KOVAR Home Loan Application Revised 05/2024

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|  | KOVAR APPLICATION FOR GROUP HOME LOAN |  |

1. Project Mortgagor (sponsor/borrower):

(Name of Organization)

(Address)

 , Virginia

(City/Town) (Zip Code)

(Contact Person) (Telephone)

(Alternate Person) (Telephone)

B. Mortgagor is: non-profit 501(c) (3) ; Governmental Agency

 (Yes/No) (Name)

(Please explain)

2. Community Service Board (CSB) providing support:

(Name)

(Address)

 , Virginia

(City/Town) (Zip Code)

(Contact Person) (Telephone)

(Alternate Person) (Telephone)

NOTE: If additional space is needed, use additional sheets showing number and paragraph of question.

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b. CSB will provide mortgagor with funds to support project mortgage and related

Housing expenses?

Yes No Other .

(explain)

If the answer to Question 2b is yes, CSB is to complete parts 12 and 13.

c. If this loan application is granted, will the facility operated on the property upon which the loan is made be open to all persons with intellectual disabilities without regard to race, color, gender, creed, or national origin?

Yes No Other .

(explain)

3. Project:

a.

(Property Location Address)

 Virginia

(City/Town/County) (Zip Code)

b. Site control by mortgagor corporation: (check only one)

[ ] owns property [ ] has option to buy

[ ] has a sales agreement [ ] has lease with option to buy

[ ] other .

(Explain)

(Options and agreements to purchase should have a life of at least 120 days with provision

to extend for an additional 30 days from date of application submission to KOVAR.)

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4. Development Method: (check only one)

a. [ ] Acquisition without rehabilitation Sales Price $ .

b. [ ] Acquisition with rehabilitation Sales Price $ .

 Estimated cost of rehabilitation $ .

Total $ .

c. [ ] Rehabilitation only Estimated cost $ .

d. [ ] New construction Land Sales Price $ .

Estimated construction cost $ .

Estimated “soft” costs (legal, architect, permits, etc.) $ .

Total

Devel. Costs $ .

5. Loan Requested:

Estimated value of completed project $ .

Loan amount requested $ .

(Maximum loan amount cannot exceed 75% of appraised value - maximum of $150,000 for a ten-year loan, maximum of $350,000 for a fifteen-year , or a maximum of $500,000 for a twenty-year loan (subject to change) - of project - actual loan amount will be determined by use of Virginia Housing Development Authority (VHDA) underwriting procedures.)

Show the amount (25% or more) of equity or down payment to be provided. $ .

Describe the source of equity funds (federal, state or local grants/loans or private donations in the form of cash or property) on an attached sheet.

6. Housing Type: (check only one)

a. [ ] Single family detached, number of bedrooms: .

b. [ ] Townhouse, number of bedrooms: .

c. [ ] Multi-family, number of apartments: .

d. [ ] Condominium units, number of units in complex: .

e. [ ] Congregate (living units with community dining room and kitchen):

number of bedrooms , and/or individual apartments

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7. Description of the residential service to be offered in the facility: (check only one):

a. [ ] Group home

b. [ ] Supervised apartment

8. Client Population to be Served:

a. Primary Disability Identification

[ ] Intellectual Disability

b. Age: (check all that apply)

 Children/Adolescents (0-18)

 Adults (19-64)

 Elderly (65+)

c. Sex:

 Female Male Both

d. Level of Disability:

Intellectual Disability

 Mild Severe

 Moderate Profound

e. Number of clients with intellectual disabilities: (enter figures in both spaces)

 Number of clients who will be served on an annual basis once the facility’s program is fully operational.

 Number of clients who will be served during the first fiscal year of operation (normally smaller than the first figure due to start-up/phase-in of the program).

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9. Description of Program of Services to be Offered Through the Residential Facility:

a. Static Capacity: (enter figures in both spaces)

 Number of beds for which the facility will be approved and staffed once it is fully operational.

