HOME STRETCH
HOUSING ASSISTANCE FUND APPLICATION

Purpose of Fund

The Home Stretch Housing Assistance Fund, managed by Alameda County Health Care Services Agency, provides financial assistance for costs related to accessing housing. To be eligible, applicants must be enrolled in Medi-Cal in Alameda County and currently experiencing homelessness, at-risk of homelessness, or have experienced homelessness in the past 24 months; or be identified as a frequent user of multiple systems by Alameda County Care Connect.

The applicant must be working with an agency that serves households experiencing homelessness or at risk of homelessness in Alameda County.

Eligible applicants may apply for financial assistance for the following areas:

Up to $8,000 per household per year		Up to $8,000 per household per year
Rental Assistance	**Move In Assistance**	**Safety and Accessibility**
Eligible expenses: Security deposit and 1st month's rent.	*Eligible expenses:* Utility start-up costs, application fees, essential home furnishings, household items such as food preparation items and bed/bath linens, and non-emergency, non-medical transport such as a moving company. See "Approved Home Furnishings and Household Items" checklist.	*Eligible expenses:* Needed items and services to make the home safe and accessible: medically necessary items such as hospital beds and Hoyer lifts; unit modifications to meet accessibility needs such as ramps and grab bars; pest control; and hoarding clean up.

Instructions for Applicants and Service Providers:

1. Please carefully read the Home Stretch Housing Assistance Fund policy and the application before beginning this application.

2. The application should be completed jointly by the eligible service provider and the applicant or their parent/ guardian.

3. Please complete the entire application form on the following pages. Questions in this application refer to the applicant unless otherwise specified.

4. Legible handwritten forms are accepted, but typed forms are preferred.

5. All applications must include applicant information, service provider information and general information. If there are sections of the application that do not apply to the type of financial assistance requested, those sections may be skipped.

6. Fax the fully completed application to Home Stretch Housing Assistance Fund at 1 (877) 489-4642 or send by *secure* e-mail to HomeStretchFund@acgov.org. Please only use e-mail that is secure according to federal and state privacy standards.

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Please use this checklist to ensure all of the necessary application materials are received:

- ☐ Fully Completed Home Stretch Housing Assistance Fund Application.
- ☐ Signed HMIS Release of Information.
- ☐ Copy of applicant's lease or rental agreement.
- ☐ Approved Home Furnishings and Household Items checklist for home furnishing and household items.
- ☐ Copy of utility bill with account number information for utility startup costs.
- ☐ Verification of medical necessity from a medical professional for requests for unit modifications or medical equipment. For medical equipment, verification that the applicant has attempted to obtain the items using their health insurance is also necessary.
- ☐ Business Vendor Add/Update Form if the application requests security deposit or rent payment, or a new vendor is being used for unit modifications, moving services or safety and accessibility requests.
- ☐ Verification of housing authority inspection, if applicable.

The HCSA finance department requires *a signed, original invoice AND original W-9 form* in order to process approved payments to landlords/property managers and other new vendors. ***These two (2) documents cannot be faxed; the originals must be mailed*** *to the HCSA Housing Solutions for Health office:*

HCSA Home Stretch Housing Assistance Fund
1900 Embarcadero, STE 206
Oakland, CA 94606

- ☐ Fully completed, signed, original invoice;
- ☐ Original W-9 form with signature.

Contact Information: HomeStretchFund@acgov.org or (510) 567-8030.

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SERVICE PROVIDER INFORMATION

Name of Referring Service Provider: _____
(First, Middle, Last, Suffix)

Name of Referring Service Agency: _____

Name of Referring Service Program: _____

Service Provider Phone Number: _____

Service Provider E-mail Address: _____

Service Provider Address: _____
(Number, Street, City, Zip Code)

_____

APPLICANT INFORMATION

Name of Applicant: _____
(First, Middle, Last, Suffix)

If the applicant is a child, name of parent/guardian: _____
(First, Middle, Last, Suffix)

Social Security #: _____ Applicant's Date of Birth: _____

Applicant's Current Address, (if applicable): _____

_____
(Number, Street, City, Zip Code)

Applicant's Phone Number: _____ Applicant's E-mail Address: _____

HUD DEMOGRAPHIC INFORMATION

Gender: Male ☐ Female ☐ Trans Female (MTF) ☐ Trans Male (FTM) ☐
Gender Non-Conforming ☐ Client Refused ☐

Race: White ☐ Black or African American ☐ Asian ☐
American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐
Client Refused ☐

Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Client Refused ☐

Sexual Orientation: Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐
Questioning/Unsure ☐ Client Refused ☐

Veteran Status: Yes ☐ No ☐

Due to the confidential nature of client information, this information shall be used by authorized staff only.

