**EXHIBIT 1HSA**

**QUALIFIED SERVICE PROVIDER CAPACITY DETERMINATION**

**(Due through the online Application by April 23, 2021)**

The Applicant shall submit a completed Exhibit 1HSA - Qualified Service Provider Capacity Determination form and a complete copy of the qualified service provider’s most recent independent audit (fiscal year 2019 or later) through the online Application on April 23, 2021.

**Proposed LIHTC Project Information**

Project Developer:

Project Name:

Project Address:

Project City, State, Zip:

Project’s Targeted Homeless Population (if applicable):

**Qualified Service Provider (primary office address)**

Name:

Address:

City, State, Zip:

Contact Person:

Phone Number:

Email Address:

**Continuum of Care Information**

Name:

Contact Person:

Phone Number:

Email Address:

[ ]  Exhibit 2HSA Continuum of Care Review has been submitted to the appropriate contact.

*If the qualified service provider’s primary office address listed above is not within the MSA in which the proposed project will be located, provide the address of its local office:*

Address:

City, State, Zip:

Phone Number:

Provide a brief organizational history of the qualified service provider, including the agency’s mission statement, as it relates to supportive housing and services:

Type of Organization

[ ]  501(c)(3) Nonprofit

[ ]  Government entity

The qualified service provider shall have received a funding award since October 1, 2017, under one or more federal programs providing housing related services to families experiencing homelessness.

List the federal funds to assist families experiencing homelessness that the qualified service provider has been awarded since October 1, 2017:

|  |  |  |
| --- | --- | --- |
| Federal Program | Award Date | Award Amount |
|       |       |       |
|       |       |       |
|       |       |       |
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How many full-time equivalent staff members perform work specifically related to supportive housing services?

Number of qualified service provider’s total FTEs:

Number of FTEs officed within MSA where the Project will be located:

Include a complete copy of the qualified service provider’s most recent independent audit (fiscal year 2019 or later) with the Exhibit 1HSA submission through the online Application. Describe any findings noted on the audit and explain how the findings have been resolved:

List the total annual operating budget of the qualified service provider in the current fiscal year:

Describe the homeless and housing stability services the organization currently provides:

Answer the following questions as relates to the qualified service provider’s previous and current supportive housing and/or related service experience within the city in which the proposed Project will be located:

Describe experience providing case management to families experiencing homelessness:

Describe experience providing assistance to homeless households in obtaining mainstream benefits, increased income and/or employment assistance and training:

Describe experience providing financial management/budgeting services to homeless households:

Describe how the qualified service provider will maintain a sufficient number of eligible tenants for the proposed project over the long-term:

Describe any collaborations or partnerships that will address the needs of the set-aside unit tenants:

Explain how the qualified service provider will ensure requirements are met for Homeless Management Information System (HMIS) data collection, data entry, and reporting related to the Project:

I certify that I am duly authorized by this organization to submit this Exhibit on the organization’s behalf, and that to the best of my knowledge, all information in this Exhibit is accurate and complete. I acknowledge that submission of this Exhibit is not a guarantee of award. Further, I give permission to the Iowa Finance Authority (IFA) to perform due diligence, perform credit checks, contact the organization’s financial institutions and perform other related activities necessary for reasonable evaluation of this Exhibit. I understand that all information submitted relating to this Exhibit is a public record. I certify that all representations, warranties, or statements made or furnished in connection with this submission are true and correct in all material respects. I understand that it is a criminal violation under Iowa law to engage in deception and knowingly make, or cause to be made, directly or indirectly, a false statement in writing for the purpose of procuring assistance from a state agency or subdivision.

Name of Qualified Service Provider

Typed Name of Authorized Signatory

Authorized Signature

Title

Date