

CARE RENTAL ASSISTANCE APPLICATION PACKET

LISTED BELOW ARE YOUR RESPONSIBILITIES REGARDING RECEIPT AND RETURN OF THE *APPLICATION*:

Rental Assistance Applications:

- All rental assistance applications must be **fully completed**.
- You must include all required information,
- A Case manager will contact you to complete information by phone.

Faxed/Mailed Rental Applications:

- If you are faxed or mailed an *Application*, you must **fully complete** it and return it to CARE. Applications will be reviewed when received.
- CARE accepts no responsibility for receipt of the faxed or mailed *Application*.

Returning Rental Applications:

- Return the completed *Application* and all required documentation to the CARE office by mail or the in the return box at the CARE office and call to **schedule an appointment to meet with a case manager by telephone to review the application**.
- You may fax or mail the completed *Application* and required documentation back to CARE.
 - CARE accepts no responsibility for receipt of the faxed or mailed *Application*. You may contact CARE to verify that the *Application* was received by CARE and that all required information is completed / included.
 - Incomplete *Applications* will not be placed into consideration for assistance.

Based on safety concerns due to COVID 19 processing of rental assistance applications may be delayed or take additional time. Please be patient as we work to keep our staff safe and continue to serve our community

CARE RENTAL ASSISTANCE APPLICATION PACKET

RENTAL ASSISTANCE APPLICATION PACKET CONTAINS: OBTAINING AN APPLICATION / RESPONSIBILITIES (1 PG), INSTRUCTIONS / PROCESS SHEET (1 PG), APPLICATION (2 PGS), BUDGET WORKSHEET (1 PG), LANDLORD INFORMATION (1 PG), CARE IN-TAKE (2 PGS), CARE GENERAL RELEASE OF INFORMATION (1 PG), DECLARATION OF PERSONAL INCOME (1 PG), REQUIRED DOCUMENTS AND INFORMATION (1 PG),

- ONLY Completed applications will be considered for a **ONE-TIME**, emergency rental assistance grant, incomplete applications will NOT be accepted.
- Requests for ongoing rental assistance will not be considered for our Emergency Rental Assistance.
- YOU MUST INCLUDE ALL REQUIRED INFORMATION, including complete landlord information.
- Decisions regarding rental assistance are final and are based on the information you provided. If you need help filling out this form, please call to speak to a CARE staff person.

Name: _____ Phone: _____ Date: _____

ADDRESS INFORMATION:

Current Address (include apartment number if applicable):

Address: _____ Apt #: _____ City: _____ Zip: _____

Mailing Address: _____ Apt #: _____ City: _____ Zip: _____

New Address if moving (include apartment number if applicable):

Address: _____ Apt #: _____ City: _____ Zip: _____

RENTAL INFORMATION & COST:

DO YOU HAVE SUBSIDIZED HOUSING? ___NO ___YES

DO YOU HAVE AN EVICTION NOTICE? ___NO ___YES (You MUST include a copy of the notice)

IS YOUR RENT PAYMENT CURRENT & UP TO DATE? ___NO ___YES **(NO BACK RENT CAN BE PAID)**

DOES YOUR RENT MEET FAIR MARKET RENT (FMR)? ___NO ___YES Number of Bedrooms _____

COMPLETE ONLY ONE TYPE OF RENT COSTS:

MONTHLY RENT COSTS: YOUR RENT COSTS MUST BE CURRENT, WE CANNOT PAY BACK RENT

- Exact Rent Amount (**CANNOT INCLUDE LATE FEES OR BACK RENT**) \$ _____
- Amount you can pay towards your rent (you **MUST** contribute): \$ _____
- Amount you are requesting (NO more than one month's rent): \$ _____

MOVE-IN RENT COSTS: (If applicable):

- Deposit Amount (If required): \$ _____
- 1st Month Rent Amount: \$ _____
- Last Month Rent Amount: \$ _____
- Amount you can pay towards your move-in (you **MUST** contribute): \$ _____
- Total Amount you are requesting: \$ _____
- Are you already moved into this residence? ___NO ___YES

Resource	Name	Amount	Date(s) of Request
Church (list)		\$	
Church (list)		\$	
Agency (list)		\$	
Other (list)		\$	
Family (list)		\$	
Friends (list)		\$	

CARE RENTAL ASSISTANCE APPLICATION PACKET

CARE Inc. Monthly Budget Worksheet

- Please provide the following information. Please include all Household Income and Expenses for all Household members.
- You must include proof of income for the last 30 days for all adults or complete a Declaration of Personal Income (available at CARE Office) for all adults who have no income.
- This will help CARE to determine how we can assist you.

