HOUSING COUNSELING SERVICES
EMERGENCY FINANCIAL ASSISTANCE (EFA) PROGRAM APPLICATION
FOR THE DISTRICT OF COLUMBIA AND SUBURBAN MARYLAND

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: 202-765-2763
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: Acceptable documentation include: physician's statement confirming viral load & CD4 or lab report detailing viral load & CD4 counts (must be within the last 6 months).
- Verification of Residency in the District of Columbia and the following counties in Maryland: Prince George's, Montgomery, Charles, Calvert and Frederick. Acceptable documentation include: current lease; current utility statement (dated within last 90 days); mortgage statement or deed settlement agreement; Property tax bill/statement (dated within last 60 days); rent receipt verifying current address (dated within last 90 days); valid D.C./State of Maryland driver's license/identification card; valid voter registration card; current notice of decision from local Medicaid Program; paystub or bank statement verifying address; letter from government agency verifying current 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 Telephone Assistance, 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

Jurisdiction applicant resides in (check one): ☐ **District of Columbia (D.C.)** ☐ **Prince George's County, MD** ☐ **Montgomery County, MD** ☐ **Charles County, MD** ☐ **Calvert County, MD** ☐ **Frederick County, MD**

Date:_____ **Unique ID**:_____ **Ward (DC only):** ____

Applicant's Name:_____
Last Name First Name Middle

Preferred Name: _____

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

☐ Emergency Medication Assistance

Section 2: Applicant Demographic Information

1a. Gender: ☐ Male ☐ Female ☐ Transgender: MTF or FTM ☐ (circle) ☐

1b. Sex at birth: ☐ Male ☐ Female

Preferred Pronouns: _____

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)** ☐ Black/African American **(B)**
☐ Native Hawaiian or Other Pacific Islander **(PI)** ☐ White **(W)**
☐ Asian ☐ 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 ☐ No ☐

If yes, what insurance do you have:
☐ **Private Individual** ☐ **Private Employer**
☐ **Medicare Part A/B** ☐ **Medicare Part D**
☐ **Medicare Part Unspecified** ☐ **Medicaid**
☐ **VA/Other Military** ☐ **Indian Health Service**
☐ **Other** _____

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

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
FY2023 FMR (effective 10/01/2022)	$800	$1589	$1615	$1838	$2299	$2742

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 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 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**	**ADDITIONAL DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION:** **1. Applicant must sign Emergency Food 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 prior to submission.**

If the applicant is requesting rental, utility, or telephone assistance, is the household able to contribute towards their current outstanding balance(s)

☐ Yes, the household can contribute $_____ towards the outstanding balance(s).

☐ No, the household cannot contribute towards the outstanding balance(s)

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.

Please explain how EFA assistance will resolve the immediate emergency.

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;** **1. Refer applicant to Office of Employment Services and Temporary Employment Agencies** **2. Applicant will apply to at least 10 employment applications per week.**	**1. 02/01/2020** **2. 02/10/2020** **3. 02/10/2020**	**1. 02/02/2020** **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: Date:	Case Manager Signature: 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 Eligible Metropolitan Area (EMA). 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.

DCEMA CAREWARE CENTRALIZED ELIGIBILITY SYSTEM
RELEASE OF INFORMATION

Housing Counseling Services (HCS) is a Ryan White Program service provider for the D.C. Department of Health. As a service provider, utilizing the CAREWARE system, HCS participates in the D.C. Eligible Metropolitan Area (EMA) Centralized Eligibility System (CES) in which Ryan White service providers in the D.C. metropolitan region can share client eligibility information and documents to help streamline the Ryan White eligibility determination process. The CAREWARE system is a computer software program specifically developed to help collect information and coordinate services for people living with specific health conditions.

Your signature gives HCS authorization to share with other providers in D.C. Eligible Metropolitan Area (EMA) Centralized Eligibility System information and documentation you have submitted to HCS to verify your eligibility for Ryan White services, utilizing the CAREWARE system, including health status documentation, income documentation, residency documentation, and insurance documentation.

Your authorization for utilizing your eligibility information/documentation submitted with this application for Ryan White EFA services will expire five years from the date of your signature. You may revoke this authorization at any time by submitting a revocation request to HCS to the attention of the Program Manager for the EFA Program. Furthermore, you understand that this Release of Information only applies to HCS and not to other providers within the EMA Centralized Eligibility System. Information disclosed as a result of this Release of Information may be re-disclosed by other providers within the EMA Centralized Eligibility System and may no longer be protected by local, state, or federal privacy laws. Your decision not to give HCS authorization to share your eligibility information/documentation with other providers through the D.C. Eligible Metropolitan Area Centralized Eligibility System will not impact your ability to receive assistance through the Emergency Financial Assistance Program.

_____ **Yes**, I authorize HCS to share my Ryan White eligibility information/documentation with providers in the D.C. Eligible Metropolitan Area (EMA) Centralized Eligibility System.

_____ **No**, I do not authorize HCS to share my Ryan White eligibility information/documentation with providers in the D.C. Eligible Metropolitan Area (EMA) Centralized Eligibility System.

EFA Food Voucher Agreement Statement

I understand that if I have applied for and are approved for the Ryan White Emergency Financial Assistance (EFA) food 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, or non-food items. 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.

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:_____