**COVID HP ENROLLMENT HMIS#:**

|  |  |  |
| --- | --- | --- |
| **Participant Name:** | **Date Completed** | **Initials of Case Manager** |
| Region 16 CSBG |  |  |
| Consent to Services & Participant Agreement |  |  |
| Copy of signed Lease |  |  |
| Budget Worksheet |  |  |
| Services Tracking |  |  |
| Confidentiality Agreement |  |  |
| HMIS Entry |  |  |
| Staff Certification of Eligibility- COVID HP Assistance |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Region 16 CSBG** Agency: | | | | | County: | | |
| Client ID#: | | | | | Date of Referral: | | |
| Date entered: | | | | | Date of Assessment: | | |
| Date Exited: | | | | | Date of Enrollment: | | |
| SS# | | Last Name | | | First Name | | |
| DOB | | Address | | | | | |
| \*Telephone | | \*Email | | | City/ Zip | | |
| **Gender**: □ Female  □ Male  □ Other | **Household Size:** | **\*Preferred Method of Contact:** □ Telephone □ Email  **Disability:**  □ Yes □ No  **Military Status: Is Client a U.S. Citizen?** □Physical □Developmental  □ No Military □ Veteran □ Yes □ Chronic Health □ HIV/AIDS  □ Active Military □ No □ Mental Health □ SUD | | | | | |
| **Housing: Building Type:**  □ Own □ Mobile Home  □ Rent □ Single Family  □ Other Pmnt Hsing □ *Multi-Family*  □ Homeless □ Low rise( < 3 Lvls)  Date Began: \_\_\_\_\_\_\_\_ □ High rise( > 3 Lvls)  # of times homeless: \_\_\_\_\_\_\_\_  # of mths homeless: \_\_\_\_\_\_\_\_  **Education:**  □ A. 0-8 □ E. College Grad  □ B. 9-12(non-grad) □ F. Unknown  □ C. HS Grad/GED □ D. 12 +(some college) | | **Family Type:**  □ Single Parent/Female  □ Single Parent/Male  □ Two Parent HH  □ 2 Adults/No Children □ Non-related Adults w/ children  □ Single Person □ Other | **Ethnicity:**  □ Hispanic/Latino/Spanish Origins  □ Not Hispanic/Latino/Spanish Origins  **Race:**  □ African American  □ American Indian/Alaska Native  □ Asian  □ Native Hawaiian or other Pacific Islander  □ Other  □ Unknown/Not-Reported  □ White | | | **Health Insurance Type:** □ Medicaid  □ Medicare  □ VA Medical  □ Employer Provided  □ Private Pay  □ Self- Insured □ SCHIP □ SHIA  □ COBRA  □ Indian Health Services  □ None | |
| **Income-*Fixed*:**  □ SSI □ Pension  □ SSA □ Alimony  □ SSDI  □ Widow/er Benefits  □ Adoption Assist  □ Black Lung Pension  Frequency:\_\_\_\_\_\_\_\_  Total Amt:$ \_\_\_\_\_\_\_ | **Income-*Earned*:**  □ Wages  □ Self-Employment  □ Active Military Pay  □ Ohio Electronic  Child Care  Frequency: \_\_\_\_\_\_\_\_  Total Amt:$\_\_\_\_\_\_\_\_ | **Income-*Supplemental*:**  □ Unemployment  □ Utility Assistance  □ Workers’ Comp  □ Ohio Works First  □ TANF □ ADC    Frequency:\_\_\_\_\_\_\_\_  Total Amt:$\_\_\_\_\_\_\_ | **Income *Other:***  □ Cash Withdrawals from:  IRA, Annuities, Other Investments  □ Lump Sum Payout:  SSI, SSDI,Lottery Winnings, Insurance  Claim, Settlement (Estate/Trust/Divorce)  □ Interest Income  □ NONE  Frequency:\_\_\_\_\_\_\_\_  Total Amt:$\_\_\_\_\_\_\_ | | | **Non-Cash Benefits:**  □ ACA Subsidy  □ Child Care Voucher  □ Housing Choice Voucher  □ HUD-VASH  □ Other  □.PSH  □ WIC  □ Public Housing  □ SNAP (NOT Income  Countable)  Amount: $\_\_\_\_\_\_\_ | |
| **Deductible Income:** **Total Household Income:** □ Health Insurance Premiums □ Child Support Paid-Out Total Countable Income :\_\_\_\_\_\_\_\_  □ Health Care Spending Account □ Attorney Fees for estate or ***-(minus)*** Total Deductible Income :\_\_\_\_\_\_\_\_  □ Medicaid Spend Down (deductibles) trust settlements **TOTAL HH INCOME**:\_\_\_\_\_\_\_\_  □ Medicare Part D (RX Premium) Frequency:\_\_\_\_\_\_\_\_ Total Amt:$\_\_\_\_\_\_\_\_ **Federal Poverty Level %:**\_\_\_**30**\_\_\_\_\_ | | | | | | | |
| **Household Members** | | | | | | | |
| Social Security # |  |  | |  |  | |  |
| Last Name |  |  | |  |  | |  |
| First Name |  |  | |  |  | |  |
| Date of Birth |  |  | |  |  | |  |
| Gender |  |  | |  |  | |  |
| Disabled |  |  | |  |  | |  |
| Ethnicity |  |  | |  |  | |  |
| Education |  |  | |  |  | |  |
| Health Insurance |  |  | |  |  | |  |
| Veteran |  |  | |  |  | |  |
| Income Period |  |  | |  |  | |  |
| Income Amount |  |  | |  |  | |  |
| Income Source |  |  | |  |  | |  |

