

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.

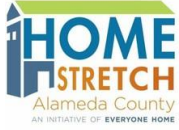
Eligible applicants may apply for financial assistance for the following areas:

| Up to \$8,000 per household per year | | Up to \$8,000 per household per year |
|---|--|--|
| Rental Assistance | Move In Assistance | Safety and Accessibility |
| <i>Eligible expenses:</i> Security deposit and 1 st month's rent. | <i>Eligible expenses:</i> 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. | <i>Eligible expenses:</i> 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.

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



HOME STRETCH HOUSING ASSISTANCE FUND APPLICATION



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

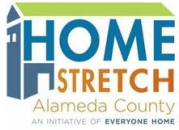
- Fully Completed Home Stretch Housing Assistance Fund Application.
- Signed HMIS Release of Information.
- Copy of applicant's lease or rental agreement.
- Approved Home Furnishings and Household Items checklist for home furnishing and household items.
- Copy of utility bill with account number information 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.



HOME STRETCH HOUSING ASSISTANCE FUND APPLICATION



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

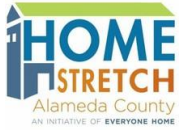
Race: White Black or African American Asian
American Indian or Alaskan Native Native Hawaiian or other Pacific Islander
Client Refused

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

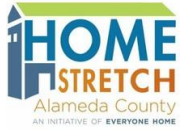
If yes, what type (i.e. employer-provided, Medicare)? _____

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.



HOME STRETCH HOUSING ASSISTANCE FUND APPLICATION



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

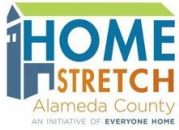
Does the applicant have income from any source? Yes No

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? _____



HOME STRETCH HOUSING ASSISTANCE FUND APPLICATION



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

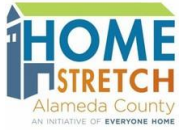
Please include a copy of the utility bill with the applicant's account number.

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.



HOME STRETCH HOUSING ASSISTANCE FUND APPLICATION



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)

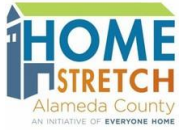
OTHER ALLOWABLE EXPENSES – MOVING SERVICE – IF APPLICABLE

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:

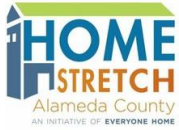
| | |
|--|-------------------------|
| Medically Necessary Items (such as a hospital bed) | Amount = \$ _____ |
| Unit Modifications | Amount = \$ _____ |
| Pest Control | Amount = \$ _____ |
| Estimated Total Requested: | Total Amount = \$ _____ |

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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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:
