

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission:

- Preapplication
- Application
- Changed/Corrected Application

*2. Type of Application

- New
- Continuation
- Revision

* If Revision, select appropriate letter(s)

*Other (Specify)

3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Mississippi Development Authority

*b. Employer/Taxpayer Identification Number (EIN/TIN):
64-6000736

*c. Organizational DUNS:
809399686

d. Address:

*Street 1: Post Office Box 849
Street 2: _____
*City: Jackson
County: Hinds
*State: Mississippi
Province: _____
*Country: United States
*Zip / Postal Code: 39205-0849

e. Organizational Unit:

Department Name:

Division Name:

Community Services

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Mr. *First Name: Steven
Middle Name: C.
*Last Name: Hardin
Suffix: _____

Title: Division Director

Organizational Affiliation:

*Telephone Number: 601-359-3179

Fax Number: 601-359-3108

*Email: shardin@mississippi.org

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***9. Type of Applicant 1: Select Applicant Type:**

A.State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (Specify)

***10 Name of Federal Agency:**

U.S. Department of Housing and Urban Development

11. Catalog of Federal Domestic Assistance Number:

14.257

CFDA Title:

Homelessness Prevention and Rapid Re-Housing (HPRP)

***12 Funding Opportunity Number:**

*Title:

XII of Division A of the American Recovery and Reinvestment Act of 2009 (Recovery Act)

13. Competition Identification Number:

N/A

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

This funds will be made available across the state. All eighty-two counties will be covered by the three Continuum of Care Coalitions.

***15. Descriptive Title of Applicant's Project:**

To provide HPRP funds to eligible program participants through the Continuum of Care Coalitions across the state to include financial assistance, housing relocation/stabilization services, data collection/evaluation, and administrative costs.

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16. Congressional Districts Of:

*a. Applicant: State of Mississippi

*b. Program/Project: All

17. Proposed Project:

*a. Start Date: September 2009

*b. End Date: September 2012

18. Estimated Funding (\$):

*a. Federal	_____	\$13,348,427
*b. Applicant	_____	
*c. State	_____	
*d. Local	_____	
*e. Other	_____	
*f. Program Income	_____	
*g. TOTAL	_____	\$13,348,427

***19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

- a. This application was made available to the State under the Executive Order 12372 Process for review on 4/30/09
- b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- c. Program is not covered by E. O. 12372

***20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

- Yes No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U. S. Code, Title 218, Section 1001)

** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions

Authorized Representative:

Prefix: Mr. *First Name: Joseph

Middle Name: P.

*Last Name: Deason

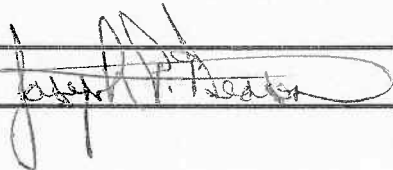
Suffix: _____

*Title: Deputy Director, Chief Financial Officer

*Telephone Number: 601-359-3449

Fax Number: 601-359-3108

* Email: jdeason@mississippi.org

*Signature of Authorized Representative: 

*Date Signed:

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***Applicant Federal Debt Delinquency Explanation**

The following should contain an explanation if the Applicant organization is delinquent of any Federal Debt.

N/A