COVID-19 Eviction Prevention Program

Application Form

The goal of the COVID-19 Eviction Prevention Program (Program) is to provide emergency payment of rent to prevent eviction and ensure housing stability for Low and Moderate Income (LMI) households financially impacted by job loss, furlough, or reduced hours as a result of the COVID-19 Pandemic.

The information you provide in this application will be used to determine if you are eligible to receive financial assistance. Please answer all questions to the best of your ability. Program staff are available to provide assistance if you need help completing this form.

GENERAL INFORMATION

Applicant	**Co-Applicant**
Name:	Name:
Race: □ White □ African American □ Asian □ Hispanic □ Native American/Alaska Native □ Other Multiracial	Race: □ White □ African American □ Asian □ Hispanic □ Native American/Alaska Native □ Other Multiracial
Age: Date of Birth:	Age: Date of Birth:
Gender: □ Male □ Female □ Other	Gender: □ Male □ Female □ Other
Home Phone: Work Phone: Mobile Phone: Email:	Home Phone: Work Phone: Mobile Phone: Email:
US Veteran: □ Yes □ No	US Veteran: □ Yes □ No

Social Security #

CURRENT FINANCIAL CRISIS

My/our financial crisis is a direct result of the COVID-19 Pandemic for the following reason (s):

□ 1. A serious illness □ 2. A delay in receiving approved benefits

□ 3. An unexpected job layoff, reduction in hours, or termination of employment

□ 4. An unexpected loss of daycare □ 5. Other:

Please describe the nature of your crisis in detail. If additional space is needed, please use the other side of this page.

TYPE OF ASSISTANCE NEEDED

Rental	I have received a legal notice that I am going to be evicted. □ Yes □ No _____ Number of months behind in rent payments. $_____ Total amount owed in back rent and late fees. $_____ Regular monthly rent amount.

EMPLOYMENT/INCOME INFORMATION

Applicant	**Co-Applicant**
Employment status: □ Work full time □ Laid off □ Work part-time □ Unemployed □ Retired □ Other:	Employment status: □ Work full time □ Laid off □ Work part-time □ Unemployed □ Retired □ Other:
Income: Annual Monthly Hourly Hours worked per week	Income: Annual Monthly Hourly Hours worked per week
Income source (list all): □ Wages □ Social Security □ TANF □ Unemployment Insurance □ SSI □ SSDI □ Other (describe):	Income source (list all): □ Wages □ Social Security □ TANF □ Unemployment Insurance □ SSI □ SSDI □ Other (describe):
If you are laid off or unemployed, for how long? □ 1 – 4 weeks □ 5 – 12 weeks □ 13 – 26 weeks □ 27 weeks or more	If you are laid off or unemployed, for how long? □ 1 – 4 weeks □ 5 – 12 weeks □ 13 – 26 weeks □ 27 weeks or more
If you are unemployed, describe your efforts to get another job:	If you are unemployed, describe your efforts to get another job:
List current/most recent employer: Company Name: Dates of employment: _____ to _____ Amount earned: Reason for leaving:	List current/most recent employer: Company Name: Dates of employment: _____ to _____ Amount earned: Reason for leaving:
Available Assets: □ Cash $_____ □ Checking $_____ □ Savings $_____ □ Investment $_____	

HOUSEHOLD INFORMATION

Other people living in the household:

Name:_____ Date of Birth: _____ Age: ____ Monthly Income:_____

Name:_____ Date of Birth: _____ Age: ____ Monthly Income:_____

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Name:_____ Date of Birth: _____ Age: ____ Monthly Income:_____

Name:_____ Date of Birth: _____ Age: ____ Monthly Income:_____

HOUSING INFORMATION

Address where you currently live:
Street:
City: State: Zip Code: Dates: _____ to _____

Current mailing address (if different than above):
Street:
City: State: Zip Code: Dates: _____ to _____

Previous address: (If less than 6 months at your current address)
Street:
City: State: Zip Code: Dates: _____ to _____

What best describes your current housing arrangement:

- □ Rent my home/apartment/mobile home
- □ Live with relative or friends and being asked to leave
- □ Live in a mobile home and pay rent on the lot
- □ Live in a Hotel
- □ Homeless

Have you ever lost your housing before? □ Yes □ No

If yes, please give the date(s) and reason(s):

Have you or another household member received rental assistance related to Coronavirus Pandemic from _____ _____ or other agencies in the past six (6) months? □ Yes □ No

If yes, please list the name of the agency/program, date(s), and reason(s):

NOTE: If you choose to complete this application before having a meeting with staff, you do not need to sign the application until you fully understand the program guidelines and expectations.

□ Yes □ No	I have been provided with information about the program and expectations.
□ Yes □ No	I understand that if my personal and/or financial circumstances change significantly, I must contact Program staff as soon as possible.
□ Yes □ No	I/we do hereby authorize Program staff to contact employers to verify my eligibility for participation in the program.
□ Yes □ No	I/we do hereby authorize Program staff to contact my/our landlord to verify my eligibility for participation in the program.
□ Yes □ No	I/we do hereby authorize Program staff to share information with affiliated agencies for the purpose of file review to verify program compliance.

By signing this document, I indicate that the information provided in this application is true and accurate; that I understand the requirements of the program; and that I agree to cooperate with Program staff. If I have willfully provided false information or choose not to cooperate with staff, I understand I will be terminated from the program immediately.

Applicant	Date
Co-Applicant	Date
Program Staff Member	Date

CITY OF WILLIAMSBURG
CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, _____
(FULL PRINTED NAME OF AUTHORIZING PERSON)

_____
(INDIVIDUAL'S ADDRESS) *(INDIVIDUAL'S BIRTHDATE)* *(INDIVIDUAL'S SSN)*

I want the following confidential information about me to be exchanged:

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed,	☐	☐	Medical Records	☐	☐	Criminal Justice Records
☐	☐	Psychological Records	☐	☐	Employment Records			
☐	☐	Substance Abuse Records	☐	☐	All of the Above			

Other Information (write in): specific information about benefits (including but not limited to SNAP, Medicaid, TANF, Daycare, VEC)

I want *Williamsburg Department of Human Services* 401 Lafayette Street Williamsburg, VA 23185

And the following entities will be able to use and exchange this information amongst them:

☐ Williamsburg Department of Human Services Eligibility Worker/Social Worker/Family Services Worker
☐ United Way
☐ St. Bede
☐ Salvation Army
☐ Church Outreach programs in the City of Williamsburg and James City County and York County
☐ Landlord ☐ Williamsburg Redevelopment and Housing Authority
☐ Dominion Power ☐ Family members
☐ Employer ☐ _____
☐ _____ ☐ _____

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination

I want this information to be shared by the following means: *(check all that apply)*
☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data ☐ Fax

This authorization is effective from the date of signature.

This authorization is good until: ☐ My service case is closed. ☐ Other: one year from date of signature

I can withdraw this authorization at any time by telling the referring agency. The listed agencies must stop sharing information after they know my authorization has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as valid authorization to share information. **If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.** However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s _____ Date: _____

(AUTHORIZING PERSON OR PERSON _____