Family SERVICES
ERU@fsmontco.org
Ph: 610-630-2111 x235
Fax: 610-630-4003

YOUR WAY HOME MONTGOMERY COUNTY

Updated November 2021

Your Way Home Emergency Rent & Utility Coalition Application

Instructions

This data is collected for purposes of assessing initial intake and eligibility for the Your Way Home Emergency Rent and Utility Coalition's program in response to COVID-19, called ERUC-CV. The information contained in this form will be input into Montgomery County's Homeless Management Information System (HMIS), Clarity, with your signed permission. If you permit it, this agency may share limited information about you with other Your Way Home Montgomery County (YWH) agencies from whom you may also seek services. We will not deny you help if you do not want us to share your personally identifying information.

Additionally, this is a written statement from the beneficiary documenting monthly (Gross) Income at time of application, the number of beneficiary members in the family or household, and the relevant characteristics of each member for the purposes of income determination. For the purposes of this regulation, income will be defined according to the Code of Federal Regulations at 24 CFR, Part5.

The information provided on this form is subject to verification at any time, and Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony and assistance can be terminated for knowingly and willingly making a false or fraudulent statement to a department of the United States Government. All adult beneficiary members must then sign this statement to certify that the information is complete and accurate, and that source documentation will be provided upon request.

Date: _____

Please check (√) one or more boxes:

☐ This agency may share my personally identifying information within YWH Data Systems.

☐ Please treat information about my children age 17 or younger the same as mine.

Please be aware that we may also share the following information:

- Services you receive
- Your income
- Referral status for housing services
- Military history
- Living situation and housing history
- Your housing plan

☐ This agency may **not** share my personally identifying information within YWH Data Systems.

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PART I: Household Information & Composition

Head of Household Contact information

First Name: _____ Last Name: _____

Date of Birth: _____

Social Security Number: _____ - ____ - _____ (Not Required)

Email Address: _____

Phone Number: _____

Street Address: _____

City, State, Zip code: _____

Are you a Montgomery County Resident? ☐ Yes ☐ No

Gender (choose one):
☐Female ☐Male ☐Trans Female ☐Trans Male ☐Gender Non-Conforming
☐Don't Know ☐Refuse to Answer

Race (choose as many as applies):
☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander
☐White ☐Don't Know ☐Refuse to Answer

Ethnicity (choose one):
☐Non-Hispanic/Non-Latino ☐Hispanic/Latino ☐Don't Know ☐Refuse to Answer

Veteran Status (choose one):
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have a Physical Disability?
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the physical disability expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have a Developmental Disability?
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the developmental disability expected to impair your ability to live independently?
☐No ☐Yes ☐Don't Know ☐Refuse to Answer

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Do you have a Chronic Health Condition?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have HIV/AIDS?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the HIV/AIDS expected to substantially impair your ability to live independently?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have a Mental Health Condition?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, is the mental health condition expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Do you have a Substance Abuse Condition?

☐No ☐Alcohol Abuse ☐ Drug Abuse ☐Both alcohol and drug abuse ☐Don't Know ☐Refuse to Answer

If Yes for alcohol abuse, drug abuse, or both, is the substance use condition expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

Are you a Domestic Violence Victim or Survivor?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, when did the experience occur?

☐Within the past 3 months ☐ Three to six months ago ☐Six months to one year ago

☐One year ago or more ☐Don't Know ☐Refuse to Answer

If Yes, are you currently fleeing?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

On the night previous to this application, where did you sleep? _____

How long have you been sleeping at the location you wrote in above?

☐One night or less ☐Two to six nights ☐One week or more, but less than one month

☐One month or more, but less than 90 days ☐90 days or more, but less than one year ☐One year or longer

☐Don't Know ☐Refuse to Answer

Are you currently covered by Health Insurance?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, answer 'Yes' or 'No' for each health insurance choice. Answer 'no' for sources that have been terminated, even if you received it in the past

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No	Yes	Source
☐	☐	Medicaid
☐	☐	Medicare
☐	☐	PA CHIP
☐	☐	Veteran's Administration (VA) Medical Services
☐	☐	Employer-provided Health Insurance
☐	☐	Health insurance obtained through COBRA
☐	☐	Private Pay Health Insurance
☐	☐	Indian Health Services Program
☐	☐	State Health Insurance for Adults
☐	☐	Other Health Insurance: _____

Do you currently receive any non-cash public benefits from any source?

