City of Albany CARES ACT
Community Development Block Grant Program
Subrecipient Quarterly Report Form
CARES ACT Funded Activities

Community Development Dept.
P.O. Box 490
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(541) 917-7550
anne.catlin@cityofalbany.net
www.cityofalbany.net/cdbg

Agency Name:	Program Name:	
Agency Address:	Telephone:	Fax:
Contact Person (Name/Title):	E-mail Address:	
Report Period (check one or provide date range): ☐ July 1 – Sept 30 ☐ Oct 1 – Dec 31 ☐ Jan 1 – Mar 30 ☐ April 1 – June 30		Year:
Signature	Date:	

I. Activity/Program Status. Provide a summary of progress made on preventing, preparing for, or responding to impacts of COVID 19, addressing performance measures described in your application and CDBG contract, and any benefits gained from the program/activity.

If there is little or no progress to report, please explain:

a) the circumstances and challenges; and
b) outline plans, steps, and strategies to complete activity/address issues (attach additional pages or complete form in word).

II. COVID 19 Impact Data: Please report on the number of clients this quarter with the below COVID impacts:

____ Laid off/Hours reduced/can't find job ____ Essential worker childcare or other needs

____ Virtual work/school impacts ____ Virtual resources needed

____ Homeless ____ Unable to work/Caring for family due to COVID

____ Other _____

III. Number of unduplicated NEW clients this quarter: _____

Please report data about the **NEW UNDUPLICATED** people served THIS quarter in the following tables:

A. Income Status (% of Median Family Income "MFI")

	No.
Total Persons at or below 30% MFI	
Total Persons between 30%- 50% MFI	
Total Persons between 50%- 80% MFI	
Total Persons Assisted >80% MFI	

B. Race / Ethnicity of Persons Assisted

Race Categories	**Race Totals**	**Ethnicity: Hispanic or Latino***
American Indian/Alaska Native*		
American Indian/Alaska Native* and White		
American Indian/Alaska Native* and Black/African American		
Black or African American		
Black or African American and White		
Asian		
Asian and White		
Native Hawaiian/Other Pacific Islander		
White		
OTHER:		
Total Number of Persons Assisted		

***NOTE:** HUD does not consider Hispanic or Latino to be a race for reporting purposes; residents whose ancestors are from South America or Central America, are "American Indian or Alaska Native."

C. IF KNOWN:

	No.
Total Number of Unduplicated People Assisted	
Female Head of Household	
Homeless Individuals (including children, youth)	
Elderly persons (62+)	

IV. Feedback/Other: Please provide any additional comments or feedback you may have about the program or CDBG/CARES Act funding in general.

V. Please calculate CDBG funds spent this quarter and if applicable, amount of other funds spent to provide the activity. Then if applicable, explain how the agency avoided duplication of benefit/use of CDBG funds with other funds. (CDBG CARES funds cannot be used to reimburse for expenses already covered by other resources.)

Time Period for Report: _____

A. Total Costs to provide service: $ _____

B. Other funds spent this quarter: $ _____ Use of Funds: _____

C. Unmet need (Line A less Line B) $ _____

D. CDBG CARES Act Funds Spent: $ _____ Use of Funds: _____

CERTIFICATION: I Certify that the information provided above is an accurate and complete disclosure. I understand that to perjure myself to obtain assistance is a fraudulent offense for which I can be prosecuted and agree to repay any funds found to be a duplication of benefits. I understand and consent to verification of this information by the City or Department of Housing and Urban Development for compliance.

Name (written): _____ **Title:** _____