Household Income	Name	\$\$	Household Expenses	\$\$
Monthly Employment/Wages: Gross (Before deductions) 30 days			Housing: Rent/Mortgage Cost	
Monthly Employment/Wages: Net (After deductions) 30 days			Utilities	
Unemployment – Weekly amount Report required			Electricity	
Child Support Received			Other Heating (non-electric)	
TANF			Water/Sewer	
SSI			Garbage	
SSD			Phone: Land Line	
SS Retirement			Phone: Cellular	
Other Retirement			Cable TV/Internet	
Veterans Benefits (Non-medical)			Food Costs Without Food Stamps	
Tribal Benefits			Cigarettes/Alcohol	
Stocks/Bonds/Trust/Other			Child Support Paid	
Other Income			Child Care	
Other Income			Car/Transportation	
Total Monthly Income			Car Payment	
			Car Insurance	
			Car Repairs	
			Gasoline	
			Public Transportation	
			Clothing/Personal Care	
			Health Care	
			Medical/Prescriptions	
			Insurance Premiums	
			Insurance Co-Pays	
			Credit Cards	
			Savings	
			Court Fees	
			Other Expenses	
			Total Monthly Expenses	

Total Household Income:	
Total Household Expenses:	
Discretionary Income:	

(Note: Discretionary Income = Total Household Income minus Total Household Expenses)

CARE RENTAL ASSISTANCE APPLICATION PACKET

LANDLORD CONTACT INFORMATION:

- YOU **MUST** HAVE A RESIDENCE/APARTMENT BEFORE ANY RENTAL ASSISTANCE CAN BE CONSIDERED. LOOKING FOR A RESIDENCE/APARTMENT DOES NOT MEET THIS REQUIREMENT.
- YOUR LANDLORD'S INFORMATION IS **REQUIRED** BEFORE ANY RENTAL ASSISTANCE CAN BE CONSIDERED. YOU MUST PROVIDE THE NAME, CONTACT PHONE NUMBER AND FULL MAILING ADDRESS.
- ANY RENTAL ASSISTANCE GRANTED WILL BE SENT DIRECTLY TO THE LANDLORD.

Landlord Name: _____ Phone: _____

Mailing Address: _____ City: _____ Zip: _____

Landlord's Email Address : _____

A copy of your lease agreement may be required: Please provide one or discuss this with the Case Manager
Comments:

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## **ADDITIONAL NOTES:**

1. ATTACHED CARE IN-TAKE MUST ALSO BE COMPLETED.
2. YOU WILL NEED TO MEET WITH A CASE MANAGER BY PHONE AFTER YOU TURN IN YOUR COMPLETED APPLICATION (MEETING IS **ONLY** TO REVIEW THE COMPLETED APPLICATION).
  - a. ADDITIONAL SUPPORTING DOCUMENTATION MAY BE REQUIRED

# CARE Inc. IN-TAKE FORM

Revised 05/11/2016

## Application for Services

|                   |                                 |              |               |
|-------------------|---------------------------------|--------------|---------------|
| Last Name:        | First Name:                     | Middle Name: | Phone Number: |
| Physical Address: | Mailing Address (if different): | City:        | State: Zip:   |

| RACE GROUP CODES                      |                                             | ETHNICITY GROUP CODES              |  |
|---------------------------------------|---------------------------------------------|------------------------------------|--|
| 1 - American Indian / Alaska Native   | 5 - Middle Eastern/Arab American/N. African | 1 - H - Hispanic / Latino          |  |
| 2 - Asian/Asian American/ South Asian | 6 - Native Hawaiian/ Other Pacific Islander | 2 - NH - Non-Hispanic / Non-Latino |  |
| 3 - Black or African American         | 7- White                                    | 3 - DK - Don't Know                |  |
| 4 - Indigenous N, Cen or S America    |                                             | 4 - RF - Refuse                    |  |