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HUD DEMOGRAPHIC INFORMATION

What is the City, State of last permanent housing? _____

What is the City, State of high school last attended? _____

What is the City, State of family residence when born? _____

Is the applicant currently experiencing homelessness? Yes ☐ No ☐

Is this applicant the head of household? Yes ☐ No ☐

Is the applicant currently enrolled in Medi-Cal? Yes ☐ No ☐

If the applicant isn't enrolled in Medi-Cal, do they have other health insurance? Yes ☐ No ☐

If yes, what type (i.e. employer-provided, Medicare)? _____

HOUSING HISTORY

Current and planned future living situation after receiving assistance. Please check one box for **CURRENT** and one box for **PLANNED:**

Current	Planned	Living Situation*	Current	Planned	Living Situation
		Place not meant for habitation			Permanent housing (other than RRH) for formerly homeless persons
		Emergency shelter including hotel/motel paid for with voucher			Rental by client, no ongoing housing subsidy
		Safe Haven			Rental by client, with VASH subsidy
		Interim Housing			Rental by client, with GDP TIP subsidy
		Foster care home or foster care group home			Rental by client with other housing subsidy (including RRH)
		Hospital or other residential non-psychiatric medical facility			Residential project or halfway house with no homeless criteria
		Jail, prison or juvenile detention center			Staying or living in a family member's room, apartment or house
		Long-term care facility or nursing home			Staying or living in a friend's room, apartment or house
		Psychiatric hospital or other psychiatric facility			Transitional housing for homeless persons
		Substance Use Treatment Facility or Detox			Client doesn't know
		Hotel or motel paid for without emergency shelter voucher			Client Refused
		Owned by client, no ongoing housing subsidy			Other:

** A list of definitions for these living situations is available. If you are not sure of the correct response, please contact the Home Stretch Office.*

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Length of stay in prior living situation: _____

Approximate date homelessness started: _____

Number of times on the streets, in emergency shelter, or Safe Haven in the past 3 years: _____

Total number of months homeless on the streets, in ES, or Safe Haven in the past 3 years: _____

HUD DEMOGRAPHIC INFORMATION – PART 2

Does the applicant have a disabling condition?	Yes ☐	No ☐	Long term? Yes ☐	No ☐
Does the applicant have a physical disability?	Yes ☐	No ☐	Long term? Yes ☐	No ☐
Does the applicant have a developmental disability?	Yes ☐	No ☐		
Does the applicant have a chronic health condition?	Yes ☐	No ☐		
Does the applicant have HIV - AIDS?	Yes ☐	No ☐		
Does the applicant have a mental health problem?	Yes ☐	No ☐		
Does the applicant have a substance use problem?	Yes ☐	No ☐	Long term? Yes ☐	No ☐
Is the applicant a domestic violence victim or survivor?	Yes ☐	No ☐		

Date of last occurrence? _____

Are you currently fleeing domestic violence? Yes ☐ No ☐

Does the applicant have income from any source? Yes ☐ No ☐

What is the applicant's source of income? _____

How much is the applicant's monthly income? _____

Does the applicant receive any non-cash benefits? Yes ☐ No ☐

What types, if any, of non-cash benefits does the applicant receive? _____

_____

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HOUSING STABILITY PLAN AND INFORMATION

This assistance is meant to be one time and have a lasting impact. Please describe the applicant's plan to maintain this housing moving forward. Are there any additional resources or supports that are needed? Please add pages if needed.

RENTAL ASSISTANCE INFORMATION – IF APPLICABLE

What size is the applicant's current/proposed unit? _____How many people will live there? _____

What is the total rent the client will pay? _____

What is the total rent for the unit: _____

Is there a housing subsidy like Section 8, VASH, Shelter + Care, if so which one? _____

Has the unit passed a housing authority inspection? Yes ☐ No ☐
If yes, please include a copy of the inspection report with the application.

