

Appropriations Project Request - Fiscal Year 2020-21

For projects meeting the Definition of House Rule 5.14

1. Title of Project: City of Green Cove Springs - Augusta Savage Social Services Complex
2. Date of Submission: 11/14/2019
3. House Member Sponsor: Bobby Payne
Members Copied:

4. DETAILS OF AMOUNT REQUESTED:

- a. Has funding been provided in a previous state budget for this activity? No
If answer to 4a is "No" skip 4b and 4c and proceed to 4d, Col. E
- b. What is the most recent fiscal year the project was funded?
- c. Were the funds provided in the most recent fiscal year subsequently vetoed?
- d. Complete the following Project Request Worksheet to develop your request:

| FY: | Input Prior Year Appropriation for this project for FY 2019-20 <i>(If appropriated in 2019-20 enter the appropriated amount, even if vetoed.)</i> | | | Develop New Funds Request for FY 2020-21 <i>(Requests for additional RECURRING funds are prohibited.)</i> | | |
|--------------------|---|-------------------------------|---|---|--|---|
| Column: | A | B | C | D | E | F |
| Funds Description: | Prior Year Recurring Funds | Prior Year Nonrecurring Funds | Total Funds Appropriated <i>(Recurring plus Nonrecurring: column A + column B)</i> | Recurring Base Budget <i>(Will equal non-vetoed amounts provided in Column A)</i> | Additional Nonrecurring Request | TOTAL Nonrecurring plus Recurring Base Funds <i>(Will equal the amount from the Recurring base in Column D plus the Additional Nonrecurring Request in Column E.)</i> |
| Input Amounts: | | | | | 350,000 | 350,000 |

5. Are funds for this issue requested in a state agency's Legislative Budget Request submitted for FY 2020-21? No
 - 5a. If yes, which state agency?
 - 5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? Department of Children and Families
 - 5c. Has the appropriate state agency for administering the funding, if the request were appropriated, been contacted? No
 - 5d. Describe penalties for failing to meet deliverables or performance measures which the agency should provide in its contract to administer the funding if appropriated.
Return funding, Increase Liquidated Damages

6. Requester:

- a. Name: Steve Kennedy
- b. Organization: City of Green Cove Springs
- c. Email: skennedy@greencovesprings.com
- d. Phone #: (904)297-7500

7. Contact for questions about specific technical or financial details about the project:

- a. Name: Steve Kennedy
- b. Organization: City of Green Cove Springs
- c. Email: skennedy@greencovesprings.com
- d. Phone #: (904)297-7500

8. Is there a registered lobbyist working to secure funding for this project?

- a. Name: Joe Mobley
- b. Firm: The Fiorentino Group
- c. Email: jmobley@thefiorentinogroup.com
- d. Phone #: (904)866-3122

9. Organization or Name of entity receiving funds:

- a. Name: City of Green Cove Springs
- b. County (County where funds are to be expended): Clay
- c. Service Area (Counties being served by the service(s) provided with funding): Clay, Putnam

10. What type of organization is the entity that will receive the funds? (Select one)

- For Profit
- Non Profit 501(c) (3)
- Non Profit 501(c) (4)
- Local Government
- University or College
- Other (Please describe)

11. What is the specific purpose or goal that will be achieved by the funds being requested?

Centralizing additional Social Services to provide for better services and availability for clients. We have received letters of interest from the Way Free Medical Clinic and Clay Behavioral Health Center.

12. Provide specific details on how funds will be spent. (Select all that apply)

| Spending Category | Description | Nonrecurring (Should equal 4d, Col. E) Enter "0" if request is zero for the category |
|--|---|---|
| Administrative Costs: | | |
| <input type="checkbox"/> a. Executive Director/Project Head Salary and Benefits | | |
| <input type="checkbox"/> b. Other Salary and Benefits | | |
| <input type="checkbox"/> c. Expense/Equipment/Travel/Supplies/Other | | |
| <input type="checkbox"/> d. Consultants/Contracted Services/Study | | |
| Operational Costs: | | |
| <input type="checkbox"/> e. Salaries and Benefits | | |
| <input type="checkbox"/> f. Expenses/Equipment/Travel/Supplies/Other | | |
| <input type="checkbox"/> g. Consultants/Contracted Services/Study | | |
| Fixed Capital Construction/Major Renovation: | | |
| <input checked="" type="checkbox"/> h. Construction/Renovation/Land/Planning Engineering | Rehab 5 old classroom spaces to be used for social service providers such as the Way Free Medical Clinic and/or Clay Behavioral Health Center, or any other such agency that would need space that would support the delivery of Social Services. | 350,000 |

| | | |
|-------|--|---------|
| TOTAL | | 350,000 |
|-------|--|---------|

13. For the Fixed Capital Costs requested with this issue (In Question 12, category “h. Fixed Capital Outlay” was selected), what type of ownership will the facility be under when complete? (Select one correct option)

For Profit

Non Profit 501(c) (3)

Non Profit 501(c) (4)

Local Government (e.g., police, fire or local government buildings, local roads, etc.)

