HOUSING COUNSELING SERVICES
EMERGENCY FINANCIAL ASSISTANCE (EFA) PROGRAM APPLICATION
DISTRICT OF COLUMBIA

Financial Assistance Application Information Sheet
Applicants may apply for Ryan White Emergency Financial Assistance (EFA) by completing this application with their case manager and submitting a completed application package to: Housing Counseling Services, Inc. Emergency Financial Assistance Program 2410 17th Street, N.W., Suite 100, Washington DC 20009 Tel: 202-667-2681 Fax: 202-667-0862 Email: efaprogram@housingetc.org

A completed application package will consist of the following documents:

- ❖ Emergency Financial Assistance Program Application: **All sections must be completed**
- ❖ Verification of HIV Status: Acceptable documentation include: physician's statement confirming HIV diagnosis; lab report detailing viral load counts (must be within the last 6 months); or confirmatory HIV test (multi-spot, P4antigen, or western-blot);
- ❖ Verification of District of Columbia (D.C.) Residency: Acceptable documentation include: current lease; current utility statement (dated within last 90 days); mortgage statement or deed settlement agreement; D.C. property tax bill/statement (dated within last 60 days); rent receipt verifying D.C. address (dated within last 90 days); valid D.C. driver's license/D.C. identification card; valid D.C. voter registration card; current notice of decision from D.C. Medicaid; paystub or bank statement verifying D.C. address; letter from government agency verifying D.C. address; unexpired homeowner/rental insurance policy; D.C. Healthcare Alliance Proof of Residency Form. **If homeless**, provide letter from service provider on agency letterhead or a completed homeless verification form.
- ❖ Documentation of all household income, including Public Assistance received, within the last 30 days. (if an adult household member has no income, he/she must submit a *Zero Income Affidavit.*
- ❖ Picture ID for all adult (18 years or older) members of household
- ❖ Verification of all minor children (younger than 18) in household (acceptable documentation to demonstrate dependency include: birth certificate, court documentation, or tax return from most recent tax year)
- ❖ Completed and signed EFA Referral Certification Form for each EFA service category applicant is applying for (A Certification Form is not required for Moving Expenses and Emergency Medication service categories)
- ❖ Signed Consent to Release Medical Information Form (Page 12)
- ❖ Case manager submitting EFA Application must sign Page 12
- ❖ **See Section 4 of application for additional documentation that must be submitted for each service area the applicant is applying;**
- ❖ **Important: If determined eligible for first month's rent, delinquent rent, delinquent utility, delinquent telephone, or moving cost assistance, the applicant must provide documentation that any balance in excess of the EFA benefit amount authorized by HCS has been paid before HCS will issue payment to the vendor.**
- ❖ **The case manager's supervisor must review and sign this application on Page 12 (failure to sign, will result in immediate denial of the EFA application).**

Upon receipt of the application package, HCS will send the referring case manager a confirmation of receipt. **Failure to submit all required application documentation within 7 days of application submission will result in the denial of the financial assistance application. HCS may request additional documentation to verify eligibility and/or circumstances presented in the application.**

Section 1: Applicant Information

Date: ____________ **Unique ID**: _______________________ **Ward:** ________

Applicant's Name:____
Last Name First Name Middle

Current Address: ____
Street Apt. #

____
City State Zip Code

Length of time at this address: _____years _____months

_____________________ _______________________ _______________________
Home Phone **Cell Phone** **Email**

Do you currently live in a unit that is supported by a federal, state, or local housing subsidy (includes Section 8, Public Housing, TBRA, and Shelter Plus Care)? ____Yes ____No
If yes, you may be ineligible for EFA rental and utility assistance.

