HOME TBRA Referral Form

Date of Referral: _____

Referring Agency: _____ **Name:** _____

Contact Email: _____ **Phone:** _____

Head of Household Information:

Name: _____ **Phone:** _____

Email: _____

Best form of Contact: ☐ Phone ☐ Email ☐ Other: _____

Current Living Situation: ☐ Street ☐ Shelter ☐ Family/Friends ☐ Rental ☐ Other: _____

Is Household Income At or Below 60% AMI? ☐ Yes ☐ No
If no, household is not eligible for HOME TBRA program.

Documentation that must accompany referral to be processed:

- Income verification for all household members over age 18
  - Must have two months' worth of documentation unless on fixed income where a singular award letter is required and dated within the last 180 days.
- Asset verification for all household members over age 18
  - Must have two months' worth of documentation – examples of assets being bank account, saving account, etc.
- Completed Application for Assistance that is attached.
  - All questions must be answered completely and all adult household members signing application.

Staff Use Only

Referral Received Date: _____ All Required Documentation Received: ☐ Yes ☐ No

If no, follow-up steps taken and dates: _____

_____

Eligibility: ☐ Yes ☐ No, and if no, explain reason and date of letter of notice of ineligibility:

_____

Staff Handling Referral: _____

APPLICATION FOR ASSISTANCE

Please complete all information requested in ink. **Do not leave blanks,** if the question does not apply, enter N/A, if you do not understand a question, or if you need help completing this form, please ask. This agency may be unable to process your application if it is incomplete. If information submitted on this application, changes, please contact the office to update as soon as possible. Please print clearly.

Date of Application _____

I. Applicant Information

Applicant Name_____ Date of Birth_____ Age_____

Address (where you live now) _____ Social Security No._____

City_____ State_____ Zip Code_____ Telephone_____

Mailing Address (if different) _____ City_____ State_____ Zip Code_____

II. Household Member Information: Please list all persons who will live in the assisted unit beginning with the applicant.

PLEASE PROVIDE INDENTIFICATION FOR EACH HOUSEHOLD MEMBER (such as: driver's license, state issued ID, social security cards, birth certificates, etc.). If applicable, please provide custody court orders. If you do not have this information, please make agency staff aware, so they may assist you in obtaining proper documentation.

Name	Sex	Relationship to Applicant	Date of Birth	Place of Birth	Social Security Number	*Race or Hispanic

*Race: White, Black, American Indian/Alaska Native, Asian or Pacific Islander, Hispanic, Other

You are not required to report if someone in your household has a disability, however, if a household member has a disability you may qualify for additional deductions in your rent amount. Does any household member have a disability?
☐Yes ☐No ☐ Prefer not to answer If yes, list name(s): _____

Is there any specific accommodation you would like to request that would allow you to fully utilize our programs? ☐Yes ☐No
If yes, please explain: _____

You can voluntarily provide information on an alternate contact person. If we are unable to contact you, we will try to contact the alternate person on your behalf. NAME: _____ TELEPHONE NUMBER: _____
ADDRESS: _____

III. Household Income

Please provide all income/earnings information below for **all household members**. This income may include but is not limited to: Employment Income, Self-Employment Income, Unemployment Compensation, Social Security, K-TAP, Disability Income, Child Support, Pensions, Baby-Sitting Income, Odd Jobs Income, etc. If you have no income, write NONE below.

Name of Household Member Receiving Income	Employment or Self-Employment Gross Weekly Income and Employer Name	Weekly Unemployment Benefits	Social Security/ SSI Monthly Benefits	K-TAP Monthly Income	Child Support Monthly Income	Other Income List-Type and Monthly Amount

Does anyone in your household have any other earnings/income or receive any money not listed above? ☐Yes ☐No
If yes, list type and amount monthly: _____

Does anyone help you pay your bills? ☐Yes ☐No If yes, list name and monthly amount: _____

WARNING: Section 1001, of Title 18 of the U.S. code, makes it a criminal offense to make willful false statements or misrepresentation to any department or agency of the United States as to any matter within its jurisdiction

IV. Household Assets:

Does anyone in your household have a checking account? ☐Yes ☐No
Balance $_____ Bank Name: _____

Does anyone in your household have a savings account? ☐Yes ☐No
Balance $_____ Bank Name: _____

Does anyone in your household own real estate or property? ☐Yes ☐No
Type_____Value_____Address_____

Does anyone in your household have any of the following: Money Market Account? ☐Yes ☐No; Certificate of Deposit? ☐Yes ☐No; IRA Account? ☐Yes ☐No; Stocks? ☐Yes ☐No; Bonds ☐Yes ☐No; Other (list)_____

Has anyone in your household disposed of an asset for less than Fair Market Value in the past two years? ☐Yes ☐No
If yes, please list_____

V. Preferences:

This agency gives a preference to households that are Currently homeless on the street or in shelter.

Does your household qualify for this preference? ☐Yes ☐No

VI. Potential Deductions

A. Childcare

Does your household have un-reimbursed child care expenses? ☐Yes ☐No If yes, please give details:

Provider Name: _____Provider Phone Number: _____

Provider Address: _____

List of Children in Care: _____

Monthly Amount Paid by Household: $_____

B. **Medical/disability expenses**

Does your household have un-reimbursed medical/disability expenses? ☐Yes ☐No If yes, please give details:

(1) Provider Name: _____Provider Phone Number: _____

Provider Address: _____

Monthly Amount Paid by Household: $_____

(2) Provider Name: _____Provider Phone Number: _____

Provider Address: _____

Monthly Amount Paid by Household: $_____ (If additional space is needed, attach an additional sheet.)

VII. Conflict of Interest

Are you an employee or board member of this agency? ☐Yes ☐No

Are you related to an employee or board member of this agency? ☐Yes ☐No

If yes to either question above, please explain:

_____

VIII. Signatures/Certification of True and Correct Information

Upon the return of this completed application, this agency will begin processing your application for assistance. Some programs may have a waiting list, and if so, you will be placed on that list. If you do not qualify, you will be notified in writing.

All adult members of household, 18 years old or older, must sign this application.

I/We hereby certify all information given on this application is true and correct, and that I/we have not knowingly withheld any fact or circumstances which would, if disclosed, affect this application unfavorably. I/We hereby authorize inquiries to be made to verify the information given in this application.

_____ _____
(Applicant Signature) (Date)

_____ _____
(Spouse Signature) (Date)

WARNING: Section 1001, of Title 18 of the U.S. code, makes it a criminal offense to make willful false statements or misrepresentation to any department or agency of the United States as to any matter within its jurisdiction