☐No ☐Yes ☐Don't Know ☐Refuse to Answer

If Yes, answer 'Yes' or 'No' for each non-cash benefit choice. Answer 'no' for sources that have been terminated, even if you received it in the past

No	Yes	Source
☐	☐	Supplemental Nutrition Assistance Program (SNAP)
☐	☐	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐	☐	TANF Child Care Services
☐	☐	TANF Transportation Services
☐	☐	Any other TANF Funded Service: _____
☐	☐	Other Public Benefit Source: _____

Other Household Members

Total Number of Persons in Household: _____

Name of Other Household Members	Relationship to Head of Household	Soc. Sec. # (not required)	Age	DOB MM/DD/YYYY	Gender	Race	Ethnicity

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Landlord Information

Landlord Name: _____

Other Contact, if applicable (e.g. Property Manager): _____

Landlord Email: _____

Landlord Phone Number: _____

Have you informed your Landlord that you have applied for this program?
☐Yes ☐No

Do you or your Landlord currently receive any rental or utility subsidy for the address on this application (e.g., Housing Choice Voucher AKA "Section 8")?
☐Yes ☐No ☐Don't Know

PART II: Household Income – Head of Household and Other Household Members

Report adjusted gross income from the previous 30 days for all household members. Only report on regular, recurrent income sources that are current as of today (i.e. not terminated). Include any income received to your household that any adult or minor receives (e.g. SSI), but do not income employment income that any minor receives.

Do you or any other Adult Household Member have any current income from any source?

☐No ☐Yes

If Yes, enter the **monthly** amount received based on current income at time of application. If unsure of exact monthly amount, enter your best estimate. Answer 'No' for sources that have been terminated, even if they were received in the past.

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)
Earned income (i.e., employment income)	No ☐	
	Yes ☐	$. 0 0
Unemployment Insurance	No ☐	
	Yes ☐	$. 0 0
Supplemental Security Income (SSI)	No ☐	
	Yes ☐	$. 0 0
Social Security Disability Insurance (SSDI)	No ☐	
	Yes ☐	$. 0 0
VA Service-Connected Disability Compensation	No ☐	
	Yes ☐	$. 0 0
VA Non-Service-Connected Disability Pension	No ☐	
	Yes ☐	$. 0 0
Private disability insurance	No ☐	
	Yes ☐	$. 0 0
Worker's Compensation	No ☐	
	Yes ☐	$. 0 0

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Temporary Assistance for Needy Families (TANF)	No	☐				
	Yes	☐	$			. 0 0
General Assistance (GA)	No	☐				
	Yes	☐	$			. 0 0
Retirement Income from Social Security	No	☐				
	Yes	☐	$			. 0 0
Pension or retirement income from a former job	No	☐				
	Yes	☐	$			. 0 0
Child support	No	☐				
	Yes	☐	$			. 0 0
Alimony or other spousal support	No	☐				
	Yes	☐	$			. 0 0
Other source If yes, specify source:_____	No	☐				
	Yes	☐	$			. 0 0
Total monthly income from all sources			$			. 0 0

PART III: COVID-Related Need

Financial Hardship and Housing Instability due to COVID-19

Check as many boxes as appropriate

☐ You were laid-off from your primary place of employment as a direct result of COVID-19.

☐ You had a reduction in income as a direct result of COVID-19.

☐ You or a member of your household has been diagnosed with COVID-19 or are experiencing symptoms ofCOVID-19 and seeking a medical diagnosis.

☐ You are providing care for a family member or a member of your household who has been diagnosed with COVID-19.

☐ A child or other person in your household for which you have primary caregiving responsibility is unable to attend school or another facility that is closed as a direct result of COVID-19 public health emergency and such school or facility care is required for you to work.

