$20,000		
Travel / Conferences	0		
Vehicle Expense	0		
Other Expenses (specify)	0		
- Hartford Healthcare On-Site Package for Serving Seniors (2 years of LPN, etc.)	$150,000	$87,342.53	
TOTAL EXPENSES	**$170,000**	**$136,287.53**	**55%**
BALANCE (total revenue less expenses)	**$0**	**$0**	

PART IV:

CDBG-CV-19 CITY OF NORWICH, CONNECTICUT APPLICANT CONFLICT OF INTEREST QUESTIONNAIRE
2019-2020 AMENDED PROGRAM YEAR

Federal, State, and City law prohibits employees and public officials of the City of Norwich from participating on behalf of the City in any transaction in which they have a financial interest. This questionnaire must be completed and submitted by each applicant for Community Development Block Grant (CDBG) funding. The purpose of this questionnaire is to determine if the applicant, or any of the applicant's staff, or any of the applicant's Board of Directors would be a conflict of interest.

Are there any members of the applicant's staff or any members of the applicant's Board of Directors or governing body who is or has/have been within one year of the date of this questionnaire (a) a City employee or consultant, or (b) a City Council member, or (c) a member of the Community Development Advisory Committee (CDAC) member?

☐ Yes ☒ No

Will the CDBG funds requested by the applicant be used to award a subcontract to any individual(s) or business affiliate(s) who is/are currently or has/have been within one year of the date of this questionnaire a City employee, consultant, City Council person or Community Development Advisory Committee member?

☐ Yes ☒ No

Are there any members of the applicant's staff or members of the applicant's Board of Directors or other governing body who are business partners or family members of a City employee, consultant, City Council person, or Community Development Advisory Committee member?

☐ Yes ☒ No

Have you read and understood the HUD regulation regarding conflict of interest, 24 CFR 570.611 (attached)?

☒ Yes ☐ No

Katherine Milde
NAME OF APPLICANT / REPRESENTATIVE

SIGNATURE OF ABOVE REPRESENTATIVE

3/15/23
DATE

PART V:

Section 3 Contractor Affidavit (*2021 Final Rule)*

Section 3 Business Concerns are:

- At least 51 percent of the business is owned and controlled by low or very low-income persons; or
- At least 51 percent of the business is owned and controlled by current public housing residents or residents who currently live in Section 8-assisted housing; or
- Over 75 percent of the labor hours performed for the business over the prior three-month period are performed by Section 3 workers

This is to certify that Norwich Human Services (*print Business name)*

_____Is a Section 3 Business Concern (Please read, review, and implement necessary items in the document entitled "Section 3 Requirements")

__X__ Is **NOT** a Section 3 Business Concern but the contract for work will require my business or sub-contractor to hire, train, or educate a new employee. (Please read, review, and implement the necessary items in the document entitled "Section 3 Requirements")

_____Is **NOT** a Section 3 Business Concern and the contract for work will **NOT** require my business or sub-contractor to hire, train or educate a new employee. (No further action is necessary unless an employee is hired during the contract period)

Authorized Signer

3/15/2023
Date

Katherine Milde
Print Name