

**Kane County
Office of Community Reinvestment
Homelessness Prevention Program
Application**

Date:	
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Section I. Applicant Information

Applicant Name:		First	Middle	Last
Social Security #:		Phone:		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Friend/Relative
Address:				
City/Town:	State:	Zip:	County:	
Email:				
Sex:	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No

Section II. Living Situation

Current Housing Status (Check one)			
<input type="checkbox"/> Literally Homeless	<input type="checkbox"/> Imminently Losing Housing	<input type="checkbox"/> Unstably Housed	<input type="checkbox"/> Stably Housed
Type residence at time of application (Check one)			
<input type="checkbox"/> Emergency shelter	<input type="checkbox"/> Foster care	<input type="checkbox"/> Staying/living with family member	<input type="checkbox"/> Staying/living w/friend
<input type="checkbox"/> Transitional housing-homeless	<input type="checkbox"/> Jail/prison/juvenile detention	<input type="checkbox"/> Psychiatric Treatment Facility	<input type="checkbox"/> Substance abuse Treatment Facility
<input type="checkbox"/> Permanent Housing for formerly homeless	<input type="checkbox"/> Non-Housing (street, park, car, bus station, etc.)	<input type="checkbox"/> Place not meant for habitation/ condemned housing	<input type="checkbox"/> Hotel/motel paid for without emergency shelter voucher
<input type="checkbox"/> Rented room/apartment/house	<input type="checkbox"/> Own your home	<input type="checkbox"/> Other:	
Length of Stay:			
Government Assistance/Benefits (Check all that apply): <input type="checkbox"/> SNAP <input type="checkbox"/> WIC <input type="checkbox"/> TANF Child Care			
<input type="checkbox"/> TANF Transportation <input type="checkbox"/> TANF <input type="checkbox"/> Subsidized Housing <input type="checkbox"/> Temporary Rental Assistance			
Other Government Assistance:			

Section III. Household Information

Fill in the table below about all of the members in your household. Start with yourself.

Name	Date of Birth	Race	Hispanic	Gender
		<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander	Yes <input type="checkbox"/> No <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
		<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander	Yes <input type="checkbox"/> No <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
		<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander	Yes <input type="checkbox"/> No <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
		<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander	Yes <input type="checkbox"/> No <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
		<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander	Yes <input type="checkbox"/> No <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
		<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander	Yes <input type="checkbox"/> No <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>

Section IV. Eligibility

To be eligible to receive Homeless Prevention Program funding your household must have been impacted by COVID-19 and meet one additional criterion.

Indicate the impact of COVID-19 below (include documentation of member of household affected by COVID-19):	
<input type="checkbox"/>	Medical expenses associated w/ COVID-19 temporarily affecting the household's ability to pay rent/utilities.
<input type="checkbox"/>	Employment: Laid off or furloughed due to COVID-19 temporarily reduced the household's income.
<input type="checkbox"/>	Temporary loss of business or a reduction of income due to COVID-19
<input type="checkbox"/>	Due to COVID-19 quarantine or isolation causing temporary reduction in household income.
<input type="checkbox"/>	Due to school/day care closing a financial provider had to stay home which reduced the household income
<input type="checkbox"/>	Other:

In addition to being affected by COVID19 your household must also meet one of these criteria:		
<input type="checkbox"/> Loss of employment	<input type="checkbox"/> Medical disability or emergency	<input type="checkbox"/> Loss or delay in receipt of public benefits
<input type="checkbox"/> Natural disaster	<input type="checkbox"/> Illegal action by a landlord	<input type="checkbox"/> Victimization by criminal activity
<input type="checkbox"/> Substantial change in household composition	<input type="checkbox"/> Displacement by a government or private action	

Some other condition which constitutes a hardship comparable to other conditions enumerated above

Please describe:

Section V. Household Budget Information

Household income by person

Household Name	Source of Income	Gross Income Amount	Paid Monthly
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	

Budget/Income by type. Please total by source.

SOURCE OF HOUSEHOLD INCOME	PRESENT INCOME/Monthly	POTENTIAL INCOME/Monthly
Earned Income	\$	\$
SSI/SSDI	\$	\$
Public Assistance (TANF, etc.)	\$	\$
Unemployment Compensation	\$	\$
SNAP (Food Stamps)	\$	\$
Child support	\$	\$
Other:	\$	\$
TOTAL	\$	\$
EXPENSES	PRESENT EXPENSES	BUDGETED EXPENSES
Rent/Mortgage	\$	\$
Electric	\$	\$
Water / Sewer	\$	\$
Gas	\$	\$
Phone	\$	\$
Cable / Internet	\$	\$
Food & Personal	\$	\$
Child Care	\$	\$
Medications	\$	\$
Car Payment / Insurance	\$	\$

Transportation / Gasoline	\$	\$
Loan Title School Payday	\$	\$
Recreation	\$	\$
Cleaning / Laundry	\$	\$
Savings	\$	\$
Credit Cards	\$	\$
Personal Loans	\$	\$
Court Fees	\$	\$
Back Taxes	\$	\$
Other:	\$	\$
Other:	\$	\$
Other:	\$	\$
TOTALS	\$	\$
SURPLUS /DEFICIT	\$	Present Income minus Present Expenses

CURRENT LIQUID ASSETS		
Savings	\$	\$
Checking	\$	\$
Cash	\$	\$
Life Ins. Policy	\$	\$
Other:	\$	\$
Total	\$	\$

Reason for Assistance:

Maintain Current Residence
 Move to New Residence
 Move from Shelter to Permanent Housing

Type of Assistance being requested:

Rental Assistance – 5 Day Notice or Court Ordered Eviction required
Monthly rent amount: \$ Amount of assistance requested: \$

Mortgage Assistance – Foreclosure notice required
Mortgage Payment Amount: \$ Amount of assistance requested: \$

Security Deposit – Unit offer letter or unsigned lease from landlord approving you for unit
Monthly rent amount: \$ Amount of assistance requested: \$

Utility Assistance – Shut off notice required

Amount of assistance requested: \$

It is important that families have a plan to pay rent/mortgage/utility for the household going forward?

