Arvin CARES

CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY (CARES) ACT SMALL BUSINESS RELIEF STABILIZATION PROGRAM GUIDELINES & APPLICATION

Funding is limited. Awards will be on a first-come, first-eligible basis

PROGRAM GUIDELINES

Summary Coronavirus Aid, Relief, and Economic Security (CARES) Act is a federally funded program under section 601(a) of the Social Security Act. City CARES funds may be used to secure economic opportunities for low-and moderate-income persons. CARES funds are targeted to business of the City that have the highest adverse impact as a result of the Coronavirus.

Purpose

The Arvin Small Business Stabilization Program (SBSP) is designed to promote economic stability by providing immediate relief in the form of a one-time forgivable loan for essential operating expenses to Arvin small businesses negatively impacted by COVID-19.

The goals of this program are:

1. **Help small businesses survive the COVID-19 crisis.**
2. **Retain employment and continue to pay employees.**
3. **Maintain the provision of goods and services for Arvin residents.**

Funding

The maximum CARES award will be $25,000 upon approval and in compliance with CARES criteria.

Eligibility

A business must meet **ALL** of the following criteria to be eligible to apply:

- Must be a private, for profit business. *Independent Contractors are not eligible for this

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program.

- Business and/or any owner may not be suspended, debarred, proposed for debarment, declared ineligible, or voluntarily excluded from participation in federal transactions.
- Businesses must have less than 20 FTE (full-time equivalent employees.)
- The business must have a physical storefront establishment within Arvin's city limits.
- Businesses must have a current Arvin business license.
- The business must have experienced a negative impact due to COVID-19, by certifying that the business has experienced at least a 25% reduction in revenue since March 1, 2020 and that grant proceeds will be used for allowable expenses under the Federal CARES Act guidelines Applicant business cannot have any unremedied City Code violations.
- No national chains. National chains are defined as franchises/for-profit corporations; **except in the case where the franchisee or brand has a Arvin-based owner**.
- Operating **as a business since January 2020**.
- Business may **NOT** be delinquent in State and/or Federal licensing and filings.

If CARES funds are awarded to a business, the business must meet the following requirement:

- Business will create/retain at least **one full-time or full-time equivalent (40 hours/week) low or moderate-income permanent job (LMI Job) within 12 months.** Moderate-income means less than or equal to 80% of the Area Median Income (AMI). See Section 4 of the application for income and details on how to meet the HUD National Objective for jobs.
- If business is retaining LMI job(s) – business must demonstrate clear objective evidence that permanent LMI job(s) would be lost without CARES assistance.

Terms Loan will be forgiven over a one-year period as the business meets the required LMI job creation/retention requirement as outlined in the written agreement.

Eligible Uses (CARES funds can be used for):
Rent
Mortgage
Utilities
Payroll
Other operating expenses

Ineligible Uses (CARES funds cannot be used for):
Loan Payments to Small Business Assoc. (SBA)
Governmental Uses or Expenses
Political Activities
Personal Property
Savings

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Application Process
Applicants must complete and submit a funding application to Self-Help Enterprises (SHE). Applications will be reviewed on a first-come, first-eligible served basis. All required supporting documentation **MUST** be submitted with completed application in order to be considered for CARES funding.

Applicants will be notified of their application's approval or rejection and funding amount, by Self-Help Enterprises staff. Amount of funding awarded to a business will be based on need. Once program funding is exhausted, other qualified applicants will be placed on a waiting list if/when additional funds become available.

Review Process
The following priorities will be considered when awarding funds:

- The business provides jobs to low-income individuals.
- The number of jobs that the business sustains during a normal business cycle (pre COVID-19 levels).
- The business demonstrates that it has lost a significant share (50% or more) of revenue due to the COVID-19 pandemic.
- The business demonstrates a strong chance of remaining open post COVID-19.
- The business has operated consistently for two years.
- Priority will be given to businesses located within low/moderate census tracts as defined by HUD.
- All eligibility criteria has been met.

