To begin the application process for rental assistance related to COVID-19, the following application package must be completed and submitted along with the applicable supporting documents. Applications are processed on a first-ready, first-served basis. For detailed information about the program and eligibility criteria, please refer to the program website at [www.hhdc-stl.org](http://www.hhdc-stl.org)

**Eligibility Requirements for Horizon Housing’s Homeless Prevention Program:**

1. Households that have been impacted in some way by COVID-19.
2. Normal yearly income pre-COVID-19 cannot exceed 80% of the St. Louis City Area Median Income (AMI).
3. Written documentation must be provided stating the full amount of rent/mortgage/utilities due, including fees, and be willing to comply with program requirements if rent is paid through the STL City ESG-CV Prevention Program, AFHT, or Omnibus Bill
4. Disability under ADA or SSI guidelines (for ESG-CV2 and AHTF funds *only*)

**CDA Income Limits**

Income Limits for the CDBG, HOME and NSP programs for 2019

**2020**

**CDBG & NSP Income Limits**

Effective: CDBG 4/1/2020 & NSP 7/1/2020

**HOME Income Limits**

Effective: July 1, 2020

\*The St. Louis Area (MO-IL) Median Family Income for FY 2020 is $82,900.  Area Median Income (AMI) limits vary depending upon household size.

\*\*The **gross** annual income (including income earned from assets) must be below the published limits above in order to qualify for funding through Community Development Administration.

Homebuyer eligibility is determined by the federal funding source used to assist the development and the HUD National Objective for the expenditure of those federal dollars (such as benefiting low- and moderate-income households).  For example, a for-sale rehabilitation project assisted with HOME funds must be sold to an owner-occupant owner whose total household income does not exceed 80% AMI.  But a for-sale rehabilitation project assisted with NSP funds may be sold to an owner-occupant owner whose total household income is less than or equal to 120% AMI.

# Document Checklist

# Each item on the checklist must be provided before request for assistance can be approved

* + Completed HHDC Homeless Prevention Program Application
	+ Valid Picture ID
	+ Current Lease Agreement for City Address
	+ Verification of Disability OR Completed Disability Verification Form (pages 15-16 of application, ESG-CV2 or AFHT funds only)
	+ Verification of Financial Impact due to COVID-19
	+ Verification of Household Income (pre-COVID AND current)

 Documents may include:

* + - Pay stubs
		- Bank Statements from previous 90 days – *if self employed*
		- Unemployment statement – showing you are not approved for the Federal Pandemic Unemployment Compensation ($600 additional weekly benefit).
		- TANF statement
		- 2019 Tax Return
		- 2020 Tax Return
		- Social Security check stubs or proof of deposit
		- Pension statement
		- Veterans benefit statement
		- Proof of alimony
		- Proof of child support
		- Workman’s compensation check stubs
		- Military pay stubs
	+ COVID-19 Impact Statement (on application AND written/typed separately)
	+ Completed Budget Form (page 9 of application)
	+ Completed Eligibility Release Form (page 10 of application)
	+ Completed Release of Information Form (page 11 of application)
	+ Completed HMIS ROI Form (page 13 of application)
	+ Landlord Required Documents
		- Affidavit
		- W-9
		- Ledger stating amounts owed
	+ Final Agreement signed by both the tenant and the landlord/lender
	+ Shut-Off Notice for Utility Bill (if applying for utility assistance as well)

If the applicant is unable to provide the documents as outlined above, a 90-day bank statement showing proof of deposits will be acceptable. However, there needs to show a decrease in income, and it is based on GROSS income.

COVID-19 HOMELESS PREVENTION PROGRAM REQUIREMENTS & DOCUMENT CHECKLIST UPDATED: March 9, 2021

|  |
| --- |
| **APPLICANT INFORMATION:** |
| **HEAD OF HOUSEHOLD (HOH):** |  |
| **CO-HEAD OF HOUSEHOLD:** |  |
| **CURRENT PHYSICAL ADDRESS:** |  |
| **CURRENT MAILING ADDRESS:** |  |
| **CONTACT NUMBER(S):** |  |
| **EMAIL ADDRESS:** |  |

