Financial Assistance Tab

|  |  |  |
| --- | --- | --- |
| **HMIS #:** | **Date Completed** | **Staff Initials** |
| Direct Client Assistance - UPDATE MONTHLY (if applicable) |  |  |
| Budget Worksheet- UPDATE MONTHLY-make copy of Budget from Enrollment tab & complete Actual Amt column |  |  |
| W-9 |  |  |
| Purchase Orders  |  |  |
| Check Requests |  |  |

**Direct Client Assistance**

|  |  |  |  |
| --- | --- | --- | --- |
| **Participant Name:** |  | **Case Manager:** |  |
|  |
| **P.O. Request Date** | **Amount Leveraged** |  **Funding Source** (Ex: RRH, PSH, HP) | **Assistance Type**(ex: App Fee, Deposit, Rental Assistance, Utility, Rental Arrears) |
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|  |  |  |  **Total Amount Leveraged** $ \_\_\_\_\_\_\_\_\_ |
| **Check** **Request****Date** | **Amount Spent** | **Funding Source**(Ex: RRH, PSH, HP) | **Assistance Type**(ex: App Fee, Deposit, Rental Assistance, Utility, Rental Arrears) |
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|  **Total Amount Spent** $ \_\_\_\_\_\_\_\_\_ |

**Budget Worksheet**

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

 **Complete in:**

 **Tab 2 Tab 4**

|  |  |  |
| --- | --- | --- |
| **Monthly Expenses** | **Estimated Amt** | **Actual Amt** |
| 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, haircut, shoes, etc) |  |  |
| Tobacco Use |  |  |
| School Expenses (fees, lunches, books, tuition, etc) |  |  |
| Installment loans or other Debt Payments (Fines, Court Costs, etc.) |  |  |
| Storage Unit (\**NOT counted when housed*) |  |  |
| 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) |  |  |
| **Monthly Rent Contribution?** 🞏 30% (less than 30% AMI) 🞏 50% (greater than 30% AMI) 🞏 NO\*  |
| \*If no, please use the space below to explain extenuating circumstances (emergency/large expenses) that prevents the household from contributing to their housing burden: |

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

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

**PURCHASE ORDER REQUEST**

**COMMUNITY ACTION COMMISSION OF FAYETTE COUNTY**

|  |  |
| --- | --- |
| **Vendor**    | **Program Information** |
| Name:  | Purchaser:  |
| Address:  |  Employee’s Name DateApproved By: |
| City/State/Zip:  |  Supervisor’s Name DateProgram:  |
| VID: Date:  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **QUANTITY** | **DESCRIPTION** | **PRICE EACH** | **ELEMENT** | **TR #** |
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**Additional Explanation for Purchases if needed:**

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Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Executive or Deputy Director Date

Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fiscal Officer Date

**COMMUNITY ACTION COMMISSION OF FAYETTE COUNTY**

**1400 U.S. Rt. 22 NW**

**WASHINGTON COURT HOUSE, OHIO 43160**

**CHECK REQUEST**

Date: Amount:

To:

Purpose:

Requested By:

Charge to Grant:

Element # / Transaction #:

Approved for Payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Executive Director or Deputy Director Signature)