Applicant Checklist

Please provide the information listed below to ensure that your application will be processed in an expedited manner. Additional documents may be required on a per-case basis.

- ☐ Completed Emergency Housing Assistance Program Intake Application;
- ☐ Properly executed Eligibility Release Form;
- ☐ Unemployment Insurance Award/Denial Letter;
- ☐ Award letters (copies of checks are allowed) from any other agencies that provided you financial assistance for housing costs in response to COVID-19;
- ☐ Proof of ownership (if an owned home) (e.g. current mortgage statement in applicant's name)
  OR
  Proof of rental housing agreement (e.g. copy of lease signed by both the tenant and the landlord/property manager)
- ☐ Copy of the applicant's driver's license (or a state issued photo ID), and for all adults (age 18 or emancipated minors) in the household;
- ☐ Complete an Affidavit of Legal Residency for all household members;
- ☐ Documentation of mortgage forbearance request denial (homeowners);
- ☐ Provide any and all proof of income for individuals that live at the property and that are over the age of 18;
  - ☐ Last 3 consecutive months of pay check stubs;
  - ☐ Last 3 consecutive months of legder reports for gig employment (e.g. Uber/Lyft earning statement)
  - ☐ Current copy of social security statement/award letter;
  - ☐ Current copy of retirement/pension statements; and
  - ☐ Current copy of unemployment statement.
- ☐ 6 months of bank statements.

***Some items required above may not apply to your situation*.**

EMERGENCY HOUSING ASSISTANCE PROGRAM (COVID-19 EHAP) INTAKE APPLICATION

-For Agency Use Only-			
Application Number (HMIS Unique Identifier):			
Agency Name:		**Date Application Received:**	

1. TO BE COMPLETED BY APPLICANT: (Head of Household, or "HoH")	
Last Name:	
First Name:	
Middle Name:	
Residence Address:	
City:	
State:	
Zip:	
Mailing Address:	
City:	
State:	
Zip:	
Home Phone:	
Daytime phone:	
Mobile Phone:	
E-mail Address:	
Gender:	
Date of Birth:	
SSN:	
Marital Status:	
Is this household member listed as disabled (Y/N)?	

***RACE (Check all that apply):**	
☐ American Indian or Alaska Native	
☐ Native Hawaiian or Other Pacific Islander	
☐ Black or African American	
☐ Asian	☐ Other Multi-Racial
☐ White	☐ Refuse to Answer

***ETHNICITY:**	
☐ Hispanic or Latino	☐ Non-Hispanic or Latino

2. HOUSING TYPE/MONTHLY COST (Check one): -This information is being collected to determine your need and amount of financial assistance for which you are eligible.	
HOUSING TYPE FOR PRIMARY RESIDENTIAL UNIT:	
☐ **Owned Home**	
Monthly Payment:	
(include Principal, Interest, Taxes, Insurance)	
☐ **Rented Home**	
Number of Bedrooms:	
Unit Type:	☐ Apartment or
	☐ Detached House/Single Family
TENANT-PROVIDED UTILITIES	
☐ Electric [☐ Heating; ☐ Cooking; ☐ Water Heating]	
☐ Gas [☐ Heating; ☐ Cooking; ☐ Water Heating]	
☐ Water	
☐ Sewer	
☐ Trash	

3. ALTERNATE CONTACTS INFORMATION: -This information is not required, and is being collected to assist us in contacting you. You may also list a contact who is helping you through this process. Anyone listedas an alternate contact will be included in the release of information allowing the nonprofit agency to contact them regarding your case.	
Contact Name (first):	
Contact Phone No.:	
Address:	
Contact Name (second):	
Contact Phone No.:	
Address:	

For the purposes of this application -"Hispanic or Latino" – is a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture/origin, regardless of race. The term, "Spanish origin," can also be used.

*This information is being collected to ensure compliance with demographic reporting requirements.

4. ADDITIONAL HOUSEHOLD MEMBERS – As of today**,** list the Head of Household and all other members of the household. Indicate the relationship of each family member to the Head of Household (spouse, sibling, etc.). In addition, indicate if there are any additional members in the near future to the household. Skip this page if you are a household of one (1)

NOTE: To receive assistance ALL MEMBERS of the household must demonstrate and certify to their legal residency.