|  |
| --- |
| **LANDLORD/LENDER INFORMATION:** |
| **LL/LENDER NAME:** |  |
| **LL/LENDER CONTACT NUMBER:** |  |
| **LL/LENDER EMAIL ADRESS:** |  |
| **LL/LENDER MAILING ADDRESS:** |  |

|  |
| --- |
| **RENT PAYMENT DETAILS:** |
| **MONTHLY RENT AMOUNT:** |  |
| **DOES ANYONE ELSE PAY A PORTION OF YOUR RENT? (check box)** | **YES**[ ]  **NO**[ ]  |
| **IF YES, PLEASE LIST NAME(S) OF PROVIDER(S):****PHONE/EMAIL OF PROVIDER(S):****MONTHLY AMOUNT BEING PROVIDED:** |  |
|  |
|  |

***The following information is collected to ensure compliance with Federal Fair Housing & Equal Opportunity regulations. Please see options to fill in the correct answer on the table for each member of the household.*

|  |
| --- |
| **Please list all persons, including yourself, who will live in the household over the next 12 months:** |
| **Legal Name** | **Birthdate** | **Social Security #** | **Race** | **Ethnicity** | **Veteran****Y or N** | **Relation to HOH** | **Gender** |
| **Example: Joe Smith** | **1/1/1998** | **111-11-1112** | **Asian** | **Non-Hispanic** | **N** | **Self** | **M** |
|  |  |  |  |  |  |  |  |
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| **HOUSEHOLD MONTHLY INCOME & BENEFITS:** |
| **Please indicate the type of income any household member is expected to receive monthly for the next 12 months, including the source and amount of the income. This can include, but is not limited to, Alimony or other spousal support, Child Support, Earned Income, General Assistance, Pension/Retirement Income from former job, Private Disability Insurance, Retirement from Social Security, SSDI, SSI, TA/TANF, Unemployment Insurance, VA Service-Connected Disability Comp, VA Non-Service-Connected Disability, Worker’s Comp, etc.****IF THIS DOES NOT APPLY TO ANYONE IN HOUSEHOLD, LEAVE BLANK.** |
| **Name** | **Income Source** | **Amount** |
| **Example: Joe Smith** | **Earned income** | **$1200** |
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| **HOUSEHOLD NON-CASH BENEFITS:** |
| **Please indicate the type of non-cash benefit any household member is expected to receive monthly for the next 12 months, including the source and amount of the income. This can include, but is not limited to, SNAP (food stamps), WIC, TANF child care services, TANF transportation services, other TANF funded services, etc.****IF THIS DOES NOT APPLY TO ANYONE IN HOUSEHOLD, LEAVE BLANK.** |
| **Name** | **Non-Cash Benefit Source** |
| **Example: Joe Smith** | **SNAP** |
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| **HOUSEHOLD HEALTH INSURANCE:** |
| **Please indicate the type of health insurance any household member has, including the source. This can include, but is not limited to, Medicaid (MO HealthNet), Medicare, State Children’s Health Insurance Program, VA Medical Services, Indian Health Services Program, Employer-provided health insurance, COBRA-provided health insurance, State health insurance for adults, private pay health insurance, etc.** **IF THIS DOES NOT APPLY TO ANYONE IN HOUSEHOLD, LEAVE BLANK.** |
| **Name** | **Health Insurance Source** |
| **Example: Joe Smith** | **Employer-Provided Health Insurance** |
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| **HOUSEHOLD DISABILITY DETAILS:** |
| **Please indicate the type of disability any household member has, and whether or not it is long term or of indefinite duration and impairs the ability to live independently. This can include, but is not limited to, Alcohol abuse, Drug abuse, Both Alcohol and Drug abuse, Chronic health condition, Developmental disability, HIV/AIDS, Mental Health problem, Physical disability, etc.** **IF THIS DOES NOT APPLY TO ANYONE IN HOUSEHOLD, LEAVE BLANK.** |
| **Name** | **Disability** | **Long Term/Indefinite Duration (check box)** |
| **Example: Joe Smith** | **Mental Health Problem** | **YES**[x]  **NO**[ ]  |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |

