YOUR WAY HOME
MONTGOMERY COUNTY

Your Way Home Emergency Rent & Utility Coalition Application

Instructions

This data is collected for purposes of assessing initial intake and eligibility for the Your Way Home Emergency Rent and Utility Coalition's program in response to COVID-19, called ERUC-CV. The information contained in this form will be input into Montgomery County's Homeless Management Information System (HMIS), Clarity, with your signed permission. If you permit it, this agency may share limited information about you with other Your Way Home Montgomery County (YWH) agencies from whom you may also seek services. We will not deny you help if you do not want us to share your personally identifying information.

Additionally, this is a written statement from the beneficiary documenting monthly (Gross) Income at time of application, the number of beneficiary members in the family or household, and the relevant characteristics of each member for the purposes of income determination. For the purposes of this regulation, income will be defined according to the Code of Federal Regulations at 24 CFR, Part 5.

The information provided on this form is subject to verification at any time, and Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony and assistance can be terminated for knowingly and willingly making a false or fraudulent statement to a department of the United States Government. All adult beneficiary members must then sign this statement to certify that the information is complete and accurate, and that source documentation will be provided upon request.

Date: _____

Please check (√) one or more boxes:

☐This agency may share my personally identifying information within YWH Data Systems.

☐Please treat information about my children age 17 or younger the same as mine.

Please be aware that we may also share the following information:

- Services you receive
- Your income
- Referral status for housing services
- Military history
- Living situation and housing history
- Your housing plan

☐This agency may **not** share my personally identifying information within YWH Data Systems.

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PART I: Household Information & Composition

Head of Household Contact information

First Name: _____ Last Name: _____

Date of Birth: _____

Social Security Number: _____ - ____ - _____ (Not Required)

Email Address: _____

Phone Number: _____

Street Address: _____

City, State, Zip code: _____

Are you a Montgomery County Resident? ☐ Yes ☐ No

Gender (choose one):
☐Female ☐Male ☐Trans Female ☐Trans Male ☐Gender Non-Conforming
☐Don't Know ☐Refuse to Answer

Race (choose as many as applies):
☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander
☐White ☐Don't Know ☐Refuse to Answer

Ethnicity (choose one):
☐Non-Hispanic/Non-Latino ☐Hispanic/Latino ☐Don't Know ☐Refuse to Answer

Veteran Status (choose one):
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have a Physical Disability?
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the physical disability expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have a Developmental Disability?
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the developmental disability expected to impair your ability to live independently?
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

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Do you have a Chronic Health Condition?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have HIV/AIDS?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the HIV/AIDS expected to substantially impair your ability to live independently?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have a Mental Health Condition?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the mental health condition expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have a Substance Abuse Condition?

☐No ☐Alcohol Abuse ☐ Drug Abuse ☐Both alcohol and drug abuse ☐Don't Know ☐Refuse to Answer

If Yes for alcohol abuse, drug abuse, or both, is the substance use condition expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Are you a Domestic Violence Victim or Survivor?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, when did the experience occur?

☐Within the past 3 months ☐ Three to six months ago ☐Six months to one year ago

☐One year ago or more ☐Don't Know ☐Refuse to Answer

If Yes, are you currently fleeing?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

On the night previous to this application, where did you sleep? _____

How long have you been sleeping at the location you wrote in above?

☐One night or less ☐Two to six nights ☐One week or more, but less than one month

☐One month or more, but less than 90 days ☐90 days or more, but less than one year ☐One year or longer

☐Don't Know ☐Refuse to Answer

Are you currently covered by Health Insurance?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, answer 'Yes' or 'No' for each health insurance choice. Answer 'no' for sources that have been terminated, even if you received it in the past

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No	Yes	Source
		Medicaid
		Medicare
		PA CHIP
		Veteran's Administration (VA) Medical Services
		Employer-provided Health Insurance
		Health insurance obtained through COBRA
		Private Pay Health Insurance
		Indian Health Services Program
		State Health Insurance for Adults
		Other Health Insurance: _____

Do you currently receive any non-cash public benefits from any source?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, answer 'Yes' or 'No' for each non-cash benefit choice. Answer 'no' for sources that have been terminated, even if you received it in the past

No	Yes	Source
		Supplemental Nutrition Assistance Program (SNAP)
		Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
		TANF Child Care Services
		TANF Transportation Services
		Any other TANF Funded Service: _____
		Other Public Benefit Source: _____

Other Household Members

Total Number of Persons in Household: _____

Name of Other Household Members	Relationship to Head of Household	Soc. Sec. # (not required)	Age	DOB MM/DD/YYYY	Gender	Race	Ethnicity

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Landlord Information

Landlord Name: _____

Other Contact, if applicable (e.g. Property Manager): _____

Landlord Email: _____

Landlord Phone Number: _____

Have you informed your Landlord that you have applied for this program?
☐Yes ☐No

Do you or your Landlord currently receive any rental or utility subsidy for the address on this application (e.g., Housing Choice Voucher AKA "Section 8")?
☐Yes ☐No ☐Don't Know

PART II: Household Income – Head of Household and Other Household Members

Report adjusted gross income from the previous 30 days for all household members. Only report on regular, recurrent income sources that are current as of today (i.e. not terminated). Include any income received to your household that any adult or minor receives (e.g. SSI), but do not income employment income that any minor receives.

