HRCAP
Hampton Roads Community Action Program
Maximizing Opportunities & Transforming Lives

# Required Documentation

Please provide the listed documentation pertaining to the type of assistance being requested. All documents must be submitted at one time. Applications with any missing documents will not be accepted. You may submit your application via Email emergencyfoodandshelter@hrcapinc.org or Fax (757)586-5250. Office (757)247-0379 opt 1

## Rent Relief:

- ☐ Valid lease in the head of household's name
- ☐ Landlord affidavit (includes a W-9 IRS form) required from landlord when approved for assistance
- ☐ RMRP Landlord and Renter Household Agreement (see Attachment C)
- ☐ Proof of income (paystubs, unemployment, benefit letters, child support etc.)
- ☐ Valid Driver's license or State Issued Photo I.D.
- ☐ Proof of past due balance (late letter, eviction notice, or court summons)

## Mortgage Relief:

- ☐ Mortgage Statement in the head of household's name
- ☐ Documentation that the household has applied for and been denied forbearance from their lending institution
- ☐ W-9 IRS form from lending institution (only required once approved)
- ☐ Proof of income (paystubs, unemployment, benefit letters, child support etc.)
- ☐ Valid Drivers license of photo I.D

Please refer any questions regarding your application to Naisha Amado or Tiffany Rosado at (757)247-0379 Extension 344 or 345. You can also email emergencyfoodandshelter@hrcapinc.org Thank you!

Rent must be at/below 150% FMR (Fair Market Rent)

| 150% FMR by Unit Size | | | | |
|---|---|---|---|---|
| 0 Bedrooms | 1 Bedroom | 2 Bedrooms | 3 Bedrooms | 4 Bedrooms |
| 1,428.00 | 1,437.00 | 1,704.00 | 2,404.50 | 2,991.00 |

Gross Household Income at/below 80% AMI (Area Median Income)

| | | | | |
|---|---|---|---|---|
| 50% AMI (PRIORITIZED THROUGH 7/20/20) | 1 Person | 2 People | 3 People | 4 People |
| | $28,900 | $33,00 | $37,150 | $41,250 |
| | 5 People | 6 People | 7 People | 8 People |
| | $44,550 | $47,850 | $51,150 | $54,450 |
| 50% AMI (PRIORITIZED THROUGH 7/20/20) | 1 Person | 2 People | 3 People | 4 People |
| | $28,900 | $33,00 | $37,150 | $41,250 |
| | 5 People | 6 People | 7 People | 8 People |
| | $44,550 | $47,850 | $51,150 | $54,450 |

| | | | | |
|---|---|---|---|---|
| 80% AMI | 1 Person | 2 People | 3 People | 4 People |
| | $46,200 | $52,800 | $59,400 | $66,000 |
| | 5 People | 6 People | 7 People | 8 People |
| | $71,300 | $76,600 | $81,850 | $87,150 |

*Hourly Wage x Hours per week x 52 week = Annual Income

Does not include 1-time stimulus

NOT ELIGIBLE IF…

Already receiving rent assistance (Section 8, Public Housing, Other Assistance) Income did not decrease (Fixed income), even if expenses increased due to COVID-19 Rent amount is not past due or current due

*Section 8 under federal eviction moratorium until July 25, 2020.

# RMRP Income Declaration

(Individuals applying for assistance must be facing eviction or displacement due to COVID related hardship. Cases are approved on a case by case basis)

Please check ALL that apply:

- ☐ I have a valid lease or mortgage statement in my name
- ☐ I have experienced loss of income due to Covid-19
- ☐ I have been laid off due to Covid-19
- ☐ My place of employment has closed due to Covid-19
- ☐ I have experienced a reduction in work hours due to Covid-19
- ☐ I must stay home to care for children due to closure of day care and or school
- ☐ I have lost child or spousal support
- ☐ I have been unable to find work due to Covid-19
- ☐ I am unwilling or unable to participate at my place of employment due to a high risk of exposure to COVID-19 and have a rent or mortgage amount that is at or below 150 percent Fair Market Rent (FRM)
- ☐ I have a gross household income at or below 80 percent Area Medium Income (AMI)

I certify that I have been counseled about other programs available to me to about rental and mortgage assistance. I have spoken with_____from HRCAP on _____, 2020.