|  |
| --- |
| **HOUSEHOLD DOMESTIC VIOLENCE HISTORY:** |
| **Please indicate the domestic violence history of any household member, the approximate time period the experience occurred (within the last 3 months, 3-6 months, 6-12 months, 1+ year), and whether or not the person is currently fleeing.** **IF THIS DOES NOT APPLY TO ANYONE IN HOUSEHOLD, LEAVE BLANK.** |
| **Name** | **Time Period** | **Currently Fleeing? (check box)** |
| **Example: Joe Smith** | **1+ year ago** | **YES**[ ]  **NO**[x]  |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |
|  |  | **YES☐ NO☐** |

|  |
| --- |
| **CHRONIC HOMELESSNESS DETERMINATION:** |
| **IF YOU ARE CURRENTLY IN TEMPORARY OR PERMANENT HOUSING, PLEASE CHECK ONE:** | **IF YOU ARE CURRENTLY IN AN INSTITUTION, PLEASE CHECK ONE:** | **IF YOU ARE CURRENTLY HOMELESS, PLEASE CHECK ONE:** |
| [ ] Residential project or halfway house with no homeless criteria[ ] Hotel or motel paid for without emergency shelter voucher[ ] Transitional housing for homeless persons (including homeless youth)[ ] Host-home (non-crisis)[ ] Staying or living in a friend’s room, apartment, or house[ ] Staying or living in a family member’s room, apartment, or house[ ] Rental by client, with gpd tip subsidy[ ] Rental by client, with VASH subsidy[ ] Permanent housing (other than RRH) for formerly homeless persons[ ] Rental by client, with RRH or equivalent subsidy[ ] Rental by client, with HCV voucher (tenant or project based)[ ] Rental by client in public housing unit[ ] Rental by client, no ongoing housing subsidy[ ] Rental by client, with other ongoing housing subsidy[ ] Owned by client, with ongoing housing subsidy[ ] Owned by client, no ongoing housing subsidy | [ ] Foster care home or foster care group home[ ] Hospital or other residential non-psychiatric medical facility[ ] Jail, prison, or juvenile detention facility[ ] Long-term care facility or nursing home[ ] Psychiatric hospital or other psychiatric facility[ ] Substance abuse treatment facility or detox center | [ ] Place not meant for habitation (e.g. a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside[ ] Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY funded host home shelter[ ] Safe Haven |
| LENGTH OF TIME SPENT (PLEASE INDICATE): |  |

**COVID-19 RENTAL/MORTGAGE ASSISTANCE SELF CERTIFICATION**

I, \_\_\_\_\_\_\_\_\_\_, certify all information provided in this application, including the following statements to be true by my initial next to each statement and by providing my signature on the form.

Initial the following that you are certifying to as part of your application for assistance:

\_\_\_\_\_\_\_\_\_\_ I have a loss of income as a direct result of the COVID-19 pandemic, equal to or exceeding the grant amount.

\_\_\_\_\_\_\_\_\_\_ Briefly describe your loss of income below:

\_\_\_\_\_\_\_\_\_\_ I have not been reimbursed, nor will I apply for future reimbursement for the amount of income loss, for the months of rental/mortgage/utility grant funds have/will be provided, by any program of insurance or other government program.

Note the following that you have received, initialing each line to show it has been reviewed:

\_\_\_\_\_\_\_\_\_\_\_ State funds received related to COVID-19, explain:

\_\_\_\_\_\_\_\_\_\_\_ Federal funds received related to COVID-19, explain:

\_\_\_\_\_\_\_\_\_\_\_ Other funds received related to COVID-19, explain:

Any rental/mortgage/utility assistance, amounts and months:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **Print Name**  | **.** |  **Signature**  | **.** |  **Date**  |
|  |  |  |  |  |
|  |  |  |  |  |

***INCOME & BUDGET FORM***

HOUSEHOLD INCOME \*Please record the income for each household member (HHM)\*

***BOX 1***

|  |  |  |
| --- | --- | --- |
| **EXAMPLE: SOURCE: SSI** | **HHM RECEIVING: JANE DOE** | **+ $780** |
| SOURCE: | HHM RECEIVING:  | + $ |
| SOURCE: | HHM RECEIVING:  | + $ |
| SOURCE: | HHM RECEIVING:  | + $ |
| ***TOTAL HOUSESHOLD INCOME (ADD TOTALS FROM THIS BOX)*** | ***(+) $*** |

HOUSEHOLD BUDGET – FIXED BILLS/EXPENSES/SUBSCRIPTIONS \*These amounts should be the same each month\*