I verify that the information I have provided is true:

Head of Household Signature:

Date:

CONSENT FOR EXCHANGE OF INCOME/FINANCIAL INFORMATION

The following is an authorization for exchange of information for the following individual:

NAME:	Relationship	Date of Birth	Last 4 digits Soc. Sec. #

I, the undersigned, hereby authorize the following agencies and their officers and employees to discuss any financial, medical, social, educational, legal, and psychological information concerning the above-named household with the Kane County Office of Community and any other agencies listed below. I, the undersigned, acknowledge that the information that will be shared by any of the agencies listed below may be confidential and privileged, and I hereby expressly waive that confidentiality and privilege for any information shared by any of the agencies and officers and employees listed below. This exchange of information will only be used to help coordinate referral, assessment and related helpful actions for my family and myself with regards to housing.

Using your INITIALS, indicate which agencies you authorize to exchange information:	Use this space to specify an agency/organization or department as needed:
<input type="checkbox"/> Bank	
<input type="checkbox"/> Employer (s)	
<input type="checkbox"/> Housing Authority	
<input type="checkbox"/> Illinois DHS	
<input type="checkbox"/> Illinois DCFS	
<input type="checkbox"/> Landlord(s)	
<input type="checkbox"/> Social Security Administration	
<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	

The consent becomes effective on this date _____ and may be revoked in writing by the undersigned at any time except to the extent that action has already been take. My written revocation of this consent form will be effective upon receiving the written revocation. This consent shall expire on _____ or one year from the effective date, whichever comes first. I understand that I am to receive a copy of the authorization. A photocopy of this consent is as valid as the original. If I choose not to sign this consent, I will be referred to appropriate services and shall not be denied services.

In signing this form, I also understand the following: I certify that all statements made on this application are true and correct for the best of my knowledge and belief. I understand that any willful misstatement of material fact will be grounds for disqualification or termination of assistance. I have read, or have had explained to me, the following guidelines under which assistance is provided, and accept the provisions therein:

- o Financial Assistance is not guaranteed even when a person appears to be eligible during the first client screening.
- o All information will need to be verified with appropriate documentation before any financial assistance is given.
- o The information that the Applicant (person applying) provides is truthful, complete and accurate.
- o All information provided will be entered in the Kane County Homeless Management Information System (HMIS) database.

Individual

Date

Intake Case Manager

Date

KANE COUNTY HOMELESS PREVENTION PROGRAM (HPP)

CLIENT INFORMED CONSENT AUTHORIZATION

FOR RELEASE OF INFORMATION

Client Name:	Modified Social Security #: XXX-XX-	Date of birth:
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I hereby authorize the Kane County Office of Community Reinvestment, a participating member of the Continuum of Care for Kane County, and it's HMIS (Homeless Management Information System), to disclose information contained in/with this application with other member agencies of the Continuum of Care for Kane County. Such agencies include, but are not limited to: Community Crisis Center, Ecker Center, Hesed House/PADS, Lazarus House, PADS of Elgin, and Prairie State Legal Services. Additionally, I authorize the Kane County Office of Community Reinvestment to disclose said information to the following entities:

Landlord/Mortgage Lender

Name:	Address:
Phone:	Email:

Other Agency

Name:	Address:
Phone:	Email:

Other Individual

Name:	Address:
Phone:	Email:

However, I DO NOT authorize the following information to be shared. (Please a check mark by any item you do not wish to be shared and it will be excluded from this authorization.)

<input type="checkbox"/> Name	<input type="checkbox"/> Race	<input type="checkbox"/> Veteran Status	<input type="checkbox"/> Modified Social Security #
<input type="checkbox"/> Ethnicity	<input type="checkbox"/> Date of Birth	<input type="checkbox"/> Gender	<input type="checkbox"/> Disability Status/Condition
<input type="checkbox"/> Type of Residence prior to entry	<input type="checkbox"/> Length of stay at prior residence	<input type="checkbox"/> Zip code of prior residence	

I understand it is necessary to share this information to prevent duplication of data and services. I also understand that other statistical components of services I receive are entered in to the HMIS system and reported to HUD (U.S. Department of Housing and Urban Development) on a consolidated basis (without identifying individuals served) as required for funding. I also understand:

- My decision to not disclose information through HMIS will not affect the quality or quantity of service I am eligible to receive from this agency and will not be used to deny outreach, shelter or housing. However, I do understand services in the region may improve if accurate information is provided.
- I may revoke this consent at any time, but that there may have been information shared and services provided based upon this Consent when it was in effect. Ending this Consent cannot change that;
- Any notice by me to end this Consent must be in writing;
- This Consent will automatically expire 1 year from the date I sign this Consent;
- The entities specified above are released from any legal responsibility or liability for disclosure of the information described above and as authorized by my signature below; and Information may be disclosed to other agencies to assist in obtaining requested services.
- A copy or facsimile (FAX) of this Consent may be utilized in place of the original signed Consent.

This Consent has been explained to me. I have read it (or it was read to me) and understand its' provisions. I have been given a reasonable amount of time to ask questions and consider whether to permit the sharing of the designated information. I hereby willingly agree to the sharing of that described information on myself and any dependents listed below.

On the next page, please list any dependent children under 18 in household, if any (first and last names):

Client Signature: _____

Date: _____

Client Signature: _____

Date: _____

(Second Adult if Any)

Witness Signature: _____

Date: _____