****REQUIRED DOCUMENTS****

You will not be able to leave and return to your application. Ensure you have the following documents ready to upload before begining this form:

(1) Business License
(2) Proof of Insurance
(3) Financial Statement that includes (a) Income Statement, (b) Balance Sheet, (c) Statement of Cash Flows
(4) Current signed IRS Tax Return

You will also need the followng information to fill out the form:
DUNS number, and Tax ID/EIN

Guidelines and Application are available at: www.selfhelpenterprises.org
Complete applications should be submitted to:

Self-Help Enterprises
CovidRelief@selfhelpenterprises.org
P.O. Box 6520, Visalia, CA 93291
559-802-16XX

Questions should be directed to: XXX, Project Technician, (559) 802-16XX

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CARES Act
Small Business Stabilization Loan Application

1. BUSINESS INFORMATION

Business Name:_____

Business Owner Full Name:_____

Business Address:_____

City/ State/ Zip:_____

Business Owner Address:_____

City/ State/ Zip:_____

Business Phone:_____ Email Address:_____

Website:_____ Contact Phone:_____

Type of Business (please list usual activities):_____

Are you an Independent Contractor? ☐**Yes** ☐ **No**

Does the business own or lease the building it occupies? ☐**Yes** ☐ **No**

Was your business forced to shut down due to COVID-19? ☐**Yes** ☐ **No**

Is the business veteran owned? ☐**Yes** ☐ **No**

Is the business minority owned? ☐**Yes** ☐ **No**

Is the business women owned? ☐**Yes** ☐ **No**

Business License#_____ Start Date:_____

Tax ID#/EIN #_____ DUNS#:_____

The DUNS# is required for all federally funded programs. Obtaining a DUNS number is free. *Obtain one by calling* ***1-866-705-5711*** *or by applying online at http://fedgov.dnb.com/webform.* If awarded funds, you must also register your business with SAM.GOV. This is a free service. Please create a user login and follow the steps to register the business with SAM.GOV. **Registration is required.**

FUNDING REQUEST:$_____ (The maximum is $25,000)

Grant requests may not be fully funded due to availability and/or the approved grant expenses.)

How did you hear about this program:_____

_____

Organizational Structure (check one):

☐Sole Proprietorship ☐Corporation

☐General Partnership ☐Limited Liability Company (LLC)

☐Limited Partnership (LP) ☐Limited Liability Partnership (LLP)

☐Other:

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2. ESTIMATED ADVERSE ECONOMIC IMPACT (Pre February 1, 2020 and Post February 1, 2020):

a. How has your business been impacted by COVI D-19? (Example: Sales decline in dollars, walk in traffic, etc.)

b. Describe what adverse economic effects COVID-19 has had on your business to date.

c. What is your recovery plan?

d. Is the owner of the business also an employee of the business?

e. How many full-time (FT) and part-time (PT) employees did you employ prior to COVID-19? (Pre-February 1, 2020). Owner included if an employee of the business.

f. How many full-time (FT) and part-time (PT) employees do you currently employ? How has this number changed? (Post February 1, 2020) Owner included if an employee of the business.

g. Proposed number of full-t ime (FT) and part-time (PT) positions that will be created or retained with CARES funds. FT ____ PT____ (include the owner if an employee of the business)

h. Will you be ☐ retaining or ☐ creating a Full Time equivalent (FTE) job with these loan funds? (Full time equivalent job is any one employee working 40 hours or multiple employees working a total of 40 hours - the owner can be included in this number if he/she is an employee of the business)

1. Job title(s):_____
2. List special skills or education required for each position._____
3. Expected time needed to hire (number of days following receipt of funds):_____
4. Hourly Rate:_____
5. Average hours per week per employee:_____
6. How/where will the position be advertised? _____
7. Is this position held by the owner? ☐Yes ☐No
8. Notes you would like to provide for consideration._____

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3. FINANCIAL INFORMATION

a. Please list the operating expenses that the CARES award would pay for and attach verification of costs/expenses, include a description and amount (such as lease, utilities, payroII etc.)

b. Please list other sources of funding for business expenses; including revenues, personal funds, grants and loans applied for and/or received. Include funding source and amount within the year.

c. Have you applied for any other relief funding? If so, what and when?

d. Have you received notification that you are eligible for relief funding? If so, what?

e. Have you received any other relief funding? If so, how much?