***BOX 2***

|  |  |
| --- | --- |
| **EXAMPLE: RENT** | **- $500** |
| RENT/MORTGAGE | - $ |
| PARKING | - $ |
| PHONE | - $ |
| INTERNET | - $ |
| CAR PAYMENT | - $ |
| CAR INSURANCE | - $ |
| RENTER’S INSURANCE | - $ |
| HEALTH INSURANCE | - $ |
| OTHER (SPECIFY):  | - $ |
| OTHER (SPECIFY):  | - $ |
| OTHER (SPECIFY):  | - $ |
| ***TOTAL HOUSESHOLD FIXED BILLS/EXPENSES/SUBSCRIPTIONS (ADD TOTALS FOR THIS BOX)*** | ***(-) $*** |

HOUSEHOLD BUDGET – SPENDING FOR ADDITIONAL EXPENSES\*These amounts should vary month to month\*

***BOX 3***

|  |  |
| --- | --- |
| **EXAMPLE: WATER/SEWER/TRASH** | **- $70** |
| WATER/SEWER/TRASH | - $ |
| ELECTRIC/GAS | - $ |
| FOOD/GROCERIES/DINING | - $ |
| TOILETRIES/HOUSEHOLD SUPPLIES | - $ |
| GAS FOR VEHICLE | - $ |
| CREDIT CARD PAYMENT | - $ |
| LOAN PAYMENT | - $ |
| OTHER (SPECIFY):  | - $ |
| OTHER (SPECIFY):  | - $ |
| OTHER (SPECIFY):  | - $ |
| ***TOTAL HOUSESHOLD SPENDING FOR ADDITONAL EXPENSES (ADD TOTALS FOR THIS BOX)*** | ***(-) $*** |

***BOX 4***

|  |  |
| --- | --- |
| ***TOTAL HOUSEHOLD SPENDING (ADD TOTALS FROM BOXES 2-3)*** | ***(-)$*** |

|  |  |
| --- | --- |
| ***REMAINING TOTAL (SUBTRACT BOX 4 TOTAL FROM BOX 1 TOTAL)*** | ***(=) $*** |

**ELIGIBILITY RELEASE / RELEASE OF INFORMATION**

Your signature on this form, and the signature of the co-head if applicable, authorizes the state or any of its duly authorized representatives to obtain information from a third party regarding your eligibility and participation in the COVID-19 Homeless Prevention Program. Each applicant must sign this form. This is valid from January 1, 2021-December 31, 2021.

Privacy Act Notice Statement: City of St. Louis requires the collection of the information listed in this form to determine an applicant's eligibility for the Program. This information will be used to establish the level of benefits for which the applicant is eligible and to verify the accuracy of the information furnished. Information received from an applicant or as a result of verifying an applicant's eligibility may be released to appropriate Federal, State, and local agencies or, when relevant, to civil, criminal, or regulatory investigators, and to prosecutors. Failure to provide any information may result in delay or rejection of your eligibility approval. City of St. Louis is authorized to ask for this information under the National Affordable Housing Act of 1990.

Inquiries to the following sources may be needed to process this application:

|  |  |
| --- | --- |
| Past and Present Employers | Agencies Providing Welfare or Assistance |
| Unemployment Agencies | Social Security Administration |
| Retirement Systems | Veterans Administration |

Information may be released to the following sources related the assistance received as a result of this application. The purpose of sharing this information is only to coordinate services and prevent a duplication of benefits:

Agencies Providing Welfare or Assistance St. Louis Municipalities providing assistance

All St. Louis Non-Profit Entities providing prevention funds

St. Louis City Department of Human Services St. Louis United Way 211

Applicant’s Authorization: I authorize Horizon Housing Development Company, to obtain information about me and my household that is pertinent to determining my eligibility for participation in the program. I acknowledge that:

* 1. A photocopy of this form is as valid as the original; AND
	2. I have the right to review information received using this form; AND
	3. I have the right to a copy of information provided to the County of St. Louis City and to request correction of any information I believe to be inaccurate; AND
	4. The Head of Household and the Co-Head, if applicable, will sign this form and cooperate with Horizon Housing Development Company in the eligibility verification process.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Print Name** | **.** | **Signature** | **.** | **Date** |  |
|  |  |  |  |  |  |  |