Type of financial assistance you are applying for (select all that apply):

____First Month's Rent ____Past Due Rent ____Utility Assistance

____Moving Cost Assistance ____Telephone Assistance ____Food Voucher

____Hygiene Voucher ____Emergency Medication Assistance

Section 2: Applicant Demographic Information

1a. Gender: ___Male ____Female ____Transgendered: MTF or FTM (circle)

1b. Sex at birth: ___Male ____Female

2. Ethnicity: __Latino/Hispanic __Not Latino/Hispanic

If Hispanic, please choose all that apply: __Mexican, Mexican American/Chicano/a __ Puerto Rican

__ Cuban __ Other Hispanic, Latino/a, or Spanish origin **(please describe)** __________________

3. Race: (Check only one)

Single Race

__ American Indian/Native American **(I)**
__ Native Hawaiian or Other Pacific Islander **(PI)**
___ Asian
___ Black/African American **(B)**
___ White **(W)**
___ Other

If Native Hawaiian or Other Pacific Islander, please choose all that apply:

___ Native Hawaiian
____ Guamanian or Chamorro
____ Samoan
____ Other Pacific Islander **(please describe)**

If Asian, please choose all that apply:

___ Asian Indian **(AI)** ____ Chinese **(CH)** ____ Filipino **(F)** ____Japanese **(JA)**
___ Korean **(KR)** ____Vietnamese **(VT)** ____ Other Asian **(please describe)**

Or Multi-Race

__ American Indian or Alaska Native and White **(IW)** __ Black/African American and White **(BW)**
__ Asian and White **(AW)** __ American Indian/Alaska Native & Black /African American **(IB)**
__ Other Multiple Race **(O)**

4. Language: Is English your primary language? __Yes __ No If no, primary language: ___________

5. Marital Status

___ Single ___Married ___Separated ___Divorced ___Domestic Partnership

6. Current Housing Situation:

___ Renter ___Live with Family/Friends ___Own Home___Hospital/Rehabilitation Center
___Homeless, living on the street or in shelter/transitional housing ___Other____________________

7. Is anyone in your household a U.S. military veteran (not including a reservist)?___Yes ___No
If yes, provide the veteran's name(s)___________________Discharge Status:________________

8. Current Viral Load (within last six months): ______________________________

9. Date of HIV Diagnosis: ______/______/__________
MM DD YYYY

10. Do you currently have medical insurance? __Yes (**Insurance Provider_________________**) **__No**

11. Date of last contact with health care provider: ________________

12. Highest level of education completed:_______________________

13. Employment Training:

Have you participated in an employment training program within the last 12 months __Yes __No
If yes, did the employment training result in employment? __Yes ___No

EMERGENCY CONTACT (Whom should the program call in case of emergency?)

Name:_____________________________________ Relationship: ________________________

Address:____
Street Apt City State Zip

Phone Number: ______________________ **Email:** ___________________________________

Is the emergency contact aware of applicant's HIV status? ___Yes ___ No

Section 3: Household Composition, Income, Expenses Information, and Financial Resources

HOUSEHOLD COMPOSITION & INCOME INFORMATION

Complete this section for all persons currently in household. Include all household income.

Does your household receive Food Stamps? __Yes __No If yes, provide the dollar amount: $_________

NAME	RELATION TO APPLICANT	DATE OF BIRTH & AGE	RACE*	SOCIAL SECURITY NUMBER	HIV POSITIVE (Y or N)	MONTHLY GROSS INCOME	ANNUAL GROSS INCOME	SOURCES OF INCOME (Work, SSDI, TANF, Child Support, etc.)
1.	Applicant							
2.								
3.								
4.								
5.								
Please submit additional form to list other household members.						Total	Total	

*** For race, use abbreviations in parenthesis for responses to Question 3 on Page 3**

HOUSEHOLD EXPENSES INFORMATION

Enter expected expenses for next month for applicant's household. This information will be used to help determine applicant's need for financial assistance. If applicant does not pay toward the expense category, please enter "0"

Expense	Amount	Expense	Amount	Expense	Amount
Rent/Mortgage		Car Loan		Education	
Electric		Car Insurance		Entertainment	
Gas/Oil		Car Repairs		Household Items	
Phone		Other Transportation Costs		Loan(s)	
Water/Sewer		Child Care		Personal Care	
Food		Child Support		Other	
Insurance Medical/Life		Laundry		Other	
Doctor/Dentist		Clothing		Other	
Medication		Credit Card(s)		Total Expenses	

Section 4: Financial Assistance Request

The maximum benefit an applicant can receive, during a 12 month period, for the Emergency Rental Assistance service area is three times (3X) one month's Fair Market Rent based on unit size.

Unit Size	Room	Eff.	1BR	2BR	3BR	4BR
2019 FMR (effective 10/01/2018)	$800	$1415	$1454	$1665	$2176	$2676

If requesting Emergency Rental Assistance for First Month's Rent, complete this section

Note: Residents of subsidized housing are ineligible for first month's rent assistance unless moving to a unit that will not be subsidized.