**ANSWER ALL AS Y, N  
OR USE CODE**

| List all household members<br>(all people living in your home must<br>be listed) | Social Security<br>Number | DOB | Relationship<br>to Applicant | Gender | Veteran | Homeless | Race group<br>codes | Ethnicity group<br>codes | OHP/Medicaid | Medicare | VA HealthCare | Private Ins. |
|----------------------------------------------------------------------------------|---------------------------|-----|------------------------------|--------|---------|----------|---------------------|--------------------------|--------------|----------|---------------|--------------|
|                                                                                  |                           |     |                              |        |         |          |                     |                          |              |          |               |              |
| 1.                                                                               |                           | / / | Self                         |        |         |          |                     |                          |              |          |               |              |
| 2.                                                                               |                           | / / |                              |        |         |          |                     |                          |              |          |               |              |
| 3.                                                                               |                           | / / |                              |        |         |          |                     |                          |              |          |               |              |
| 4.                                                                               |                           | / / |                              |        |         |          |                     |                          |              |          |               |              |
| 5.                                                                               |                           | / / |                              |        |         |          |                     |                          |              |          |               |              |
| 6.                                                                               |                           | / / |                              |        |         |          |                     |                          |              |          |               |              |
| 7.                                                                               |                           | / / |                              |        |         |          |                     |                          |              |          |               |              |
| 8.                                                                               |                           | / / |                              |        |         |          |                     |                          |              |          |               |              |

| Source of Income<br>(Use reference numbers above to indicate<br>who receives the income) | Information needed to verify income                | HH<br>Member #<br>(see above) | Amount Received<br>in the Last 30 Days |
|------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------|----------------------------------------|
| <input type="checkbox"/> Wages or Tips from Employment (gross )                          | Pay stubs: min. of the previous 30 days            |                               |                                        |
| <input type="checkbox"/> Wages or Tips from Employment (gross )                          | Pay stubs: min. of the previous 30 days            |                               |                                        |
| <input type="checkbox"/> Self Employment                                                 | Self Emp. Worksheet may be required                |                               |                                        |
| <input type="checkbox"/> Pension & Retirement Benefits (Private)                         | Award letter (monthly stmt, or bank stmt may work) |                               |                                        |
| <input type="checkbox"/> Social Security Benefits (retirement)                           | Award letter (monthly stmt, or bank stmt may work) |                               |                                        |
| <input type="checkbox"/> SSI Benefits                                                    | Award letter (monthly stmt, or bank stmt may work) |                               |                                        |
| <input type="checkbox"/> SSD Benefits                                                    | Award letter (monthly stmt, or bank stmt may work) |                               |                                        |
| <input type="checkbox"/> TANF                                                            | Print out from DHS, must show amount               |                               |                                        |
| <input type="checkbox"/> Veteran's Benefits                                              | Award letter (monthly stmt, or bank stmt may work) |                               |                                        |
| <input type="checkbox"/> Unemployment Benefits                                           | Print out from Unemployment Office (with name)     |                               |                                        |
| <input type="checkbox"/> Worker's Compensation Benefits                                  | Award letter (monthly stmt, or bank stmt may work) |                               |                                        |
| <input type="checkbox"/> Alimony and/or Child Support                                    | Current Court Documents/Reports                    |                               |                                        |
| <input type="checkbox"/> Assistance from relatives/friends                               | Source:                                            |                               |                                        |
| <input type="checkbox"/> Other Income Not Listed Above                                   | Source:                                            |                               |                                        |
| <input type="checkbox"/> Food Stamps (SNAP)                                              | List amount                                        |                               |                                        |
| <input type="checkbox"/> Tribal Income                                                   | List source/amount:                                |                               |                                        |

|                                  |                               |                            |
|----------------------------------|-------------------------------|----------------------------|
| <b>Printed Name of Applicant</b> | <b>Signature of Applicant</b> | / /<br><b>Today's Date</b> |
|----------------------------------|-------------------------------|----------------------------|

**PLEASE COMPLETE THE FOLLOWING INFORMATION FOR YOUR HOUSING:  
(COMPLETE AS APPROPRIATE)**

**\* OWN / RENT / OTHER**

1.  Own  Rent -No subsidy  Rent-Subsidized (NOHA or Other)  Other (staying w/family/friends, etc.)  
Explain: \_\_\_\_\_
2. How long at this location: \_\_\_\_\_

**\* HOMELESS**

1. Approximate date homelessness began? \_\_\_\_\_
2. Where did you stay last night? \_\_\_\_\_
3. Have you been continuously Homeless for one year or longer? \_\_\_\_\_
4. Number of episodes of Homelessness in the past 3 years: \_\_\_\_\_
5. Total number of months homeless in the past 3 years: \_\_\_\_\_
6. Last Permanent Address \_\_\_\_\_ Zip Code \_\_\_\_\_  
(Minimum: City & State)