☐ You are unable to reach your place of employment (or commence employment) because of imposed quarantine or self-quarantine (at direction of health care provider) as a direct result of the COVID-19 public health emergency.

☐ You have become the breadwinner or major support for a household as a direct result of COVID-19.

☐ You had to quit your job as a direct result of COVID-19.

☐ Your place of employment is closed as a direct result of COVID-19.

☐ Without the assistance provided by this program, I would become homeless or am currently homeless.

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Rent & Utility Assistance Needed

Due to these COVID-19 impacts, I need assistance with (choose one):

☐Rent ☐Utilities ☐Both

Rent per Month (as shown on my lease): $_____ # of Months owed in Rent: _____

Total Rental Arrearages (including any documented late fees or other fees) at time of application: $_____

I have arrearages owed for the following Utilities: ☐Gas ☐Oil ☐Electric ☐Water/sewer ☐Internet
☐None of These ☐ Other: _____

Total Utility Arrearages (including any documented late fees or other fees) at time of application: $_____

Duplication of benefits affidavit

Section 312 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, (42 U.S.C. 5121–5207) (Stafford Act)

Recipient agrees that if they receive further federal benefits for the same services received under this ERUC-CV program, the recipient will report receiving benefits within one (1) month of receipt of additional proceeds and/or benefits. If recipient fails to report additional federal benefits, then the County of Montgomery may require immediate repayment in full of the entire grant amount provided by the County of Montgomery.

Since March 1, 2020, have you or any other adult member of your household received rental or utility assistance for the address on this application, from any other source?

☐Yes ☐No

If Yes, please describe the source of the previous funding, the months you were assisted, and total amount received:

_____

PART IV: Certification

I/We HEREBY affirm and verify that I/We have not received payment or other financial assistance that would create a duplication of benefits under this grant program.

I/we certify that this information is complete and accurate. I/we agree to provide, upon request, documentation on all income sources. I acknowledge that I understand that making the certification is under penalty of perjury and intentional misrepresentation in self-certifying that I may call in one or more of these categories is fraud.

Additionally, when you sign this form, it shows that you understand the following:

- Persons with access to Your Way Home (YWH) Data Systems are trained in security protocols to protect your data and are only permitted to view your data when you are specifically working with their agency.
- If you request services from another YWH agency, your information will be shared for referral purposes only.
- YWH may use information derived from your data to create reports to share with funders, the community, and partners to better understand the scope of homelessness and the services being provided. Your personally-identifying information will never be used on these reports.

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Head of Household:		
Signature	**Printed Name**	**Date**
Other Adults Residing in Household (no signatures needed):		
Name		
Name		
Name		

**If household is unable to digitally or physically sign certification, this certifies that the household provided verbal certification to the agency providing services:

Signature of nonprofit provider representative: _____

Printed name of nonprofit provider representative: _____

Date: _____

Agency Use Only: YWH Code (If HoH did not agree to share personally-identifying info): _____

Emergency Rent and Utilities (ERU) Program
CHECKLIST

- ☐ Photo IDs for all adult members of the household
- ☐ Rental/Lease agreement
- ☐ Past 30-day income documentation
- ☐ Proof of financial hardship (such as unemployment verification or proof of application, letter from past employer ie: loss of hours, etc. Please call if unsure of what to send.)
- ☐ 3rd party verification of address (such as copy of driver's license, utility bill, etc.)
- ☐ Copy of any past due utility bills (gas, electric and/or, water)
- ☐ Completed application with signature (Electronic signature is acceptable.)
- ☐ Completed Emergency Rent and Utilities Coalition Program Agreement with signature (see page 10; electronic signature is acceptable.)

Note: When you are completing the application, page 6 will ask you about financial hardship related to COVID. The last box on page 6 ***MUST BE CHECKED*** *in order to process your application.*

Name_____
Address_____
City, State, Zip_____
Phone Number_____
Email_____

Signature_____

Date_____

Return your completed application and documentation to:

Family Services
Attn: ERU
3125 Ridge Pike
Eagleville, PA 19403
ERU@fsmontco.org
Fax: 610-630-4003

If you have questions or need assistance, please contact 610-630-2111 ext. 235 or ERU@fsmontco.org

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Emergency Rent and Utilities Coalition Program Agreement

By signing this form I agree to the following statements:

- I will communicate with my case manager regularly and in a timely fashion.
- I will work collaboratively with my case manager, my landlord, and my utility companies, to secure and provide all necessary documentation.
- I have received, read, and agree to the Rights & Responsibilities Page.
- I have received, read, and understand the Grievance Procedure should my application be denied.