 Number of beds available during the first fiscal year of operation (normally smaller than the first figure due to start-up/phase-in of the program).

b. Briefly describe the service model which will be used to deliver the type of residential Service

checked in item # 7, above. The description should explain how the particular service needs of the client population described in item # 8 will be addressed. (Please use additional sheets if

necessary).

c. Licensure: Will this facility be required to be licensed by the Virginia Department of Behavioral Health and Developmental Services (VDBHDS), or other governmental agency, in order to operate?

 Yes No

If yes, have you discussed the applicability/suitability of the facility with the

Licensure Office? Yes No

Name of Licensure Staff member contacted: .

Date of Contact: Telephone Number: .

d. Staffing: Complete the following table showing each of the direct service staff projected

to be employed in this facility (give job titles, not names):

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Position/Title | FTE | Sun | Mon | Tues | Wed | Thurs | Fri | Sat |
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e. Implementation: Enter projected schedule or status for all of the following items that apply.

 Application date plus number of weeks or estimated dates

 Zoning approval

 Consultation with VDBHDS Licensure Office

 Loan closing

 Health Department inspections completed

 Fire Marshall’s certificate

 Building inspection approval

 Occupancy certificate obtained

 Staff hired

 Clients screened

 Clients occupy facility

f. Project Manager Name:

(Address)

 , Virginia

(City/Town) (Zip Code)

(Contact Person) (Telephone)

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10. Project Operating Budget: Enter all applicable items in both columns for the budget of the program that will deliver services in the facility

First Year Annualized

FY Oper. Budget

FY

a. Revenues:

1. BH/ID/DD General Funds

2. Other .

3. TOTAL STATE FUNDS .

(1+2)

4. Local Gov’t Appropriations .

5. Other Local Match .

6. TOTAL LOCAL MATCHING FUNDS .

(4+5)

7. Direct Client Fees .

8. Parent Fees .

9. Insurance Fees/Medicaid .

10. Other Fees (Auxiliary Grants) .

11. TOTAL FEE REVENUES .

(7-10)

12. Gov’t Rent Subsidies .

13. Other Federal Funds .

14. TOTAL FEDERAL FUNDS .

(12+13)

15. TOTAL REVENUES .

(3+6+11+14)

b. Expenses:

1. Personnel Costs .

2. Staff Development Costs (training) .

3. Mortgage .

4. Property Taxes .

5. Utilities: Heat/Water/Electricity .

6. Telephone .

7. Facility Maintenance .

8. Facility Insurance .

9. Other: .

10. Equipment (other than furniture) .

11. Furniture/Furnishings .

12. Equipment Maintenance .

13. Facility Supplies .

14. Food/Drugs/Medical Supplies .

15. Transportation Equipment .

16. Transportation Services - Insurance .

17. Consultants .

18. Liability Insurance .

19. Other:

20. TOTAL EXPENSES .

(1-19)

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11. Chief Executive Officer of the Mortgagor Corporation:

Signature Title

Name (Typed) Date

12. Program Services:

a. Name of Program/Service in the CSB’s FY 20\_\_\_\_ Program Application/Performance Contract which contains the funds necessary to operate this project: .

b. Program/Service operated by: (check only one)

 This CSB directly

 CSB-established private, non-profit corporation (name: )

 Contract agency (name: )

If a contract agency, describe the nature of the contractual relationship (e.g. for the entire

program/service, for services for specific individuals, for purchases of identified beds or services:

c. List the other necessary services and the name of the programs(s) which will provide them:

Service Program

13. Certifications by the CSB regarding proposed project located at:

.

(address) (City/State/Zip Code)

a. I certify that funds are available in our budget to operate this project, and that other necessary

emergency, outpatient, day support, case management and transportation services will be available to residents of this project when the site becomes operational.

b. I further certify that, to the best of my knowledge, the mortgagor has the intent and ability to provide the services deemed necessary for the success of the project; that the proposed location and type of housing are suitable for the contemplated residents and that there exists a need in the area of housing for persons with intellectual disabilities; and that the development is economically feasible to the extent that it is projected to have or to receive funds in an amount

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sufficient to pay for debt service and all of the requisite services deemed necessary for the success of the project.

Name of CSB providing assurances and certifications:

Signature of Executive Director or Chairman Title

Name (Typed) Date

(Mortgagor)

Signature of Executive Director or Chairman Title

Name (Typed) Date