



# Rent | Mortgage | Utility | Water/Sewer Assistance Application



				<b>Application Date – mt/day/year</b>	
Have you already received a 3-day, eviction, or foreclosure (mortgage) notice? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Primary Applicant</b>					
<b>First Name:</b>		<b>Middle Name</b>		<b>Last Name</b>	
<b>Social Security Number:</b>		<b>Date of Birth – mt/day/year</b>		<b>Gender</b>	
				<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	
<b>Disabled</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Veteran</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>SNAP (Food Stamps)</b>	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Current Residential Address</b>					
Street Address:					
Street Address Line 2:					
City:		State:		Zip Code:	
				County:	
Phone Number:			Email Address:		
<b>Race</b>		<b>Education</b>		<b>Ethnicity</b>	
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown/Not Reported <input type="checkbox"/> Other:		<input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 (Non-Grad) <input type="checkbox"/> HS Grad/GED <input type="checkbox"/> 12 + Post-Secondary <input type="checkbox"/> 2-4 Yr. College Graduate <input type="checkbox"/> Graduate or other post-secondary school		<input type="checkbox"/> Hispanic, Latino, or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino, or Spanish Origins	
<b>Household Information – Applicant Only</b>					
<b># In Household</b> (including yourself)	<b>Family Type</b>	<b>Work Status</b>		<b>Health Insurance Type</b>	<b>Source of Income</b>
	<input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Two-Parent Household <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults/No Children <input type="checkbox"/> Non-related Adults with children <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Other:	<input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (short-term, 6 months or less) <input type="checkbox"/> Unemployed (long-term, more than 6 months) <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Furloughed <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/not reported <input type="checkbox"/> Youth ages 14-24 who are neither working nor in school <input type="checkbox"/> Other:		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children’s Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Other:	<input type="checkbox"/> Employment <input type="checkbox"/> Unemployment <input type="checkbox"/> Self-Employment <input type="checkbox"/> No Income <input type="checkbox"/> Social Security <input type="checkbox"/> TANF/ADC <input type="checkbox"/> SSI/SSD <input type="checkbox"/> Pension <input type="checkbox"/> Disability <input type="checkbox"/> Child Support <input type="checkbox"/> Other (please specify):
<b>Housing Status</b>					
<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Other:					
<b>Income Period</b>				<b>Income Amount for last 30 days – if Zero, explain on page 2</b>	
<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly (26 pays/year) <input type="checkbox"/> Bi-Monthly (24 pays/year) <input type="checkbox"/> Monthly					



Has COVID-19 caused economic hardship?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

**If your request is COVID-19 related, how have you been affected?  
(Check all that apply)**

- Childcare
- Minor Child(ren) – remote learning
- Minor Child(ren) – increased expenses (e.g. food, medical)
- Applicant is high risk (e.g. age, medical condition)
- Household member is high risk (e.g. age, medical condition)
- Increased expenses due to COVID (e.g. transportation, food delivery, etc.)
- Health care expenses
- Reduced Work Hours
- Unemployed or furloughed
- Housing costs increased
- Other (Provide brief description):

**What type of assistance do you need? Check all that apply**

- Rent
- Water/Sewer
- Gas
- Electric
- Bulk Fuel
- Emergency Services
- Mortgage
- Other (Provide brief description):

**Additional details about your emergency situation. If you have zero income in the last 30 days, how are you paying your bills?**

1. Additional Household Member		
<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>
<b>Social Security Number</b>	<b>Date of Birth</b>	<b>Gender</b>
		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
<b>Race</b>	<b>Education</b>	<b>Ethnicity</b>
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown/Not Reported <input type="checkbox"/> Other:	<input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 (Non-Grad) <input type="checkbox"/> HS Grad/GED <input type="checkbox"/> 12 + Post-Secondary <input type="checkbox"/> 2-4 Yr. Grad College	<input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins
<b>Disabled</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Veteran</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Relationship</b> (e.g. daughter, son, spouse, etc.)
<b>Health Insurance Type</b>	<b>Source of Income</b>	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Other:	<input type="checkbox"/> Employment <input type="checkbox"/> Unemployment <input type="checkbox"/> Self-Employment <input type="checkbox"/> No Income <input type="checkbox"/> Social Security <input type="checkbox"/> TANF/ADC <input type="checkbox"/> SSI/SSD <input type="checkbox"/> Pension <input type="checkbox"/> Disability <input type="checkbox"/> Child Support <input type="checkbox"/> Other (please specify):	
<b>Income Period</b>		<b>Income Amount</b>
<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly (26 pays/year) <input type="checkbox"/> Bi-Monthly (24 pays/year) <input type="checkbox"/> Monthly		
2. Additional Household Member		
<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>
<b>Social Security Number</b>	<b>Date of Birth</b>	<b>Gender</b>
		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
<b>Race</b>	<b>Education</b>	<b>Ethnicity</b>
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown/Not Reported <input type="checkbox"/> Other:	<input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12 (Non-Grad) <input type="checkbox"/> HS Grad/GED <input type="checkbox"/> 12 + Post-Secondary <input type="checkbox"/> 2-4 Yr. Grad College	<input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins
<b>Disabled</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Veteran</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Relationship</b> (e.g. daughter, son, spouse, etc.)
<b>Health Insurance Type</b>	<b>Source of Income</b>	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> None <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Other:	<input type="checkbox"/> Employment <input type="checkbox"/> Unemployment <input type="checkbox"/> Self-Employment <input type="checkbox"/> No Income <input type="checkbox"/> Social Security <input type="checkbox"/> TANF/ADC <input type="checkbox"/> SSI/SSD <input type="checkbox"/> Pension <input type="checkbox"/> Disability <input type="checkbox"/> Child Support <input type="checkbox"/> Other (please specify):	
<b>Income Period</b>		<b>Income Amount</b>
<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly (26 pays/year) <input type="checkbox"/> Bi-Monthly (24 pays/year) <input type="checkbox"/> Monthly		





## Authorization for Information Exchange

By signing this authorization, I grant permission for the sharing of information which is to be used to determine eligibility for participation in the Community Services Block Grant (CSBG) or other agency programs under the umbrella of Community Action as operated by the Miami Valley Community Action Partnership for either myself or my family members.

I understand this release will terminate one year from the date I sign this authorization or sooner if I request so in writing.

I understand that all information obtained in association with this release will be held in strict confidence by the recipient.

I further direct that information shared resulting from my signature shall not be further disclosed without my specific written authorization.

I further declare that I understand and permit an information exchange strictly for disclosure purposes related to Miami Valley Community Action Partnership programming.

I also hereby give permission to release to and /or secure information from the following organizations for the purpose of securing services I have requested:

List Organizations:

---

---

---

---

---

---

---

I certify that information in this application is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Name (print or type) \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*A typed/electronic signature satisfies legal requirements and is permissible pursuant to Ohio Revised Code §1306.06  
example: /s/ Mary Tenant