**\* Domestic Violence Survivorship**

1. Are you a survivor? \_\_\_\_\_
2. Approximate date of occurrence? \_\_\_\_\_
3. Are you currently fleeing? \_\_\_\_\_

**HOUSEHOLD INFORMATION REGARDING EDUCATION & DISABILITIES:**

| HH Member #<br>(from pg. 1) | Years of Education Completed | Disability<br>(Yes or No) | Disability Type or<br>Explanation<br>(Physical or Mental) | Chronic or<br>Temporary | Are you seeing someone<br>regarding this disability?<br>(Yes or No) |
|-----------------------------|------------------------------|---------------------------|-----------------------------------------------------------|-------------------------|---------------------------------------------------------------------|
| 1                           |                              |                           |                                                           |                         |                                                                     |
| 2                           |                              |                           |                                                           |                         |                                                                     |
| 3                           |                              |                           |                                                           |                         |                                                                     |
| 4                           |                              |                           |                                                           |                         |                                                                     |
| 5                           |                              |                           |                                                           |                         |                                                                     |
| 6                           |                              |                           |                                                           |                         |                                                                     |
| 7                           |                              |                           |                                                           |                         |                                                                     |
| 8                           |                              |                           |                                                           |                         |                                                                     |

**FOR CARE OFFICE USE ONLY: SERVICE NOTES**

|                                |                           |                   |                       |
|--------------------------------|---------------------------|-------------------|-----------------------|
|                                |                           |                   |                       |
|                                |                           |                   |                       |
|                                |                           |                   |                       |
|                                |                           |                   |                       |
| Funding Source:                |                           | Amount            | Service Provided By:  |
| Funding Source:                |                           | Amount            | Service Provided By:  |
| <b>CASE MANAGEMENT FUNDING</b> | EHA-HP / EHA-RR / EHA-VET | EHAC-HP / EHAC-RR | HSP / ESG-HP / ESG-RR |

*Homeless definition: Any person staying at an emergency housing shelter out of necessity, any person living in transitional housing, any person living on the streets or staying somewhere not intended for human habitation, people who were turned away from emergency services, and people provided a voucher in order to stay at a motel or campground. People living in permanent supportive housing or those receiving rental or mortgage assistance, Federal definition does not include people who are staying with other people out of economic necessity (often referred to as doubled-up or couch surfing)*

**Refer clients for additional services**

- Medical (TCHD)    Dental (TCHD)    DHS    Women's Resource Center    TFCC    Other \_\_\_\_\_

## CARE, INC. GENERAL RELEASE OF INFORMATION FOR CLIENT SERVICES

**Consent:** I authorize and direct any Federal, State or Local agency, organization, business, landlord or individual to release information to and receive information from CARE, Inc. staff. Information will be used to complete and verify my application for participation in any CARE, Inc. emergency assistance program. I understand and agree that this authorization, or the information obtained by its use, may be given to and used by CARE, Inc. in administering and enforcing program rules and policies. It may also be consent for CARE, Inc. to release information from my file and about my rental history to credit bureaus, collection agencies and future landlords. This includes my payment history, lease violations, and/or violation of any CARE, Inc. policies.

**Information Covered:** I understand that depending on the program policies previous or current, information regarding my household or myself may be needed. Verification and inquiries that may be requested include but are not limited to:

|                                |                                                          |
|--------------------------------|----------------------------------------------------------|
| Identity and Marital Status    | Employment, Income, Donations and Assets                 |
| Residences and Rental Activity | Medical, Mental Health Information and Disability Status |
| Credit and Criminal Activity   | Social Security with Date of Birth                       |

I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility for CARE, Inc. emergency services.

**Groups or Individuals that may be asked:** The groups or individuals that may be asked to release the above information (depending on program requirements) include but are not limited to:

|                                 |                                               |
|---------------------------------|-----------------------------------------------|
| Previous and Current Landlords  | Vocational Rehabilitation                     |
| Potential Landlords             | Social Security Administration                |
| Banks, Financial Institutions   | Veteran's Administration                      |
| Department of Human Services    | Public and Mental Health Agencies/Providers   |
| Past and Present Employers      | Alcohol and Drug Treatments                   |
| Courts and Post Offices         | Credit Report Providers and Credit Bureaus    |
| Schools and Colleges            | Retirement Systems                            |
| Law Enforcement/Parole Agencies | Oregon Housing and Community Services         |
| Support and Alimony Providers   | Medical and Child Care Providers              |
| Community Action Agencies       | The Oregon Balance of State Continuum of Care |
| Helping Hands                   | Homeless Management Information System        |
| Utility Companies               | Other (please list): _____                    |
| Faith-based Referral Agencies   |                                               |

**Computer Matching Notice and Consent:** I understand and agree that CARE, Inc. may conduct computer-matching programs to verify the information supplied for my application. If a computer match is done, I understand that I have a right to notification of adverse information found and a chance to disprove incorrect information. CARE, Inc. may in the course of its duties, exchange automated information with other Federal, State, County or Local agencies, including but not limited to: State Employment Agencies, Department of Defense, Office of Personnel Management, the US Postal Service, the Social Security Agency and State Welfare and Food Stamp Agencies; OHCS-OPUS partner Agencies.

