TN Department of Human Services

CSBG Community Needs Assessment (CNA) Amendment Request Form

COVER PAGE AND CERTIFICATION

Agency Name: _____ **Contract Fiscal Year:**_____

Primary Agency Contact Information:

Contact Name: _____ Title: _____
Phone _____ Email: _____

Secondary Agency Contact Information (could be a planner or program director):
Contact Name: _____ Title: _____
Phone _____ Email: _____

Was the Needs Assessment completed utilizing a subcontractor? Yes____No____

Date of Last Community Needs Assessment Completed: _____

Date of Current Strategic Plan Completion: _____ Strategic Plan Term: _____
(Term of 3 - 5 years)

Date of Last Community Action Plan Completed and/or Amended: _____

Certification of Community Needs Assessment

The undersigned hereby certifies that the needs assessment information submitted for CSBG Funding (Regular and Supplemental) is correct and has been authorized by the governing body of this organization. If not approved by the board, it will be presented to the board on _____ for approval and at that time this certification page will be re-submitted to the Department.

_____	_____	_____
Board Chair (printed name)	Board Chair (signature)	Date
_____	_____	_____
Executive Director (printed name)	Executive Director (signature)	Date

Submission Date: _____
Month/Day/Year

What services and strategies domains will be affected by the amended Community Needs Assessment? *(Mark all that apply)*

- ☐ **Employment** (EMP)
- ☐ **Education and Cognitive Development** (ED&CD)
- ☐ **Income, Infrastructure, and Asset Building** (II&AB)
- ☐ **Housing**
- ☐ **Health and Social/Behavioral Development** *including nutrition* (H&S/BD)
- ☐ **Civic Engagements and Community Involvement** (CE&CI)
- ☐ **Services Supporting Multiple Domains** (SSMD)
- ☐ **Linkages** *(e.g. partnerships that support multiple domains)*
- ☐ **Agency Capacity Building** (ACB)
- ☐ **Other** *(e.g., emergency management /disaster relief)*

Describe the area and individuals impacted by the identified need. Provide information and data (quantitative and qualitative) on the estimated number of persons and households impacted by this need and on the impact of the families and the community by city and county.

Types of information to include, but not be limited to, the following: city/cities, zip codes, description of the neighborhoods (e.g., primarily low-income, availability of public facilities and social service agencies, etc.), and demographic information on the households/individuals (e.g., income, racial make-up, indirect damage such as loss of job, education, housing etc.). Data and information gathered can include statistics, newspaper articles, news stories, surveys, interviews, data from 211 or other organization's data needs. Eligible entities will be required to maintain documentation for monitoring purposes. (Attach additional sheet, if needed)

Describe how the amendment will affect the needs of your community and how the perceived outcomes will be tracked to influence the transformation of the services provided.
(Attach additional sheet, if needed)

Describe any gaps in services related to the identified needs. Organize your answer in terms of the cities and counties impacted if the gaps and services differ.
(Attach additional sheet, if needed

Describe what outreach has been or will be done to identify potentially eligible households/individuals that are affected by the identified need. Discuss which entities (schools, government, non-profits, churches, etc.) will be contacted to do outreach and where outreach has or will occur. Organize your answer in terms of the cities and counties impacted.
(Attach additional sheet, if needed)

Describe the need for funds to assist persons impacted. Types of information include, but are not limited to:

a. **An estimate of how many households and/or individuals in need of assistance**
b. **The type of assistance these households need**

For State Office Use Only

Date Received: **Effective date:**

Action Taken: APPROVED ☐ **DENIED** ☐

Community Services Office Signature **Date**

Describe the plan to coordinate services and/or funding with other organizations/entities (e.g., churches, local governments, schools, non-profits, etc.) to assist the individuals impacted by the identified need. Also, describe any efforts that will be undertaken with coordinating partners to avoid duplication of services. Organize your answer in terms of the cities and counties impacted if they differ in coordination of services.
(Attach additional sheet, if necessary)

Describe how you plan to provide the proposed services through your current service delivery system or through partner organizations or subcontractors. Organize your answers in terms of the cities and counties impacted if they differ.
(Attach additional sheet, if necessary)

Please submit 30 days prior to your proposed effective date.

Signature: **Date:**

_____ _____
Executive Director

_____ _____
Program Manager

_____ _____
Fiscal Director

For State Office Use Only

Date Received: _____ **Effective date:** _____

Action Taken: APPROVED ☐ **DENIED** ☐

_____
Community Services Office Signature **Date**