I further understand that failure to comply with the above mentioned statements could result in the following:

- A delay in receiving the necessary Emergency Rental Assistance.
- A denial of my application.

I agree with the terms and requirements to receive Emergency Rental and Utilities Assistance. I also understand that providing false information may result in disqualification or termination from the program.

I understand that this is not an entitlement program. Decisions on participation are based on a review of information about a household and whether that household meets the criteria that are outlined in the federal program regulations, and the availability of funds.

_____ _____

Client Signature Date

OHCD Emergency Rent and Utilities Assistance Rights and Responsibilities

Client's Rights

- You have the right to be treated with respect and dignity at all times.
- You have the right to receive services free from pre-requisites, judgments, biases, prejudice, or any other conditions not based on basic program eligibility.
- You have the right to receive services at times and locations that are convenient to you, although delays may occur due to the volume of applications.
- You have the right to open communication with staff.
- You have the right to review your program file or receive a summary of your program record with a written and signed request.
- You have the right to the safety, security, and confidentiality of all information obtained as a result of program enrollment and to ensure privacy at all times.
- You have the right to protection from any and all forms of abuse (physical, verbal, sexual, psychological), harassment, humiliation, threats, retaliation, neglect, exploitation (financial or other), and any other forms of mistreatment as a result of program participation.
- You have the right to make complaints regarding services received by contacting immediate program supervisors or the Your Way Home Program Manager.
- You have the right to be informed of eligibility and program criteria and any changes made to these criteria.

Client's Responsibilities

- You have the responsibility to treat staff with respect and dignity
- You have the responsibility to ensure all requested documentation is received by your your assigned ERU coordinator, including rent receipts, utility payment receipts, paystubs, and other requested documentation.
- You have the responsibility to update staff with current contact information.
- You have the responsibility to ask questions about your services so that you better understand them.
- You have the responsibility to abide by all terms as stated on your lease.
- You will contact your assigned ERU coordinator if you are still in need of rental assistance at the time of recertification (indicated on your approval letter).

You may be discharged from services under the following circumstances:

- You no longer meet eligibility criteria.
- You falsify documents or falsify information regarding leasing information, COVID impact, other eligibility criteria, and/or income.
- You do not meet the responsibilities outlined in this document.
- You exhibit harassment or threats towards any staff member, volunteer, or community participant.
- You move to another county, state, or country or if your whereabouts are unknown.
- You have received the total number of eligible months of assistance.

OHCD Emergency Rent and Utilities Client Exit/Termination Grievance Procedure

Your Way Home wants you to be satisfied with the services we provide and will make every effort to informally resolve any concerns you may have. Per your rights as outlined in Client Rights & Responsibilities, you are free to contact your case manager's direct supervisor at any time to discuss concerns you may have.

You may also pursue a formal grievance should your application for rent or utility assistance be denied. A staff member, family member, friend or advocate may represent you during your grievance process.

- The first step in filing a formal grievance is to submit the grievance in writing to the Program Manager within 10 business days of your denial letter:

  April McNeal
  Homeless Prevention Program Manager, Your Way Home
  P.O. Box 311
  Norristown, PA 19404
  Fax: 610-278-3636

  Your formal grievance must include specific reasons why the Program Manager should reconsider your participation in the program and any supporting documentation.

- You will be notified within one business day that your grievance has been received.

- After reading and/or listening to your concerns, the Program Manager will make a determination in writing within 5 business days. You will be provided a copy of the determination and the reasons leading up to the determination within 10 business days.

Your Way Home is prohibited from retaliating against you for filing a grievance. Throughout the grievance process, we will monitor for retaliation and protection of your rights.