**AUTHORIZATION FOR DISCLOSURE/RELEASE OF CONSUMER INFORMATION**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize and request:**

**(Name of Consumer, Parent, Guardian/Legal Representative)**

To **disclose/release information**

\_\_**Horizon Housing Development**\_\_\_\_\_\_\_\_  **To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_3001 Arsenal St. Louis, MO. 63118\_\_ \_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Name and address of agency requesting information) (Name and address of agency releasing information)**

**Individual whose information being requested:**

 **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The Purpose of this Disclosure is:**

* **Service Planning** 🞏 **Eligibility Determination**

**🞏 Continuity of Services/Care 🞏 Consumer Request**

**🞏 Other \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_**

**The Specific Information to be disclosed is:**

**🞏 Financial Information to Determine Eligibility**

**🞏 Medical Psychiatric Assessment**

**🞏 Educational Testing, IEP, transcript, grading reports**

 **🞏 Other\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_**

1. I understand that my medical/health/educational information records are confidential. I understand that by signing this authorization, I am allowing the release of medical/health information. The protected health information (PHI) in my medical records includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and alcohol/drug abuse.

2. Alcohol and drug abuse information records are specifically protected by Federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Consumer, Parent, Guardian/Legal Representative)

3. THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE. Prohibition on Disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

4. This authorization becomes effective on \_\_\_\_\_\_\_\_\_. This authorization automatically expires on the following date\_\_\_\_\_\_\_\_\_. If I fail to specify an expiration date, this authorization will expire in one year.

5. I have received a copy of this agency’s Notice of Privacy Practices.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**NOTICE OF REVOCATION**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.**

**Consumer/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Institute for Community Alliances**

**Homeless Missourians Information System Network**

**Client Informed Consent to Share and Release of Information**

HMIS606\_008(2)

The **Homeless Missourians Information Systems Network** is a group of agencies working together to provide services to homeless and low-income individuals in the State of Missouri. This group includes shelter, housing, food, state, private and non-profit social service agencies, and faith-based organizations. I give this partner agency permission to share the following information regarding my household. I understand that this information is for the purpose of assessing needs for housing, utility assistance, food, counseling and/or other services.

**The information being shared may consist of the following:**

* Identifying and/or historical information regarding my household.
* My household income, non-cash benefits, and health insurance information.

**I understand that:**

* Information I give concerning physical or mental health problems will not be shared with other partner agencies in any way that identifies me or other members of my household.
* The partner agencies have signed agreements to treat my household’s information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the HMIS.
* Staff members of the partner agencies who will see my household’s information have signed agreements to maintain confidentiality regarding my household’s information.
* The partner agencies may share non-identifying information about the people they serve with other parties working to end homelessness.
* I have the right to ask if I may refuse to answer certain questions.
* The sharing of information does not guarantee that services will be provided. Declining to share information does not prohibit the provision of services.
* This authorization will remain in effect for twelve months unless I revoke it in writing.
* If I revoke my authorization, all information about my household entered into the database from that date forward will not be shared with partner agencies.
* A list of the partner agencies within the network may be viewed prior to signing this form.

**HORIZON HOUSING DEVELOPMENT COMPANY** **HORIZON HOUSING HESG-CV PREVENTION**

Agency Name Project Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (*please print*) Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Personnel Name (*please print*) Agency Personnel Signature Date

Head of Household Client ID Number:

 Approved 2020

**Excerpt** **of HMIS Privacy and Security Notice**

***A written copy of the full Privacy Policy is available to all who request it.***

***It is also available on this agency’s web site.***

The information you may agree to allow us to collect and share includes: basic identifying demographic data, such as name, address, phone number and birth date; the nature of your situation and the services and referrals you receive from this agency. This information is known as your **Protected Personal Information or PPI.**

II. CONFIDENTIALITY RIGHTS:

This agency has a confidential policy that has been approved by its Board of Directors. This policy follows all HUD confidentiality regulations that are applicable to this agency, including those covering programs that receive HUD funding for homeless services. Separate rules apply for HIPAA privacy and security regulations regarding medical records.