Do you or any other Adult Household Member have any current income from any source?

☐No ☐Yes

If Yes, enter the **monthly** amount received based on current income at time of application. If unsure of exact monthly amount, enter your best estimate. Answer 'No' for sources that have been terminated, even if they were received in the past.

Source of income	Receiving income from source?		If yes, monthly amount from source (round to nearest dollar)
Earned income (i.e., employment income)	No	☐	
	Yes	☐	$. 0 0
Unemployment Insurance	No	☐	
	Yes	☐	$. 0 0
Supplemental Security Income (SSI)	No	☐	
	Yes	☐	$. 0 0
Social Security Disability Insurance (SSDI)	No	☐	
	Yes	☐	$. 0 0
VA Service-Connected Disability Compensation	No	☐	
	Yes	☐	$. 0 0
VA Non-Service-Connected Disability Pension	No	☐	
	Yes	☐	$. 0 0
Private disability insurance	No	☐	
	Yes	☐	$. 0 0
Worker's Compensation	No	☐	
	Yes	☐	$. 0 0

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Temporary Assistance for Needy Families (TANF)	No	☐				
	Yes	☐	$			. 0 0
General Assistance (GA)	No	☐				
	Yes	☐	$			. 0 0
Retirement Income from Social Security	No	☐				
	Yes	☐	$			. 0 0
Pension or retirement income from a former job	No	☐				
	Yes	☐	$			. 0 0
Child support	No	☐				
	Yes	☐	$			. 0 0
Alimony or other spousal support	No	☐				
	Yes	☐	$			. 0 0
Other source If yes, specify source:_____	No	☐				
	Yes	☐	$			. 0 0
Total monthly income from all sources			$			. 0 0

PART III: COVID-Related Need

Financial Hardship and Housing Instability due to COVID-19

Check as many boxes as appropriate

☐ You were laid-off from your primary place of employment as a direct result of COVID-19.

☐ You had a reduction in income as a direct result of COVID-19.

☐ You or a member of your household has been diagnosed with COVID-19 or are experiencing symptoms of COVID-19 and seeking a medical diagnosis.

☐ You are providing care for a family member or a member of your household who has been diagnosed with COVID-19.

☐ A child or other person in your household for which you have primary caregiving responsibility is unable to attend school or another facility that is closed as a direct result of COVID-19 public health emergency and such school or facility care is required for you to work.

☐ You are unable to reach your place of employment (or commence employment) because of imposed quarantine or self-quarantine (at direction of health care provider) as a direct result of the COVID-19 public health emergency.

☐ You have become the breadwinner or major support for a household as a direct result of COVID-19.

☐ You had to quit your job as a direct result of COVID-19.

☐ Your place of employment is closed as a direct result of COVID-19.

☐ Without the assistance provided by this program, I would become homeless or am currently homeless.

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Rent & Utility Assistance Needed

Due to these COVID-19 impacts, I need assistance with (choose one):

☐Rent ☐Utilities ☐Both

Rent per Month (as shown on my lease): $_____ # of Months owed in Rent: _____

Total Rental Arrearages (including any documented late fees or other fees) at time of application: $_____

I have arrearages owed for the following Utilities: ☐Gas ☐Oil ☐Electric ☐Water/sewer ☐Internet
☐None of These ☐ Other: _____

Total Utility Arrearages (including any documented late fees or other fees) at time of application: $_____

Duplication of benefits affidavit

Section 312 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, (42 U.S.C. 5121–5207) (Stafford Act)

Recipient agrees that if they receive further federal benefits for the same services received under this ERUC-CV program, the recipient will report receiving benefits within one (1) month of receipt of additional proceeds and/or benefits. If recipient fails to report additional federal benefits, then the County of Montgomery may require immediate repayment in full of the entire grant amount provided by the County of Montgomery.

Since March 1, 2020, have you or any other adult member of your household received rental or utility assistance for the address on this application, from any other source?

☐Yes ☐No

If Yes, please describe the source of the previous funding, the months you were assisted, and total amount received:

_____

PART IV: Certification

I/We HEREBY affirm and verify that I/We have not received payment or other financial assistance that would create a duplication of benefits under this grant program.

I/we certify that this information is complete and accurate. I/we agree to provide, upon request, documentation on all income sources. I acknowledge that I understand that making the certification is under penalty of perjury and intentional misrepresentation in self-certifying that I may call in one or more of these categories is fraud.

Additionally, when you sign this form, it shows that you understand the following:

- Persons with access to Your Way Home (YWH) Data Systems are trained in security protocols to protect your data and are only permitted to view your data when you are specifically working with their agency.
- If you request services from another YWH agency, your information will be shared for referral purposes only.
- YWH may use information derived from your data to create reports to share with funders, the community, and partners to better understand the scope of homelessness and the services being provided. Your personally-identifying information will never be used on these reports.

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Head of Household:		
Signature	**Printed Name**	**Date**
Other Adults Residing in Household (no signatures needed):		
Name		
Name		
Name		

**If household is unable to digitally or physically sign certification, this certifies that the household provided verbal certification to the agency providing services:

Signature of nonprofit provider representative: _____

Printed name of nonprofit provider representative: _____

Date: _____

Agency Use Only: YWH Code (If HoH did not agree to share personally-identifying info): _____