____
Name of Landlord/Management Company

$______________
Total Monthly Rent for Unit

$______________
First Mont's Rent Assistance Requested

____
Lease Start Date

____
# of bedrooms in unit

____
Landlord/Management Company Payment Address:

____
City/State/Zip

____
Landlord Telephone Number

ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:

1. **Copy of approval letter from landlord;**
2. **Copy of proposed lease;**
3. **Federal W-9 Form completed and signed by landlord**

If requesting Emergency Rental Assistance for Past Due Rent, complete this section

Note: Applicant's rent must be at least one month delinquent to be eligible for Past Due Rent assistance. Applicants residing in subsidized housing are ineligible for past due rent assistance.

____
Name of Landlord/Management Company

____
Payment Address:

____
City/State/Zip

____
Telephone

Type of rental property:
____Single Family Home
____Apartment/Condo
____Room rental
____Other_____________________________

# of bedrooms in your unit_____________

$____________________
Regular Monthly Payment

$____________________
Total Rent Past Due

____
(MM/DD-MM/DD)
Timeframe for delinquency

Have you received a writ or any court documents regarding this delinquency? __Yes __No

ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:

1. **Itemized statement from landlord detailing delinquent rent and fees;**
2. **Copy of current lease;**
3. **If applicant is involved in D.C. Landlord Tenant Court proceedings, copies of all court related documents**
4. **Federal W-9 Form completed and signed by landlord**

If requesting Emergency Utility Payment Assistance, complete the appropriate section below. The maximum benefit an applicant can receive, during a 12 month period, for the Emergency Utility Payments service area is $1500. Applicants residing in subsidized housing are ineligible for Emergency Utility Payment Assistance.

______________________________ **Electric Company Name** __________________ $__________ Account Number Amount Due __________________ Disconnect Notice? (MM/DD-MM/DD) ___Yes ___No Timeframe for delinquency	______________________________ Vender Payment Address: ______________________________ Vender City/State/Zip ______________________________ Vender Telephone Number **ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:** **1. Copy of disconnect notice from electric company;** **2. Copy of most recent electric bill (must be dated within past 30 days)**
______________________________ **Gas/Oil Company Name** __________________ $__________ Account Number Amount Due __________________ Disconnect Notice? (MM/DD-MM/DD) ___Yes ___No Timeframe for delinquency	______________________________ Vender Payment Address: ______________________________ Vender City/State/Zip ______________________________ Vender Telephone Number **ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:** **1. Copy of disconnect notice from gas/oil company;** **2. Copy of most recent gas/oil bill (must be dated within past 30 days)**
______________________________ **Water Company Name** __________________ $__________ Account Number Amount Due __________________ Disconnect Notice? (MM/DD-MM/DD) ___Yes ___No Timeframe for delinquency	______________________________ Vender Payment Address: ______________________________ Vender City/State/Zip ______________________________ Vender Telephone Number **ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:** **1. Copy of disconnect notice from water company;** **2. Copy of most recent water bill (must be within past 30 days)**

If requesting Emergency Telephone Service Payment assistance, complete this section. The maximum benefit an applicant can receive, during a 12 month period, for the Emergency Telephone Service Payments service area is $300.

______________________________ **Telephone Company Name** Is this a cell/mobile phone? ___Yes ___No ______________________ $__________ Account Number Amount Due __________________ Disconnect Notice? (MM/DD-MM/DD) ___Yes ___No Timeframe for delinquency	______________________________ Vender Payment Address: ______________________________ Vender City/State/Zip ______________________________ Vender Telephone Number **ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:** 1. **Copy of disconnect notice from telephone service provider;** 2. **Copy of most recent telephone bill (must be dated within past 30 days; the bill must be itemized detailing all charges). EFA can only cover telephone service charges.**

If requesting Emergency Moving Assistance, complete this section. The maximum benefit an applicant can receive, during a 12 month period, for the Emergency Moving service area is $2000. Move must be within D.C. Eligible Metropolitan Area. This service may only be accessed once in a 12 month period.