4. MEETING THE JOBS REQUIREMENTS

All CARES-funded activities must create or retain **Low or Moderate Income (LMI) Jobs** - jobs that are held by or made available to low and moderate- income (LMI) persons. HUD defines LMI person whose earnings are less than 80% of the area median income by family household size. ***See Income Limit Chart at bottom of this page.***

The applicant must satisfy the following LMI job objectives of the CARES program:

Low or Moderate Income (LMI) Job - The business must **create or retain** permanent jobs, at least 51 percent of which (computed on a full-time equivalent basis) will be made available to or held be LIM person.

The following requirements must be met for jobs to be considered created or retained.

1. If a Business ***creates jobs,*** there must be documentation (Employee Certification Form) indicating that at least 51 percent of the jobs will be held by or made available to, LMI persons.

2. If a Business ***retains jobs,*** there must be sufficient information documenting that the jobs would have been lost without the CARES assistance and that one or both of the following applies to at least 51 percent of the jobs:
    - The owner of the business is a LMI person (Employee Certification Form Required at award); or
    - The job is held by a LMI person (Employee Certification Form);or
    - The job can reasonably be expected to turn over within the following two years and steps will be taken to ensure that the job will be filled by or made available to a LMI person.

The following requirements apply for jobs to be considered ***available*** to or held by LMI persons.

1. Created or retained jobs are only considered ***available*** to LMI persons when:
    - Special skill that can only be acquired with substantial training or work experience or education beyond high school are not a prerequisite to fill such jobs, or the business agrees to hire unqualified persons and provide training; and
    - The grantee and the assisted business take action to ensure that LMI persons receive first consideration for filling such jobs.

Income Limit Chart:

HUD 80% AMI limits, per household size, for Kern County, California			
1 person≤ $39,150	2 person≤ $44,750	3 person≤ $50,350	4 person≤ $55,900
5 person≤ $60,400	6 person≤ $64,850	7 person≤ $69,350	8 person≤ $73,800

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5. DISCLOSURE ASSURANCES AND SIGNATURES

Applicant agrees that the acceptance of this application does not commit the City to enter into an agreement, to pay any costs incurred in its preparation, to participate in subsequent negotiations, or to contract for the project. Further, the acceptance of this application does not constitute an agreement by the City that any contract will be entered into by the City. The City expressly reserves the right to reject any or all applications or to request more information from the applicant.

The applicant also agrees that the City will only consider funding for an application that has been completed in full, met all eligibility requirements and has attached all supporting documentation. Applicant hereby certifies that all information contained in this document and any attachments is true and correct to the best of the applicant's knowledge.

The City, the Comptroller General of the United States, or any duly authorized representatives, will have access to any books, documents, papers and records that are directly related to the program assistance for the purposes of monitoring, making audits, examination, excerpts, and transcripts. All records supporting the costs will be maintained for a period not less than 5 years following completion of the program agreement period, agreement termination, or default, whichever shall first occur.

No person who is an employee, agent, consultant, officer, appointed official, or elected official of the City of Arvin who exercises or has exercised any functions or responsibilities with respect to CARES activities, or is in a position to participate in a decision-making process, or gain inside information with regard to such activities, may obtain a personal or financial interest or benefit, or have interest in any program assistance, either for themselves or those with whom they have family or business ties, during their tenure or for one year thereafter.