This agency will use and disclose personal information from HMIS only in the following circumstances:

1. To provide or coordinate services to an individual.
2. For functions related to payment or reimbursement for services.
3. To carry out administrative functions including, but not limited to legal, audit, personnel, planning, oversight or management functions.
4. Databases used for research, where all identifying information has been removed.
5. Contractual research where privacy conditions are met.
6. Where a disclosure is required by law and disclosure complies with and is limited to the requirements of the law. Instances where this might occur are during a medical emergency, to report a crime against staff of the agency or a crime on agency premises, or to avert a serious threat to health or safety, including a person’s attempt to harm himself or herself.
7. To comply with government reporting obligations.
8. In connection with a court order, warrant, subpoena or other court proceeding where disclosure is required.

For information on your rights regarding your HMIS record, ask your intake person for a copy of the full privacy policy

|  |
| --- |
| **Verification of Disability** |
| **Instructions**:* *A qualified professional must complete and sign this form. Please see the other side of this form for a list of qualified professionals who may provide this verification.*
 |
| **Program Information:***To be eligible for Horizon Housings ESG-CV Rental Assistance Program, an individual must meet certain disability standards*.An individual with a disability is a person who has:* A disability as defined in Section 223 of the Social Security Act. This is an inability to engage in **any** substantial activity by reason of any medically determinable physical or mental impairment, which can be expected to last for a continuous period of not less than 12 months.
* A physical, mental or emotional impairment that is expected to be of long, continued and indefinite duration; substantially impedes his or her ability to live independently; and is of such a nature that ability to live independently could be improved by more suitable housing conditions.
* A developmental disability as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act.
 |
| **Household Information** |
| **Head of Household Name:** | **Last four numbers of SSN:** |
| **Name of Individual with Disability:** | **DOB:** |
| **Certification** |
| Based on the above definition(s), it is my professional opinion that:**Name of Individual:**  |
| * Is a person with a disability
 | * Is not a person with a disability
 |
| This disability began about: . |
| ***Warning****: Section 1001 of Title 18 of the US Code makes it a criminal offense to make any willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction, punishable by fine not to exceed $10,000 and/or imprisonment of not more than 5 years.***I certify the information in this Verification of Disability is true and accurate***.* |
| Signature: | Date: |
| Phone: | Fax: | Email: |

**Qualifications to Complete the Verification of Disability**

\*Only to be completed if client is being assisted with ESG-CV2 or AFHT Funds, which requires a disability\*

Below is a list of professionals qualified to complete the Verification of Disability. If you have a degree/license/accreditation that is not listed and you believe you are qualified to assess an individual’s disability status, please contact us at (314) 865-0383.

|  |  |
| --- | --- |
| **Title** | **Acronym** |
| Certified Alcohol and Drug Counselor Level 3 | CADC lII |
| Doctor of Chiropractic Medicine | DC |
| Doctor of Osteopathic Medicine | DO |
| Licensed Clinical Social Worker | LCSW |
| Licensed Nurse PractitionerPsychiatric Mental Health Nurse Practitioner Certified Nursing SpecialistFamily Nurse Practitioner | LNP PMHNP CNSFNP |
| Medical Doctor | MD |
| Physician’s Assistant | PA |
| Qualified Mental Health Professional | QMHP |

**Additional Comments:**

## **This form is only for applicants with no household income in the last 30 days.**

**Applicants who have had household income in the last 30 days do not need to complete.**

**DO NOT** submit this form to report unemployment benefits.

Provide documentation of unemployment benefits received as your income documents.

**SELF-DECLARATION OF INCOME**

Client/Applicant Name:

Head of Household Name (if different):

Relationship to Head of Household:

This form is to be completed and signed by **each** household member 18 years of age and older claiming

**UNDOCUMENTED** or **ZERO** income for any period in the last 30 days.

*Please select all that apply to you in the previous 30 days from the application date:*

[ ] Self-Employment Wages (paid to you in cash) Amount: $

[ ] Relative or friend assistance (paid to you in cash for more than 1 month) Amount: $

## OR

[ ] I have received no form of any income within the previous 30 days.

I have been able to maintain basic necessities such as food, water, and shelter by:

I attest that the information stated above is true and understand that the above information, if misrepresented, or incomplete, may be grounds for immediate termination, denial of services, and/or penalties including disqualification from future Horizon Housing Development Company Assistance benefits.

 Signature/Date