

**FORM CGFA-191**

**FEDERAL AID INFORMATION (SURVEY) FY 20**

<b>1. Agency:</b> (Division(s) Receiving/Administering Funds)  <b>2. Program Title:</b>	<b>3. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER (CFDA #)</b>  <p align="center">-</p>	<p align="right"><b>(CGFA INTERNAL USE ONLY)</b></p>												
<b>4. Federal Granting Agency:</b>	<b>5. Agency Division and Number</b>  <p align="center">-</p>													
<b>6. Type of Program:</b> Formula Grant      Project Grant      Contract  Other (Specify): _____	<b>7. Type of Payment Mechanism:</b> "Draw Down" as required      Regular Installment  Reimbursement-portion of expenditures      Lump sum in advance Other (Specify): _____													
<b>8. Federal funds are deposited in the following State Treasury Fund(s) (*)</b>  Treasury Fund No. _____ Treasury Fund Name _____  Treasury Fund No. _____ Treasury Fund Name _____														
<b>9. Were funds Appropriated by the General Assembly?</b> FY 2019    Yes    No FY 2020    Yes    No	<b>10. Under what authority does your Agency receive and expend these funds?</b>  ILCS: Chapter _____ Section _____													
<b>11. Matching Requirements:</b> State Match Required?    Yes    No      State Match Required to be:    Cash    In Kind      If Yes, specify: <table border="1" style="float: right; margin-left: 20px;"> <tr> <td></td> <td align="center">FY 2019 %</td> <td align="center">FY 2020 %</td> </tr> <tr> <td>Federal %</td> <td></td> <td></td> </tr> <tr> <td>State %</td> <td></td> <td></td> </tr> <tr> <td>Local %</td> <td></td> <td></td> </tr> </table> Source of State Match: Treasury Fund No. _____ Treasury Fund Name _____  If no Local Match is indicated, does the program allow use of Local funds in lieu of State Match?    Yes    No				FY 2019 %	FY 2020 %	Federal %			State %			Local %		
	FY 2019 %	FY 2020 %												
Federal %														
State %														
Local %														
<b>12. Indirect Costs:</b> Is your agency operating under a federally approved indirect costs reimbursement plan?    Yes    No  If Yes, will the reimbursement amount be set by:    an indirect cost rate?    a cost allocation plan?    a negotiated lump sum for overhead costs?  Estimated indirect costs to be recovered from the federal government:    FY 2019 \$ _____    FY 2020 \$ _____														
<b>13. Source of Funds:</b> Direct from the federal government (Appendix B*) Indirect: through an intermediary (Appendix C*) (Specify Agency): _____														
<b>14. What would be the total cost to the State if federal funds available under this program were discontinued and the State assumed full financial responsibility?</b>  FY 2019 \$ _____    FY 2020 \$ _____														
<b>15. Are some of these funds subgranted to other state agencies?</b> Yes    No If YES, list probable state agency and amounts: <table border="1" style="width: 100%; margin-top: 5px;"> <thead> <tr> <th align="center">Agency</th> <th align="center">Amount</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>\$ _____</td> </tr> <tr> <td>2. _____</td> <td>\$ _____</td> </tr> <tr> <td>3. _____</td> <td>\$ _____</td> </tr> <tr> <td>4. _____</td> <td>\$ _____</td> </tr> </tbody> </table>	Agency	Amount	1. _____	\$ _____	2. _____	\$ _____	3. _____	\$ _____	4. _____	\$ _____	<b>17. Planning and Reporting Requirements:</b>  Does the granting agency require planning document?    Yes    No  Does the granting agency require other reports?    Yes    No    If YES, complete items below: A. Evaluation Report    Annual    Quarterly    Monthly    Other  B. Financial Report    Annual    Quarterly    Monthly    Other  C. Performance Report    Annual    Quarterly    Monthly    Other  D. Other (please specify) _____			
Agency	Amount													
1. _____	\$ _____													
2. _____	\$ _____													
3. _____	\$ _____													
4. _____	\$ _____													
<b>16. Are some of these funds subgranted to local governments?</b>  Yes    No														

<b>PROGRAM FISCAL INFORMATION</b>		<small>(IN THOUSANDS OF DOLLARS)</small>	
	<b>FY 2019</b> <small>(Actual)</small>	<b>FY 2020</b> <small>(Estimated)</small>	
<b>18. Formula Allocation:</b>			
Amount of funds legally available from allocation. (Enter NA if not a formula grant.)			
<b>19. Available Awards: (*)</b>			
<b>A. Amount of federal funds awarded (*)</b>			
<b>B. Amount of federal funds carried over from previous years.</b>			
<b>C. TOTAL federal funds available for expenditure (A+B).</b>			
<b>D. Amount of STATE funds awarded.</b>			
<b>E. Amount of LOCAL funds awarded.</b>			
<b>F. Amount of OTHER funds awarded.</b>			
<b>G. TOTAL funds available for expenditure (C+D+E+F).</b>			

**PROGRAM INFORMATION (\*)**  
 Please provide information on the State programs and services provided with these funds. For example, the Preventive Health Services Block Grant supports programs for hypertension, rape crisis centers, and grants to local health agencies. The area served might be "statewide" or a particular target area such as "city" or "county." Also provide an estimate of the number of persons/clients served by each program.

<b>20. State Program Name (*) additional data can be submitted on a separate page if needed</b>	<b># of Persons Served (*)</b>	<b>Area Served (*)</b>
1. _____		
2. _____		

**21. Survey completed by: Single Point of Contact for your agency**    Yes    No

Name/Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/E-mail Address: \_\_\_\_\_