

For Calendar Year Ending 12/31/2020

**NEW JERSEY HOUSING AND MORTGAGE FINANCE AGENCY
LOW INCOME HOUSING TAX CREDIT**

ANNUAL PROJECT CERTIFICATION

for

Projects in the Supportive Housing Cycle or with Set-Aside Special Needs Units

This property, in receiving its allocation of low income tax credits, was selected in part due to the commitment on the part of the owner to provide services to special needs residents living in this property. As part of NJHMFA monitoring, we are requesting the owner to complete and submit the following information:

LITC #: _____

Project Name: _____

Project Address: _____

Credit Year: _____ Special Needs Population: _____

Number of Set-Aside units: _____

Attach the following information:

a. Job description for onsite service coordinator

b. Name of organization that provides service coordination

b. Number of hours per week on-site service coordinator works

c. Monthly newsletters/calendar of events (please include at least 3 monthly newsletters/calendars)

Check the following services being provided to the residents:

- | | |
|---|--|
| <input type="checkbox"/> After School Programs | <input type="checkbox"/> Adult Day Care |
| <input type="checkbox"/> Health Promotion Programs | <input type="checkbox"/> Health Care Services/Treatment, Follow-Up |
| <input type="checkbox"/> Job Training | <input type="checkbox"/> Personal Care/Housekeeping |
| <input type="checkbox"/> Meals Program | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Financial Management Training/Counseling | |
| <input type="checkbox"/> Crisis Intervention (24 hours/7 days) | Onsite/offsite education Other (specify): |
| <input type="checkbox"/> | _____ |

For each of the services being provided to the residents, attach the following information and include any supporting documentation such as flyers and sign-sheets:

a. Name of onsite service coordinator

b. Name of organization that provides this service

c. Cost of the service and who pays for service (tenant-paid, free of charge, etc.)

d. Frequency of the service being provided

e. Number of residents that are served at the frequency of service being provided (monthly, quarterly, etc.)

NOTE: We understand that the COVID-19 pandemic has had an impact on the provision of services and programs for residents. We are requesting that you provide evidence of outreach to residents, including case management, wellness checks, virtual programming and implementation of food delivery services, in addition to any services that you were able to provide to meet the social services requirements.

Please be aware that all information provided is required for NJHMFA LIHTC monitoring and is strictly confidential. Copies of contracts with Social Service Providers must be maintained along with other project records and must be furnished upon request by NJHMFA. During the on-site visit, NJHMFA personnel may wish to review files in regard to services and speak to various participants regarding the special needs components of the project.

NOTE: Failure to comply with the special needs requirements of the application is grounds for a determination of noncompliance.

Owner's Signature: _____ Date: _____

Print Name and Title _____