Hiring or retaining a LMI job is a condition of receiving CARES funding and must be created/retained prior to award of funds. Recipient of funds will be required to report monthly for a one-year period after the job creation/retention has occurred. The Written Agreement will further outline CARES requirements during the one-year period. A recipient will be required to repay CARES funds if LMI job creation/retention is not fulfilled within the one-year period.

I UNDERSTAND AND BY SIGNING, AGREE:

All information I have provided in this application is true and correct to the best of my knowledge. I agree to notify you promptly in writing upon any material change in the information provided herein. You are authorized to make such inquiries, as you deem necessary and appropriate to verify the accuracy of this application.

I also agree to comply with nondiscriminatory employment practices and Affirmative Action Programs under Title VI and Section 112 of the Civil Rights Act of 1964 and applicable provisions of federal statutes and regulations concerning equal employment opportunity laws and civil rights laws, and the provisions of the Americans with Disabilities Act. Grant recipients must give equal consideration to all qualified job applicants and treatment of employees without regard to race, color, religion, sex (including pregnancy, gender identity and sexual orientation) national origin, age (40 or older), disability.

Signature · Business Owner	Date
Signature -Business Owner	Date

DUPLICATION OF BENEFITS AFFIDAVIT

INSTRUCTIONS

The affidavit is divided into four (4) components:

1. Assistance received from other disaster recovery business assistance programs being administered by the grantee;
2. Insurance assistance received for disaster related losses; and,
3. Government, bank and any and all other funding received by a business for disaster related losses.
4. Attachments;
5. Signature(s)

Read each component in full and provide the accurate information.

Part 1. Other Small Business Program Assistance Duplication of Benefits Affidavit

This affidavit must be completed by all businesses that have applied for and/or received any assistance from the CARES funded Small Businesses Assistance Programs being offered by [*insert administrative entity*]. The information within this affidavit will provide the [*insert administrative entity*] with vital information for processing the application required by the Stafford Act Section 312 on Duplication of Benefits.

Indicate with an "X" the program(s) for which your business is applying AND any program your business has previously received funds from.

☐ [insert name of other Small Business Program being implemented]

☐ [insert name of other Small Business Program being implemented]

☐ [insert name of other Small Business Program being implemented]

☐ [insert name of other Small Business Program being implemented]

Part 2. Insurance Duplication of Benefits Affidavit

Insurance company information must be completed even if the Company named herein did not receive insurance monies as compensation for the [*insert name of disaster event*]. If there was insurance on the damaged property, the name of the insurance company, policy number, claim number, and settled amount, if any, must be completed. Copies of the insurance policies in place at the time of disaster, and any correspondence with the insurance companies on or after [*insert date of disaster event*] must be attached to this affidavit.

This section must be signed in front of a notary public.

Before me, the undersigned authority, on this day personally appeared to the person named below, who, being by me duly sworn under penalty of perjury and penalty of violation of Federal and State laws applicable to [*insert name of company*]'s application for and receipt of a grant or forgivable loan under the [*insert name of program company applying* for] made the following statements and swore that they were true:

1. I hereby state that I am the owner of [*insert name of company*] (the "Applicant") and am duly authorized by the Applicant to make the certifications contained in this Affidavit on behalf of the Applicant.

2. I hereby state and certify to the United States Department of Housing and Urban Development and to [*insert name of administering* entity] as follows (please check one blank):

☐ On any date on or after [*insert date of disaster event*], property, flood, and/or wind, economic injury, business interruption or any other kind of insurance **WAS** carried and in force for [*insert name of company*].

☐ On any date on or after [*insert date of disaster event*], **NO** property, flood, and/or wind, economic injury, business interruption or any other kind of insurance was carried and in force for [*insert name of company*]. If insurance was carried by [*insert name of company*], fill in the information requested below using the insurance

information in effect at the time of damage to the Property due to [*insert name of disaster event*], on or after [*insert date of disaster event*].
Please provide information regarding any such insurance policies and information regarding claims filed and paid, if any, in the designated spaces below. If no claim was filed under an insurance policy listed below, fill in the applicable blank with "None."