_____ _____

Client Signature Date

# HRCAP Confidentiality Statement and Privacy Policy

**Types of information that we gather about you:**

- Information we receive from you orally, on applications or other forms, such as your name, address, social security number, assets, and income
- Information about your transactions with us, your creditors, or others, such as your account balance, payment history, parties to transactions and credit card usage
- Information we receive from a credit reporting agency, such as your credithistory

**You may opt-out of certain disclosures:**

- You have the option to "opt out" of disclosures (direct us not to make those disclosures) of your non-public personal information to third parties such as your creditors.
- If you choose to "opt out", we will not be able to answer questions from your creditors. If at any time, you wish to change your decision regarding your "opt-out", you may call us at (757)247-0379 and do so.

**Release of your information to third parties:**

- So long as you have not opted out, we may disclose some or all of the information that we collect, as described above, to your creditors or third parties where we have determined that would be helpful to you, would aid us in counseling you, or is a requirement of grant awards which make our servicespossible.
- We may also disclose any nonpublic personal information about you or former customers to anyone as permitted by law (e.g., if we are compelled by legal process).

**Please CHECK the appropriate box:**

□ I have read the above agreement and **I DO NOT** wish to opt out at this time.

□ I have read the above agreement and **I WANT TO** opt out at thistime.

**ACCEPTED AND AGREED:**

**By:**_____ **Date:** _____

**By:**_____ **Date:** _____

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## Applicant(s) Information

**Date**: _____

**Last Name**_____**First Name**_____**MI** _____

**Street Address**:_____

**City**_____**State:**_____**Zip**:_____

**DOB:**_____ **SS#** _____

**Phone:**_____**Email:** _____

**Marital Status** _____ **(if married please provide spouse name,DOB)**

## Spouse Information

**Last Name**_____**First Name**_____**MI** _____

**DOB:**_____ **SS#** _____

**The following information is collected for data purposes and will not affect the outcome of your application.**

**RACE** More than one race is permitted. *[All clients]*

| | |
|---|---|
| ☐ American Indian or Alaskan | ☐ Caucasian |
| ☐ Black or African American | ☐ Native/ Hawaiian/Pacific Islander |
| ☐ Multi-Race (any two or more) | ☐ Other: _____ |

**ETHNICITY** *[All clients]*

| | |
|---|---|
| ☐ Non-Hispanic/ Non-Latino | ☐ Hispanic/ Latino |

**GENDER** *[All clients*

| |
|---|
| ☐ Female |
| ☐ Male |
| ☐ Other: _____ |

**HEALTH INSURANCE** ***[All clients]***

☐ Yes ☐ No

**DISABLING CONDITION** ***[All clients]***

☐ Yes ☐ No

**VETERAN STATUS** *[All adults]*

☐ Yes ☐ No

**HOUSING STATUS** *[All clients]*

☐ Homeless ☐ Rent ☐ Live with family

☐ Own ☐ Risk of Losing Housing

**INCOME AND SOURCES** *[All clients]*

**Have you received any income from any source over the last 30 days?**

☐ Yes ☐ No

[IF YES] Please state whether you have received income from the following sources within the last 30 days. If you have received income from a source, state the amount of income you received in the last 30 days.

