Please complete the information for each program providing housing dedicated for individuals and/or families who are homeless. Return the completed information and attachments to the Homeless Coalition by February 3, 2012 via email to edi@homelessofhc.org or fax (813) 223-6178. Definitions are included in the attached instructions. Do not hesitate to call 9813) 223-6115, or email Edi edi@homelessofhc.org or Rich rich@homelessofhc.org if you have any questions.

Organization and Program Information

Organizaion Name: ________________________________________________________________

Program Name: _________________________________________________________________

Program contact: ___________________________ Contact Phone: ________________________

Geo Code: (location of program or majority of sites)  □ Tampa (123012)  □ Hillsborough County (129057)

Target Population A: (Select one if program is designed to serve the target population and at least 75% of those served by the program fit the descriptor. Leave blank if program does not target specific populations.)

□ SM - Single Males                      □ SF - Single Females
□ SMF - Single Males and Females        □ CO - Couples only, no Children
□ HC - Households with Children
□ SMHC - Single Males and Households with Children
□ SFHC - Single Females and Households with Children
□ SMF+HC - Single Male and Female plus Households with Children
□ YM - Youth Males (under 18 years old)  □ YF - Youth Females (under 18 years old)
□ YMF - Youth Males and Females (under 18 years old)

Target Population B: (select one if program is designed to serve the target population and at least 75% of those served by the program fit the descriptor)

□ Domestic Violence  □ Veterans  □ Persons with HIV/AIDS

McKinney- Vento Funded:  □ No      □ Yes   If yes check one - □ SHP □ ESG □ S&C □ SRO

Bed and Unit Inventory Information – Year Round

Inventory Type: □ Current (available on or before 1/31/2011)
□ New (became available between 2/1/2011 and 1/31/2012)
□ Under Development (fully funded, not yet available)

Inventory Start Date: _________________ Inventory End Date: _________________

Program Type: □ Emergency Shelter - □ Facility Based □ Voucher □ Other
□ Transitional Housing □ Facility Based □ Voucher □ Other
□ Permanent Supportive Housing
□ Safe Haven
# Beds for HH w/ Children: ____________ Units for HH w/ Children: _________
# Beds for HH w/only Children: ________ Units for HH w/only Children: _______
# Beds for HH without Children: ________ Units for HH without Children: _______
# Chronic Beds (permanent housing only): __________
Total Year-Round Beds: ______________

HMIS for Beds HH w/ Children: __________ HMIS Beds for HH w/only Children: _______
HMIS Beds for HH without Children: ___________

Bed and Unit Inventory Information – Seasonal/Over Flow
Total Seasonal Beds: ______________ Seasonal Beds Available in HMIS: __________
Availability Start Date: ____________ Availability End Date: _____________
Overflow Beds: _______________

PIT Count «Next Record»
# Beds occupied by HH w/ Children: ________ #Units occupied by HH w/ Children: _______
# Beds occupied by HH w/only Children: _____ # Units occupied by HH w/only Children: _____
# Beds occupied by HH without Children: _____ # Beds occupied by HH without Children: _____

<table>
<thead>
<tr>
<th>Sub-populations served on 1/26/2012</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronically Homeless Individuals:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronically Homeless Families:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans:</td>
<td></td>
<td>True</td>
</tr>
<tr>
<td>Severely Mentally Ill:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Substance Abuse:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons with HIV/AIDS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victims of Domestic Violence:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unaccompanied Child (under 18):</td>
<td></td>
<td>True</td>
</tr>
</tbody>
</table>

Contact Person who can answer questions about the form: ____________________________________________

Contact Number: ___________________________________ email: ________________________________

I certify I am authorized to provide confirmation that the beds and units reported are available for occupancy as indicated and dedicated for homeless individuals and or families or, if under development, that these beds will be dedicated for homeless as indicated above. Attached is the eligibility criteria for this program and screening form used to assess homeless status.

_________________________________________ ________________________
Signature Date

_________________________________________
Print Name