Does the applicant have a bank account? Yes ☐ No ☐

Does the applicant or their parent/guardian have a payee that manages their money? Yes ☐ No ☐
If yes, who is their payee: _____

HOUSING UTILITY COSTS – IF APPLICABLE

Please include a copy of the utility bill with the applicant's account number.

What is the amount owed? _____

Is the applicant required to pay a deposit in order to establish service? If so, how much? _____

What is the total amount requested? _____

In order to increase affordability of utility costs associated with PG&E, please learn more about the CARE or FERA programs. You can visit this link www.pge.com/care or call 1-866-743-2273 for more information.

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HOME FURNISHINGS AND HOUSEHOLD ITEMS – IF APPLICABLE

Please enclose a completed Approved Home Furnishings and Household Items checklist.

What is the estimated total cost of all items requested? $_____

List address where the items should be delivered: _____

_____

(Number, Street, City, Zip Code)

UNIT MODIFICATIONS AND MEDICAL EQUIPMENT – IF APPLICABLE

Please enclose verification of medical necessity from a medical professional, as well as verification that the applicant attempted to obtain any requested medical equipment through their health insurance.

Are you requesting any unit modifications? If so, what modifications are needed? _____

_____

_____

_____

Verification of need must be provided for anything listed in this section.

What is the estimated cost of the unit modifications? _____

Has the landlord agreed to the unit modifications? Yes ☐ No ☐

Are you requesting medical equipment? If so, what is needed? _____

_____

Verification of need as well as verification of an attempt to obtain the requested equipment utilizing health insurance must be included.

What is the estimated cost of the equipment?_____

Address where the items should be delivered:_____

_____

(Number, Street, City, Zip Code)

OTHER ALLOWABLE EXPENSES – MOVING SERVICE – IF APPLICABLE

For Other Allowable Expenses (i.e. Moving Service; Pest Control, etc.):

Please keep in mind that the amount of funding needed must be determined in advance. This means that a moving service with rates based on mileage is not an allowable expense.

Please write an explanation of what is needed: _____

_____

_____

_____

What is estimated cost? _____

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HOME STRETCH HOUSING ASSISTANCE FUND REQUEST SUMMARY

For the funds requested, check all that apply and place the estimated dollar amount(s) next to each expense. The individual amounts should add up to the total amount of funds requested.

Rental Assistance:

Move-in Expense – first month's rent, tenant's portion — Amount = $_____

Move-in Expense – security deposit — Amount = $_____

Total Requested: — Total Amount = $_____

Move In Assistance:

Utility Start-Up Costs — Amount = $_____

Estimated Home Furnishings & Household Items — Amount = $_____

Estimated Moving Services — Amount = $_____

Estimated Total Requested: — Total Amount = $_____

Safety and Accessibility:

Medically Necessary Items (such as a hospital bed) — Amount = $_____

Unit Modifications — Amount = $_____

Pest Control — Amount = $_____

Estimated Total Requested: — Total Amount = $_____

All payments are made to eligible third parties. The HCSA finance department requires *a signed, original invoice AND original W-9 form* in order to process approved payments to landlords/property managers and other new vendors.

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HCSA Home Stretch Housing Assistance Fund
1900 Embarcadero, STE 206
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HOME STRETCH HOUSING ASSISTANCE FUND AGREEMENT

I have requested assistance from the Home Stretch Housing Assistance Fund to help me access housing or stay housed. I understand that I have certain obligations that come with receiving this assistance.

- ✓ I agree to complete the application with my service provider and to provide accurate and truthful information.
- ✓ I agree to work with my service provider and others in my support system on my housing plan.
- ✓ I understand that staff of the Fund may follow up with my service provider or me within 13 months from the date I receive assistance to get updates on my housing situation.

I have read, understood and accepted the above agreement and verify my application contains truthful and accurate information.

Applicant Signature: _____ Date: _____

Print Name of Applicant: _____

As the service provider working with this applicant, I agree to support the applicant in working on his/her housing plan. I understand that the Home Stretch Office will contact me at six and twelve months from the date of support regarding the applicant's living situation.

Service Provider Signature: _____ Date: _____

Print Name of Service Provider: _____

FOR HOME STRETCH PROGRAM USE ONLY – DO NOT WRITE BELOW

Client ID (HMIS) #: _____ Provider Agency/Program: _____

Application incomplete Application approved Application rejected (reason):

Reviewer's Signature: _____ Date: _____

Notes:

_____

_____

_____

_____