| Source of Income | | Amount from Source (round to nearest dollar) |
|---|---|---|
| Earned Income (employment income | ☐ yes ☐ no | |
| Unemployment Insurance | ☐ yes ☐ no | |
| Supplemental Security Income | ☐ yes ☐ no | |
| Social Security Disability Income | ☐ yes ☐ no | |
| Veteran's Disability Payment | ☐ yes ☐ no | |
| Private Disability Insurance. | ☐ yes ☐ no | |
| Worker's Compensation | ☐ yes ☐ no | |
| TANF | ☐ yes ☐ no | |
| Child Support | ☐ yes ☐ no | |
| Pension (any) | ☐ yes ☐ no | |
| Other Source | ☐ yes ☐ no | |
| Alimony or other Spousal Support | ☐ yes ☐ no | |
| Total Monthly Income | | |

**NON-CASH BENEFITS** *[All clients]*

**Did you receive any non-cash benefits over the last 30 days?**

☐ No

☐ Yes

↓

**[IF YES] Which of the following non-cash benefits have you received over the last 30 days?**

| Received benefit? No | Yes | Source of non-cash benefit |
|---|---|---|
| ☐ | ☐ | Supplemental Nutrition Assistance Program (SNAP) (Formerly known as Food Stamps) |
| ☐ | ☐ | MEDICAID health insurance program |
| ☐ | ☐ | MEDICARE health insurance program |
| ☐ | ☐ | State Children's Health Insurance Program (SCHIP) |
| ☐ | ☐ | Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) |
| ☐ | ☐ | Veteran's Administration (VA) Medical Services |
| ☐ | ☐ | TANF Child Care services |
| ☐ | ☐ | TANF transportation services |
| ☐ | ☐ | Other TANF-Funded Services |
| ☐ | ☐ | Section 8, Public Housing, or other rental assistance |
| ☐ | ☐ | Other Sources: _____ |
| ☐ | ☐ | Temporary Rental Assistance |

**DOMESTIC VIOLENCE VICTIM/SURVIVOR** *[All adults and unaccompanied youth]*

**Have you ever been a victim of domestic violence?**

☐ Yes ☐ No ☐ If yes can we contact you?

**PLEASE INCLUDE ALL THE INFORMATION FOR EVERYONE IN THE HOUSEHOLD (Each adult over the age 18 will need to complete their own form to be eligible for services)**

| NAME | DATE OF BIRTH | SEX (M/F) | RELATIONSHIP |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Total household (include client):_____ Under 18 yrs.:_____ 18 yrs. to 65 yrs:_____ Over 65 yrs.: _____**

**Level of Family Income** *[All clients]*

| | | | |
|---|---|---|---|
| ☐ | Up to 50% | ☐ | 126%-150% |
| ☐ | 51%-75% | ☐ | 151%-175% |
| ☐ | 76%-100% | ☐ | 176%-200% |
| ☐ | 101%-125% | ☐ | 201% and over |

**Family Type** *[All clients]*

| | | | |
|---|---|---|---|
| ☐ | Single Parent Female | ☐ | Single Person |
| ☐ | Single Parent Male | ☐ | Two Adults NO children |
| ☐ | Two Parent Household | ☐ | Other |

**ASSISTANCE INFORMATION**: (**For Office Use Only**)

Eligibility Verification: CSBG_____ TANF _____

| 2020 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA | | | |
|---|---|---|---|
| **Persons in family/household** | **Poverty guideline** | **125% of poverty (CSBG)** | **200% of poverty (TANF)** |
| For families/households with more than 8 persons, add $4,480 for each additional person. | | | |
| 1 | $12,760 | $15,950.00 | $25,520 |
| 2 | $17,240 | $21,550.00 | $34,480 |
| 3 | $21,720 | $27,150.00 | $43,440 |
| 4 | $26,200 | $32,750.00 | $52,400 |
| 5 | $30,680 | $38,350.00 | $61,360 |
| 6 | $35,160 | $43,950.00 | $70,320 |
| 7 | $39,640 | $49,550.00 | $79,280 |
| 8 | $44,120 | $55,150.00 | $88,240 |