______________________________ **Moving Company Name** ______________________________ Street Address Moving From ______________________________ City/State/Zip Moving From Number of bedrooms in unit:_____ ______________________________ Street Address Moving To ______________________________ City/State/Zip Moving To ___________________ Proposed Date of Move (mm/dd/yyyy) $_______________ $_______________ Total Cost of Move Amount of Assistance Requested Explain reason for moving:_____________________ ______________________________ ______________________________ ______________________________	______________________________ Vender Contact Person ______________________________ Vender Payment Address: ______________________________ Vender City/State/Zip ______________________________ Vender Telephone Number **ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:** 1. **EFA Moving Cost Assistance Terms signed by applicant and submitting case manager.** 2. **Copy of moving company's written proposal to provide moving service. Estimate must be dated within 15 days of application submission.** 3. **Completed EFA Moving Assistance Inventory List.** 4. **Copy of moving company's business license and documentation of moving company meeting minimum EFA cargo, liability, and worker's comp. insurance requirements.**

If requesting an Emergency Food Voucher, an Emergency Hygiene Voucher or Emergency Medication, complete this section

Category	Additional criteria/requirements
Amount of <u>Emergency Food Voucher Assistance</u> requested: $_______________ **The maximum benefit per application is $300 for an individual and $700 for a family with children dependents ($100 per dependent – max. 4 dependents). The 12 month benefit cap for individuals is $900 and for families is $2100. Applicants may access this benefit three times (3X) in a 12 month period, at intervals of at least 3 months.** **Has the applicant applied for SNAP? ___Yes __No** **Has this household received a Special Crisis $25 Food Voucher while waiting a determination on this application? ___Yes ___No**	**ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:** **1. Applicant must sign Emergency Food Voucher/Emergency Hygiene Voucher Utilization Statement (page 12)**
Amount of <u>Emergency Hygiene Voucher Assistance</u> requested: $_______________ **Maximum benefit per application is $75. The 12 month benefit cap is $225.** **Applicants may access this benefit three times (3X) in a 12 month period, at intervals of at least 4 months.**	**ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:** **1. Applicant must sign Emergency Food Voucher/Emergency Hygiene Voucher Utilization Statement (page 12)**
Emergency Medication Assistance **What medications is applicant requesting assistance to purchase?** _______________________________________ _______________________________________ **Is this medication for the treatment of HIV?** **___Yes ___No** **Does applicant currently have medical insurance?** **___Yes ___No** **If no, has the applicant applied for Medicaid, Medicare, ADAP, HIAP, or CHIP?** **___Yes ___No** **If yes, what was the result of their application?** _______________________________________ _______________________________________ _______________________________________ **Maximum assistance is $4000 per year and is only for medications not included in ADAP formulary. Applicants may access this benefit no more than two times (2X) in a 12 month period.**	**ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:** **1. Verification of uninsured status <u>or</u> for applicants who have insurance and/or other 3rd party payer sources, submit documentation that the requested medication is not covered by their provider;** **2. Copy of medication prescription** **3. Confirmation from medical professional that medication is for treatment of applicant's HIV** ****Additional criteria apply to this category. Please contact HCS EFA staff to discuss circumstances of this request.**

Section 5: Explanation of Financial Assistance Need and Housing Stability Plan

EXPLANATION OF FINANCIAL ASSISTANCE NEED

Please explain in detail the circumstances that caused the applicant's need for Emergency Financial Assistance. Use additional pages if necessary.

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Please explain how EFA assistance will resolve the immediate emergency.

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HOUSING/FINANCIAL STABILITY PLAN

Please identify barriers the applicant is experiencing that caused their financial need. Also, explain the specific steps the applicant, their household, and the case manager will take towards stabilizing your financial situation to prevent the need for future financial assistance. Please be specific and provide details in the plan. For example, "Applicant will look for employment" is not sufficient detail, however "Applicant will submit a minimum of 10 employment applications each week" provides greater detail. (attach additional pages if necessary).

Barrier(s) to Housing Stability	Activity to Overcome Barrier(s)	Date to Start Activity	Date to Complete Activity	Person Responsible for Completing Tasks
Example: Loss of Employment	**1. Apply for unemployment benefits;** **2. Refer applicant to DC Office of Employment Services and Temporary Employment Agencies** **3. Applicant will apply to at least 10 employment applications per week.**	**1. 02/01/18** **2. 02/10/18** **3. 02/10/18**	**1. 02/02/18** **2. Ongoing** **3. Ongoing**	**Applicant** **Case Manager** **Applicant**
1.				
2.				
3.				
4.				