State agency owned facility (For example: college or university facility, buildings for public schools, roads in the state transportation system, etc.)

Other (Please describe)

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

Letters of Support have been received from the Way Free Medical Clinic and the Clay Behavioral Health Center.

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

No

17. Will the requested funds be used directly for services to citizens?

Yes

17a. What are the activities and services that will be provided to meet the purpose of the funds?

Free medical care to uninsured, low income residents from Clay County through the Way Free Medical Clinic and then Substance Abuse and Mental Health Counseling directly from Clay behavioral Health Center as well as referrals for psychiatric evaluations, assistance with medication management, emergency support, domestic violence services, clothing and household support and childcare.

17b. Describe the direct services to be provided to the citizens by the funding requested.

Free medical care to uninsured, low income residents from Clay County through the Way Free Medical Clinic and then Substance Abuse and Mental Health Counseling directly from Clay behavioral Health Center as well as referrals for psychiatric evaluations, assistance with medication management, emergency support, domestic violence services, clothing and household support and childcare.

17c. Describe the target population to be served (i.e., "the majority of the funds requested will serve these target populations or groups.").

Select all that apply to the target population:

- Elderly persons
- Persons with poor mental health
- Persons with poor physical health
- Jobless persons
- Economically disadvantaged persons
- At-risk youth
- Homeless
- Developmentally disabled
- Physically disabled
- Drug users (in health services)
- Preschool students
- Grade school students
- High school students
- University/college students
- Currently or formerly incarcerated persons
- Drug offenders (in criminal Justice)
- Victims of crime
- General (The majority of the funds will benefit no specific group)
- Other (Please describe)

17d. How many in the target population are expected to be served?

- < 25
- 25-50
- 51-100
- 101-200
- 201-400
- 401-800
- >800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select each Benefit/Outcome that applies)

| Benefit or Outcome | Provide a specific measure of the benefit or outcome | Describe the method for measuring level of benefit |
|---|--|--|
| <input checked="" type="checkbox"/> Improve physical health | Provide critical counseling for those with mental health and substance abuse issues. | Track client progress resulting from treatment in compliance with HIPPA. |
| <input checked="" type="checkbox"/> Improve mental health | Provide critical counseling for those with mental health and substance abuse issues. | Track client progress resulting from treatment in compliance with HIPPA. |
| <input type="checkbox"/> Enrich cultural experience | | |
| <input type="checkbox"/> Improve agricultural production/promotion/education | | |
| <input type="checkbox"/> Improve quality of education | | |
| <input type="checkbox"/> Enhance/preserve/improve environmental or fish and wildlife quality | | |
| <input type="checkbox"/> Protect the general public from harm (environmental, criminal, etc.) | | |
| <input type="checkbox"/> Improve transportation conditions | | |
| <input type="checkbox"/> Increase or improve economic activity | | |
| <input type="checkbox"/> Increase tourism | | |
| <input type="checkbox"/> Create specific immediate job opportunities | | |
| <input checked="" type="checkbox"/> Enhance specific individual's economic self sufficiency | Provide food pantry access, clothing and household support, employment support services and educational services | Track client progress with limitations related to HIPPA. |

| | | |
|---|---|--|
| <input type="checkbox"/> Reduce recidivism | | |
| <input checked="" type="checkbox"/> Reduce substance abuse | Provide effective and affordable counseling to substance abusing clients through support and education. | Track client progress with limitations related to HIPPA. |
| <input type="checkbox"/> Divert from Criminal/Juvenile justice system | | |
| <input type="checkbox"/> Improve wastewater management | | |
| <input type="checkbox"/> Improve stormwater management | | |
| <input type="checkbox"/> Improve groundwater quality | | |
| <input type="checkbox"/> Improve drinking water quality | | |
| <input type="checkbox"/> Improve surface water quality | | |
| <input type="checkbox"/> Other (Please describe): | | |

19. Provide the total cost of the project for FY 2020-21 from all sources of funding (Enter "0" if amount is zero):

| Type of Funding | Amount | Percent of Total | Are the other sources of funds guaranteed in writing? |
|--|---------|------------------|---|
| 1. Amount Requested from the State in this Appropriations Project Request: | 350,000 | 100.0% | N/A |
| 2. Federal: | 0 | 0.0% | No |
| 3. State: (Excluding the requested Total Amount in #4d, Column F) | 0 | 0.0% | No |
| 4. Local: | 0 | 0.0% | No |
| 5. Other: | 0 | 0.0% | No |

| | | | |
|-------|---------|------|--|
| TOTAL | 350,000 | 100% | |
|-------|---------|------|--|

20. Is this a multi-year project requiring funding from the state for more than one year?

No