***I certify this statement is true & correct to the best of my knowledge; I authorize the release of any or all information necessary for verification purposes.***

**Participant Signature: Date:**

**Approved By:** **Date:**

**Consent for Services and Participation Agreement**

Homeless Prevention (HP) offers homeless prevention assistance for households (individuals or families) at risk of experiencing homelessness but for the assistance of HP. These specific COVID HP pandemic funds are provided to prevent participants from being evicted as directly impacted by COVID pandemic circumstances. Participant agrees to provide required documentation and work to reach their goals to maintain housing stability. The purpose of this agreement is to state the terms and conditions under which the pandemic COVID HP services will be provided to program participants. This agreement will also detail the responsibilities of COVID HP program participants, and what may result in termination of COVID HP assistance.

|  |
| --- |
| ***Consent for Services*:**  **I agree to participate in the COVID Homeless Prevention (HP) program and understand it is a program that consists of a combination of financial assistance (as directly related to pandemic rental arrearages) and supportive services. I understand the goal of the program is for each participant to be able to maintain their own independent permanent housing moving forward. I agree to participate submit required program documentation & understand that I may withdraw from the COVID HP program at any time and agree to meet with Case Manager to close my household’s case.**  **Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_** |

**Participation Agreement**

I understand and agree to adhere to all the guidelines stated herein which have been fully discussed with me and agree to voluntarily sign this contract. I also agree to truthfully report any problems, changes, or concerns that occur during the length of involvement with the program. I further understand that my active participation in the COVID HP program services allows the Case Manager to support my household’s ability to maintain housing stability.

***Participant Responsibilities/Obligations (Participant must initial each of the following):***

1. I understand this COVID HP pandemic assistance is ***TEMPORARY***. I verify I can pay my monthly rental agreement, as agreed to in my signed lease that I provided to the case manager, after this COVID HP pandemic financial assistance is provided. \_\_\_\_\_\_\_\_ (Initials)

2. I understand that the services of COVID HP are one time assistance and determination factors of approval include; pandemic affected rental arrearage, needs of the household, household engagement in services, and available resources. The maximum amount of COVID HP services for any household is 6 months. This applies to this COVID HP program only. \_\_\_\_\_\_\_\_ (Initials)

3. I understand the unit receiving financial assistance through the COVID HP program must be my **only residence**. I understand that my household may not be receiving other housing/utility subsidies for any housing unit under any duplicative Federal, State, or local subsidy program. I understand that I cannot sub-lease/let/transfer lease to another household. \_\_\_\_\_\_\_\_ (Initials)

5. I understand that I need to report changes of income (up or down) to the Case Manager **within 10 days**. I agree to keep my Case Manager informed & updated of my lease compliance, income status, goal progress, rental payment plans/abilities, and other areas as needed/required. \_\_\_\_\_\_\_\_ (Initials)

6. I understand I am required to meet with my case manager and provide all required documentation. I understand that my case manager will work with me to schedule appointments to conduct the required enrollment meeting. I understand that this assistance is one time and will cover my rental arrears only. \_\_\_\_\_\_\_\_ (Initials)

**My HH’s financial assistance for pandemic rental arrearage is as follows:** \_\_\_\_\_\_\_ (Initials)

|  |  |  |
| --- | --- | --- |
| COVID HP Funds leveraged (specify amount of eligible arrearages HP will cover) | List each month in arrears:  List Late Fees (if applicable): | Total Amount requested: |

7. **I will pay my rent moving forward.** I understand that I am responsible to pay my rent as stated in my lease after the COVID HP program pays my rental arrears. I understand that, as the tenant, I am required by law to pay my rent on time, every month and in full, until the lease expires. COVID HP pandemic rental arrearage assistance is dependent upon the availability of funds, community resources, my resources, and my engagement in program services. \_\_\_\_\_\_\_\_ (Initials)