**Conditions:** I understand that I may cross out any agency that I do not want contacted for this emergency services application. I also understand that this agreement is valid for one year from the date provided, unless it is otherwise noted.

**This release of information expires one year from the date of signature or upon withdrawal by client.**

Signature

Print Name

Date

Signature

Print Name

Date



Member Counties: Baker, Benton, Clatsop, Columbia, Coos, Curry, Douglas, Gilliam, Grant, Harney, Hood River, Josephine, Klamath, Lake, Lincoln, Linn, Malheur, Marion, Morrow, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler, Yamhill

**Rural Oregon Continuum of Care (ROCC) HMIS  
Client Consent to Release of Information for Data Sharing in Rural Oregon Balance of State**

Rural Oregon Continuum of Care Homeless Management Information System (HMIS) is a computer system that is used to collect and share information on homelessness and social services throughout Rural Oregon Balance of State. The information gathered by CARE Inc. and HMIS allows agencies to plan and deliver services that help people in need. By sharing information with each other, agencies are able to simplify service delivery by coordinating services and referrals across agencies.

**Maintaining the privacy and safety of those using our services is very important to us.** The HMIS runs in compliance with all Federal and State laws and codes, including Health Insurance Portability and Accountability Act (HIPAA). Every person and agency that is authorized to read or enter information into the database has been trained on client confidentiality policies and has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights ended and may be subject to further penalties.

Services will not be denied should you choose not to share information. Information will still be collected and entered because of our federal and state requirements. **Certain minimum client information is shared throughout our HMIS in order to avoid creating duplicate client records.** Authorized HMIS persons at participating community agencies will be able to see the following data elements of all client records:

- First Name
- Last Name
- Date of Birth
- Veteran Status
- Gender
- Social Security Number (required for specific services)

**Please read the following statements and consult with your agency staff if you have any questions:**

I UNDERSTAND THAT:

- I will not be denied services if I decline to share my data beyond the minimum requirements.
- The release of my information does not guarantee that I will receive assistance.
- The partner agencies will share my basic identifying information (Name, DOB, Veteran Status, Gender, SSN) in order to improve service delivery and reduce duplicate data collection.
- Any details about the programs I participate in or information I share with agency staff will not be disclosed to any third party unless I give written authorization or it is otherwise required by law. We must still report some information because of our federal, state or funder requirements.
- This authorization will remain in effect for 7 years unless I revoke it in writing by signing a written statement or Revocation form.
- I understand that I may cancel my consent to data sharing at any time. However, doing so will not change information that has already been given out or actions already taken. Revocation will be effective as of that date.
- I have the right to see my HMIS record, ask for changes, and to have a copy of my record from this agency upon written request.

- I have the right to file a complaint if I feel I have been harmed in some way by the use of HMIS.
- I have the right to receive a copy of the HMIS Notice to Clients of Uses and Disclosures.

Maintaining the privacy and safety of those using our services is very important to us. Your record will only be shared if you give us permission to do so. There may be risks and/or benefits for you to consider before you decide whether or not to consent to the release of information.

**By writing your initials below, you agree to share the following level of information for yourself and all household members listed below with other Rural Oregon Balance of State HMIS partner agencies.**

\_\_\_ 1) In addition to the minimum required data elements (Name, DOB, Gender, Veteran Status, SSN), **I agree to share** additional demographic information (including Race and Ethnicity), program enrollment and exit information, information about the nature of my situation, services and referrals I receive, and contact information via the Rural Oregon Balance of State HMIS with other Rural Oregon Balance of State HMIS partner agencies.

\_\_\_ 2). Beyond the minimum required data elements (Name, DOB, Gender, Veteran Status, SSN), **I DO NOT agree to share** any additional information through the Rural Oregon Balance of State HMIS with other Rural Oregon Balance of State HMIS partner agencies.

**Please list the names and dates of birth of all household members participating in services:**

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**Client/Parent or Guardian Name** *(please print)*

**Client/Parent or Guardian Signature** **Date**

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*If applicable:*

*Additional Adult's Name* *(please print)*

*Additional Adult's Signature*

*Date*

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**Agency Personnel Name** *(please print)*

**Agency Personnel Signature**

**Date**

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