

City of Providence, Rhode Island – Public Service Quarterly Beneficiary Report (Yr 38 2012-2013)

Agency	Program		
Address	Telephone	FAX	Email
Contact Person	Reporting Period		

Program Annual Goal Statement, per Grant Contract:

Client Data on Race and Ethnicity for Statistical Purposes, Program Administrative Reporting or Civil Rights Compliance Reporting

Note: Identify the **ETHNICITY AND RACE** of each client. Each client is identified ethnically as either Hispanic or Not Hispanic, PLUS as either one race or multi-race.

COLLECT DATA FOR ALL CATEGORIES		ETHNIC DATA	TOTAL BENEFICIARIES	For Clients Declaring One Race						For Clients Declaring Multi-Race				Sex		Age				Income(HUD Approved)			Other Data	
				WHITE	BLACK/AFRICAN AMERICAN	ASIAN	AMERICAN INDIAN/ALASKAN NATIVE	NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER	BLACK/AFRICAN AMERICAN & WHITE	ASIAN & WHITE	AMERICAN INDIAN/ALASKAN NATIVE & WHITE	AMERICAN INDIAN/ALASKAN NATIVE & BLACK/AFRICAN AMERICAN	OTHER MULTI-RACIAL	FEMALE	MALE	UNDER 18 YEARS	18-40 YEARS	41-60 YEARS	OVER 60 YEARS	VERY LOW	LOW	MODERATE	HANDICAPPED	FEMALE HEAD OF HOUSEHOLD
Current Client Starting Balance	NOT HISPANIC OR LATINO																							
	HISPANIC OR LATINO																							

The data in the above columns is entered one time only at the beginning of the fiscal year. The information represents clients that are unduplicated. Below, the client data will be reported quarterly and due on the 15th of October, January, April and July. The numbers should reflect only the programs that are sponsored by CDBG dollars.

New Clients During Reporting Period	NOT HISPANIC OR LATINO																							
	HISPANIC OR LATINO																							

COLLECT DATA FOR ALL CATEGORIES		ETHNIC DATA	TOTAL BENEFICIARIES	WHITE	BLACK/AFRICAN AMERICAN	ASIAN	AMERICAN INDIAN/ALASKAN NATIVE	NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER	BLACK/AFRICAN AMERICAN & WHITE	ASIAN & WHITE	AMERICAN INDIAN/ ALASKAN NATIVE & WHITE	AMERICAN INDIAN/ ALASKAN NATIVE & BLACK/ AFRICAN AMERICAN	OTHER MULTI-RACIAL	FEMALE	MALE	UNDER 18 YEARS	18-40 YEARS	41-60 YEARS	OVER 60 YEARS	VERY LOW	LOW	MODERATE	HANDICAPPED	FEMALE HEAD OF HOUSEHOLD
Clients Year	Date	N O HISPANIC OR T LATINO																						
Total to	HISPANIC OR LATINO																							
Type of Services provided & Other Results during Reporting Period (attach sheet, if necessary)													Certification <i>I certify that the information provided is true and accurate. Backup documentation and eligibility determinations of the clients served are available for review at the Agency at the above address.</i> <hr/> <i>Executive Director or Authorized Official</i> <i>Date</i>											

<ul style="list-style-type: none"> Total benefiting for program year 2012-2013: Of the persons assisted, enter the number that: Now have new access to this service or benefit: _____ Now have improved access to this service or benefit: _____ Now receive a service or benefit that is no longer substandard: _____ <p style="text-align: right;">Total: _____</p>

- This form must be signed or it will be returned for signature and any payment will be held until it is returned.
- This form is due quarterly on the 15th of October, January, April and July.
- Please direct questions to Sam Gonsalves at (401) 680-8404