8. I will **follow all aspects of the lease** – I agree to follow Ohio Landlord-Tenant Laws and comply with the lease to the best of my ability. As such, I agree to the following:

* I will not commit any serious damage to the unit or permit any household member/guest to damage the unit (damage is understood to be any damage other than ordinary wear and tear).
* I will not have repeated violations of the lease.
* I understand that I must keep my unit clean and sanitary.
* I will be respectful of my neighbor’s right to a peaceful environment.
* I will avoid illegal activities and comply with lease/property rules surrounding the pet policy, lawn/grounds maintenance, overnight guests, etc.
* I understand that my HH’s compliance allows HP staff to advocate on my behalf while also maintaining a positive relationship with my current landlord, as well as future landlords.
* I will report to the landlord, or building staff, any problems with plumbing, lights, appliances, air conditioning, heating, etc.

\_\_\_\_\_\_\_\_ (Initials)

9. I understand that I/my household must not commit fraud, bribery, or illegal/violent acts including drug related activities in the unit or on the property. I understand that if my unit is vacant due to my incarceration for a period greater than 30 days, I will no longer be eligible for COVID HP. \_\_\_\_\_\_\_\_ (Initials)

***Termination of Assistance***

If the participant violates COVID HP requirements and/or this agreement, the program may recommend ending the rental/utility assistance for the participant. If the participant is noncompliant, program staff must make three attempts to contact them & document the attempts. The three attempts made by staff should be varied (verbal, in person, written or electronic). The termination process may include, but is not limited to:

1. Written/verbal notice to the participant detailing reasons for termination:
   1. Not following program requirements or agreement
   2. Participant request to withdraw from
   3. Notification of landlord of the reason for termination

If participant does not agree with the reasons for program termination, they may follow the grievance process:

***Grievance Process***

There are three (3) steps to the grievance process:

1. Discuss the matter with a staff member involved. An open discussion will usually clear up the misunderstanding and solve the problem. If the matter remains unresolved, go to step 2.
2. Request a complaint form and complete it. Forward complaint to the Homeless Director, **Stacey Johnson** @**;**

1400 U.S. Route 22 NW Washington Court House, OH 43160. If you are unable to fill out the complaint form, you may request a meeting with the Homeless Director. S/He will review the complaint and respond in writing to the participant within five (5) working days of receipt of the report. If the participant remains dissatisfied with the resolution offered, s/he may take the next step. \*\* Or in the case that the grievance is with the Homeless Director, move to step 3.

1. Request that the complaint form be forwarded to the Executive Director for review. S/He will take one of the

following two (2) steps:

* + - Give the participant a written response which would indicate the final disposition; or
    - Call a conference for the parties involved in the incident(s). The final disposition will be issued within five (5) working days of the conference.

If the decision is not satisfactory, you may file a request for an administrative appeal. Submit your written appeal, along with the response of the agency to **Patrick Hart** at 77 S. High Street, P.O. Box 1001 Columbus, OH 43216.

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

**Participant Name (Printed)**  **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Participant Signature**  **Date**(Provide copy to Participant)

**Budget Worksheet**

**PARTICIPANT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **MONTHLY**  **EXPENSES** | **Mthly**  **Amount** |
| Rent |  |
| Utilities: Electric **PIPP: Y N** |  |
| Gas **PIPP: Y N** |  |
| Water |  |
|  |  |
| Cell phone |  |
| Food expenses covered by SNAP benefit | **(**  **)** |
| Food expenses (include if HH need exceeds SNAP benefit)  **\*Calculates @ $50/person weekly (ex: 2 person HH; 50x2=100wkly. 100 x4= 400 monthly)** |  |
| Baby Formula and/or Diapers |  |
| Transportation: (car payment, gasoline or transportation fare) |  |
| Child Care |  |
| Medical (prescriptions, co-pays, medicine needs) |  |
| Insurance (Automobile, Renters) |  |
| Household Supplies |  |
| Personal Needs (clothing, shoes, haircut, etc) |  |
| Tobacco |  |
| School Expenses (school lunch, fees, tuition, books, etc) |  |
| Installment loans & other Debt Payments |  |
| Child Support Payments |  |
| Savings (please specify) |  |
| Other (please specify) |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **A: *TOTAL MONTHLY COSTS***  Exclude Food expenses covered by SNAP benefit |  |
| **B: *TOTAL NET MONTLY INCOME***  Include: Wages, child support, SSI, OWF (any eligible income) ***Do NOT include SNAP benefit***. |  |
| **C: ADJUSTED MONTHLY INCOME**  (Total NET Monthly Income – Total Monthly Costs) |  |

**Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Services Tracking Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Participant Name: Date: | | | | |
|  |  |  |  |  |
|  | Service | Provided/Referred  (Circle One) | Agency or Service  (Provided/Referred To) | |
|  | Furniture Assistance | Provided Referred |  | |
|  | Utility Assistance | Provided Referred |  | |
|  | Food Pantry | Provided Referred |  | |
|  | Clothing/Furniture Voucher | Provided Referred |  | |
|  | Job Training/ Placement Referral | Provided Referred |  | |
|  | Schooling/ Training | Provided Referred |  | |
|  | Mental Health Counseling | Provided Referred |  | |
|  | PRC Assistance | Provided Referred |  | |
|  | EF&S Application/ Assistance | Provided Referred |  | |
|  | Metropolitan Housing | Provided Referred |  | |
|  | Landlord Advocacy | Provided Referred | HP | |
|  | Budget Counseling | Provided Referred | HP | |
|  | Eviction Prevention Information | Provided Referred | HP | |
|  | Lease Review | Provided Referred | HP | |
|  | Head Start/Help Me Grow | Provided Referred |  | |
|  | Jobs & Family Services | Provided Referred |  | |
|  | Salvation Army | Provided Referred |  | |
|  | Youth Build | Provided Referred |  | |
|  | Social Security | Provided Referred |  | |
|  | Substance Abuse Counseling | Provided Referred |  | |
|  | Child Care Assistance (Title 20) | Provided Referred |  | |
|  | After-School/ Summer Camp Program | Provided Referred |  | |
|  | Other | Provided Referred |  | |

**Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Confidentiality Agreement**

***Confidentiality is protecting another person’s right to privacy***Information participants reveal to their COVID Homeless Prevention (HP) Case Manager will not be discussed with anyone else. This means that the Case Manager will not reveal a participant’s personal information to anyone, without participant’s written permission, unless required by law. Furthermore, it is agreed that participants will not discuss their HH’s participation, the specific amount of financial assistance received through the program, or time enrolled with persons not affiliated with the COVID HP program or its partners.

***A Release of Information***

This form is used to obtain this permission between the Case Manager and participant. This Confidentiality Agreement form serves as the permission between the Case Manager and participant to allow Case Managers to meet, get acquainted, and discuss social and personal interests provided with other community and social service providers and program evaluators.

***Exceptions to the Right of Confidentiality***Case Managers are asked to report information to the HP Coordinator and/or Supervisor that is required by Federal or State law. This includes information that indicates a participant is endangered, exploited, or is related to suspected fraudulent activity or other violations of the law.

***Confidentiality Pledge***As your Case Manager, I agree to protect your right to privacy and confidentiality. I will not disclose any information about you unless I am required to do so by law or authorized to do so through your signed release.

**Participant Name (Printed) Date**

**Participant Signature Date**

**Case Manager Signature Date**

**STAFF CERTIFICATION OF ELIGIBILITY- COVID HP ASSISTANCE**

**Purpose:** This form serves as documentation that: (1) the program participant named below meets all eligibility criteria for COVID Homeless Prevention assistance; (2) this eligibility determination is based on true and complete information; (3) neither the staff member making this determination nor her/his supervisor are related to the program participant through family, business or other personal ties; and (4) this eligibility determination has not resulted from, nor will result in, any financial benefit to the staff member making this determination, his/her supervisor, or anyone related to them.

**Instructions:** This form must be completed for each program participant upon the determination of her/his eligibility for COVID HP assistance. This form must be signed and dated by the case manager and supervisor who determine a household’s eligibility. This form must be kept in the COVID HP program participant’s case file. This form will remain valid, unless a different case manager re‐determines the household’s eligibility, in which, case a new form will be required.

|  |
| --- |
| **Participant Name:** |
| **Enrollment Date**: |
| **\***List all members of household: |
|  |
|  |
|  |
|  |
|  |

*\*All members in household that will benefit from COVID HP assistance must be listed here.*

**Required certifications:** Each person signing below certifies to the following: (1) To the best of my knowledge, the program participant named above meets all requirements to receive assistance under COVID HP. (2) To the best of my knowledge and ability, all the information used in making this eligibility determination is true and complete. (3) I am not related to the program participant through family, business, or other personal ties. (4) To the best of my knowledge, neither I, nor anyone related to me, has received, or will receive any financial benefit for this eligibility determination. (5) I understand that fraud is investigated by the Department of Housing and Urban Development, Office of Inspector General, and may be punished under Federal laws to include, but not limited to, 18 U.S.C. 1001 and 18 U.S.C. 641. (6) I understand that if any of these certifications is found to be false, I will be subject to criminal, civil and administrative penalties, and sanctions.

**Case Manager Signature: Date:**

**Supervisor Signature: Date:**