Would the applicant like to meet with a Housing Counseling Services Case Manager for additional assistance developing a plan to stabilize their housing and/or financial circumstances?

____Yes ____No

Section 6: Disclosures and Authorizations

Disclosure Statement

I understand that Housing Counseling Services, Inc. (HCS) may need to contact individuals and/or agencies (including but not limited to landlords/property management companies, mortgage companies, utility companies, telephone companies, employers, government agencies, medical/support service providers, pharmacies, and attorneys) to acquire information and verify eligibility for its programs and to maintain contact with me. My signature serves as my consent for HCS to contact individuals, businesses, and/or service provider(s) necessary to document my eligibility and my need.

Further, as a participant in a program funded by the local and federal government, I understand that annual audits will be conducted to verify HCS' compliance with local and federal regulations. I authorize HCS to allow the review of my personal program file, including all verifications and documentation, by the HCS Organizational Auditor or Funding Agency Compliance Auditor/Monitor. All Auditors/Monitors are prohibited from disclosing any personal client information to any source. This authorization will remain in effect as long as an Organizational Auditor or Compliance Auditor/Monitor determines that the review of client files is necessary to complete federally mandated audits, reviews and report(s). I also acknowledge that I have received Housing Counseling Services Client Rights and Responsibilities Form.

My consent is subject to revocation in writing by me at any time. This form has been read by me or to me prior to my signing it.

Applicant Signature:	Case Manager Signature:
Date:	Date:

Authorization of Representation/Release of Information/Consent for Services

The applicant authorizes that ___________________________________ (name of case manager) is permitted to represent the applicant in the process of applying to this financial assistance program and has permission to release information and receive information (including protected health information) related to all matters concerning the applicant in the process. The applicant also authorizes Housing Counseling Services (HCS) to release information (including HIV status and other protected health information) to housing and service providers operating within the HOPWA Housing System, Ryan White Services System, and to the D.C. Department of Health. This release may be revoked at any time verbally or in writing. The applicant understand that HCS will evaluate the application to determine eligibility for services available under the Emergency Financial Assistance Program Standards for the District of Columbia. HCS may need to speak with the applicant, case manager, or other parties to verify information contained within this application. My signature below confirms my consent for HCS to conduct activities necessary to fully evaluate my application. I also understand that HCS, upon review of my financial assistance application, may request that I meet with a housing counselor to discuss my housing stability or to discuss concerns regarding the circumstances of my financial assistance request. To the best of my knowledge and belief, I certify that the foregoing information is true, complete and accurate. I understand that if I have provided any false information, this may result in the denial of my application and may result in further investigation involving any intention to misuse government funds.

As an applicant I also understand that information I provide during the application process may be entered into CAREWare, which is an electronic health and social support services information system for Ryan White HIV/AIDS Program grant recipients and their providers. I understand that HCS staff may need to speak with me to collect additional information about my household for entry into CAREWare. I understand that failure to provide information requested by HCS for CAREWare may be grounds for the denial and closure of my application for housing assistance.

EFA Food/Hygiene Voucher Agreement Statement

I understand that if I have applied for and are approved for the Ryan White Emergency Financial Assistance (EFA) food and/or hygiene voucher, I acknowledge that this voucher is intended for personal expenses related to my well-being and shall not be used to purchase alcohol, tobacco products, lottery tickets, etc. Furthermore, I will not bargain, trade, nor exchange this card for other monetary value, products, and or services.

_________________________________ _________________________________

Applicant's Signature: Date:

Application completed by (Case manager name):____

Organization: ____

Address: ____

Phone Number:_____________________ Fax Number:____________________

Email Address:____

Case Manager's Signature: ____

Date:_____________________________________

By signing this application, the case manager confirms that this application was completed at the request of the applicant and in the presence of the applicant.

As this case manager's supervisor, I attest that I have reviewed this application for financial assistance. I support this application and the completed Housing/Financial Stability Plan to overcome this temporary housing or financial emergency.

Case Manager Supervisor Name:_______________________________________

Supervisor Signature: ____

Date:____________________ Phone Number:_______________________