Insurance Company Name	
Policy Number	
Type of Insurance	
Claim Number	
Settled Amount	

Insurance Company Name	
Policy Number	
Type of Insurance	
Claim Number	
Settled Amount	

Insurance Company Name	
Policy Number	
Type of Insurance	
Claim Number	
Settled Amount	

Insurance Company Name	
Policy Number	
Type of Insurance	
Claim Number	
Settled Amount	

Part 3. Government, Bank and Other Funding Sources Duplication of Benefits Affidavit

This section identifies any sources of funds that the business has received as a result of the [*insert name of disaster event*] other than insurance. Sources of funds include but are not limited to: Federal, state and local loan/grant programs, private or bank loans, nonprofit donations or loans. Please indicate below the amount allocated to your business from any and all funding sources not.

Source of Funds #1

Lender/Grant Provider Name		
Purpose		
Amount		
☐ **Government Loan**	☐ **Government Grant**	☐ **Government Forgivable Loan**
☐ **Nonprofit Grant**	☐ **Nonprofit Loan**	☐ **Nonprofit Forgivable Loan**
☐ **Private Loan**	☐ **Other:**_____	

Source of Funds #2

Lender/Grant Provider Name		
Purpose		
Amount		
☐ **Government Loan**	☐ **Government Grant**	☐ **Government Forgivable Loan**
☐ **Nonprofit Grant**	☐ **Nonprofit Loan**	☐ **Nonprofit Forgivable Loan**
☐ **Private Loan**	☐ **Other:**_____	

Source of Funds #3

Lender/Grant Provider Name		
Purpose		
Amount		
☐ **Government Loan**	☐ **Government Grant**	☐ **Government Forgivable Loan**
☐ **Nonprofit Grant**	☐ **Nonprofit Loan**	☐ **Nonprofit Forgivable Loan**
☐ **Private Loan**	☐ **Other:**_____	

Source of Funds #4

Lender/Grant Provider Name		
Purpose		
Amount		
☐ **Government Loan**	☐ **Government Grant**	☐ **Government Forgivable Loan**
☐ **Nonprofit Grant**	☐ **Nonprofit Loan**	☐ **Nonprofit Forgivable Loan**
☐ **Private Loan**	☐ **Other:**_____	

Part 4. Attachments

Attached to this Affidavit are copies of the following:

1. Each insurance policy in force on or after [*insert date of disaster event*]
2. All correspondence relating to the insurance policies described in (1) of this sentence, including correspondence regarding any claims filed under such insurance policies. No other correspondence with respect to any such insurance policies and/or claims has been received by me as of the date of this Affidavit.
2. Acceptable Documentation for each of the sources of funds acquired as a result of the [*insert date of disaster event*] disaster(s).

Part 5. Signature(s)

By executing this Insurance Affidavit, Applicant(s) acknowledge and understand that Title 18 United States Code Section 1001: (1) makes it a violation of federal law for a person to knowingly and willfully (a) falsify, conceal, or cover up a material fact; (b) make any materially false, fictitious, or fraudulent statement or representation; OR (c) make or use any false writing or document knowing it contains a materially false, fictitious, or fraudulent statement or representation, to any branch of the United States Government; and (2) requires a fine, imprisonment for not more than five (5) years, or both, which may be ruled a felony, for any violation of such Section.

Dated this the _____ day of _____, 20XX.

_____ _____

Applicant (Affiant) Signature Print Applicant name (Affiant)

_____ _____

Joint Applicant (Affiant) Signature Print Joint Applicant name (Affiant)

SUBSCRIBED AND SWORN TO before me, by the above-named Affiant(s) this, the _____day of _____, 20XX, to certify which witness my hand and official seal.

_____

NOTARY PUBLIC

My Commission Expires:_____

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