Verification of Eviction: Yes ☐ No ☐ Landlord's Name: _____

Telephone #: _____

Electric:_____Gas:_____Water: _____

Total amount of past due payments: $_____# of months past due: _____

Name on Account:_____Account Number:_____

Amount Allowed: $_____

**REMITTANCE INFORMATION (For Office Use Only)**:

| Type of Assistance | Documentation provided | Client Account #/Entered into Database |
|---|---|---|
| | | |

| Vendor Name | Vendor Address | Tax I.D. # or SSN | Phone & Fax #'s | Amount of Check |
|---|---|---|---|---|
| | | | | |

| Authorization By: | | | | Processed by: | |
|---|---|---|---|---|---|
| Date of Payment | | Check No. | | Invoice/Voucher No. | |

Attachment B

## Virginia RMRP Household Eligibility Certification Form

Tenant's Full Name: _____

**Overall Minimum Requirements**

In order to receive financial assistance through the Virginia Rent and Mortgage Relief Program, households must meet the following minimum requirements:

- ☐ The Tenant or Homeowner has a valid lease or mortgage statement in their name.
- ☐ The household has experienced a loss of income due to the Coronavirus pandemic (Head of household must complete the self-certification of loss of income below).
- ☐ The household's total rent or mortgage payment is at or below 150% FMR.
- ☐ The household's current gross income is equal to or less than 80 percent Area Median Income for household size and location (supporting documentation required). For the time period of June 29, 2020 through July 20, 2020 household's current gross income must be at or below 50 percent AMI.

Household Size (all adults/children): _____

50% of Area Median Income for Household Size: _____ Total

$ Household Annual Gross Income: $ _____

**To be completed by the head of household:** Self-certification of loss of income.

| Please describe your loss of income due to the Coronavirus pandemic including circumstance(s) resulting in loss of income. (Statement may be provided verbally and documented by staff completing form.) |
|---|
| |

I certify that the information I have provided in applying for RMRP assistance is true, accurate, and complete. Additionally, I certify that I have not received any other form of subsidy or financial assistance for the same time period and cost type. (Consent may be given verbally)

_____ _____

Print name of Tenant/Homeowner Tenant signature

Determination of eligibility completed by: Date Completed: _____

_____ _____

Print name of staff person Staff person signature

## 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,_____am signing this form for
*(FULL PRINTED NAME OF AUTHORIZING PERSON OR PERSONS)*
*(FULL PRINTED NAME OF INDIVIDUAL):*_____

_____
*(INDIVIDUAL'S ADDRESS)* *(INDIVIDUAL'S BIRTH DATE)*

My relationship to the individual is: ☐Self ☐Parent ☐Power of Attorney ☐Guardian
☐Other Legally Authorized Representative

I want the following confidential information about the individual 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, Planned, and/or Received | ☐ | ☐ | Medical Records | ☐ | ☐ | Criminal Justice Records |
| | | | ☐ | ☐ | Psychological Records | ☐ | ☐ | Employment Records |
| ☐ | ☐ | Substance Abuse Records | | | | | | |

Other Information (write in): _____

I want **HRCAP**

***(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)***

and the following agencies to be able to exchange this information:
**Hampton Roads Community Action Program Service Providers and it's Partners with signed MOU's**

Other providers as needed *(must specify)* Landlord/Service provider: _____

**I want this information to be exchanged for determining eligibility and service coordination and planning.**

**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: _____

This authorization is valid until 6/29/2025.

I can withdraw this authorization at any time by written notice to 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 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 PERSONS)*

Person Explaining Form: _____
*(Name)* *(Address)* *(Phone Number)*

Witness *(If Required)*: _____
*(Signature)* *(Address)* *(Phone Number)*

UNIFORM CONSENT TO EXCHANGE INFORMATION FORM

FULL PRINTED NAME OF CUSTOMER: _____

_____

_____

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

- ❍ Revoked in entirety
- ❍ Partially revoked as follows:_____

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

- ❍ Letter (Attached Copy Required)

DATE REQUEST RECEIVED:_____

CASE MANAGER RECEIVING REQUEST:

_____

*(Case Manager's Full Name Printed)*

_____

*(Case Manager's Signature)*