Complete for every member of the household. Use additional copies of this page if necessary

CO-APPLICANT (if applicable)	
Last Name:	
First Name:	
Middle Name:	
Preferred Phone:	
E-mail Address:	
Is this household member listed as disabled (Y/N)?	
Date of Birth:	
SSN:	
Marital Status:	
Gender:	
***RACE (Check all that apply):**	
☐ American Indian or Alaska Native	
☐ Native Hawaiian or Other Pacific Islander	
☐ Black or African American	
☐ Asian	☐ Other Multi-Racial
☐ White	☐ Refuse to Answer
***ETHNICITY:**	
☐ Hispanic or Latino	☐ Non-Hispanic or Latino

ADDITIONAL HOUSEHOLD MEMBER 1	
Name:	
Relationship to HoH:	
Gender:	
Date of Birth:	
SSN:	
Marital Status:	
Is this household member listed as disabled (Y/N)?	
***RACE (Check all that apply):**	
☐ American Indian or Alaska Native	
☐ Native Hawaiian or Other Pacific Islander	
☐ Black or African American	
☐ Asian	☐ Other Multi-Racial
☐ White	☐ Refuse to Answer
***ETHNICITY:**	
☐ Hispanic or Latino	☐ Non-Hispanic or Latino

ADDITIONAL HOUSEHOLD MEMBER 2	
Name:	
Relationship to HoH:	
Gender:	
Date of Birth:	
SSN:	
Is this household member listed as disabled (Y/N)?	
Marital Status:	
***RACE (Check all that apply):**	
☐ American Indian or Alaska Native	
☐ Native Hawaiian or Other Pacific Islander	
☐ Black or African American	
☐ Asian	☐ Other Multi-Racial
☐ White	☐ Refuse to Answer
***ETHNICITY:**	
☐ Hispanic or Latino	☐ Non-Hispanic or Latino

ADDITIONAL HOUSEHOLD MEMBER 3	
Name:	
Relationship to HoH:	
Gender:	
Date of Birth:	
SSN:	
Marital Status:	
Is this household member listed as disabled (Y/N)?	
***RACE (Check all that apply):**	
☐ American Indian or Alaska Native	
☐ Native Hawaiian or Other Pacific Islander	
☐ Black or African American	
☐ Asian	☐ Other Multi-Racial
☐ White	☐ Refuse to Answer
***ETHNICITY:**	
☐ Hispanic or Latino	☐ Non-Hispanic or Latino

For the purposes of this application -"Hispanic or Latino" – is a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture/origin, regardless of race. The term, "Spanish origin," can also be used.

*This information is being collected to ensure compliance with demographic reporting requirements.

5. ELIGIBILITY INFORMATION: ***Please note recipients of housing vouchers are ineligible.***	
i. Was your employment terminated/temporarily cut due to the COVID-19 business closures on or after March 11, 2020?	☐ Yes ☐ No
ii. At the time of the job loss, were you the owner of this residence (including manufactured housing units)? OR ii. At the time of the job loss, were you the renter (named on the lease) of this residence (including manufactured housing units)?	☐ Yes – Owner ☐ Yes – Renter ☐ No
iii. Was the unit your primary residence on the date of the job loss?	☐ Yes ☐ No
iv. Did you file an Unemployment Insurance claim with the Colorado Department of Labor and Employment related to the COVID-19 business closures on or after March 11, 2020? Note: A filed claim is not a requirement of this application, but the nonprofit agency will encourage and assist you to apply before providing housing assistance.	☐ Yes ☐ No
v. Are your payments current on your rent/mortgage?	☐ Yes ☐ No
vi. Is your primary residence currently in foreclosure?	☐ Yes ☐ No
6. OTHER ASSISTANCE RECEIVED: - Assistance provided under the Emergency Housing Assistance Program for households economically impacted by COVID-19 may not exceed a household's monthly unmet housing cost needs. List all other sources of financial or housing assistance received (local, state, federal, and private sources).	
Has anyone in your household applied for, or received any COVID-19 related assistance from any source (local, state, federal, private) other than the program for which this applicant serves? If yes, proceed with this section. If no, proceed with Section #7 Income Information.	☐Yes ☐ No
A. State of Colorado Unemployment Insurance Benefits (UI Benefits)	
i. Has anyone in your household received an award of Unemployment Insurance Benefits?	☐ Yes ☐No
ii. Date Received Determination: Date Received First Payment: Amount Approved Per Week: Amount Received to Date: Amount Approved For Entire Claim Period:	
iii. What is/are your Unemployment Insurance Claim No.(s)? (List claim numbers for all household members.)	1 2 3
B. United States Coronavirus Aid, Relief, and Economic Security Act (CARES Act)	
i. Have you received a payment from the CARES Act? (If no, continue to letter C. in this section.)	☐ Yes ☐ No
ii. Date Received: Amount Received:	
C. OTHER (e.g. City, County, Nonprofit, Faith-Based)	
i. Did you receive any other financial assistance for housing costs due to COVID-19?	☐ Yes ☐ No
ii. If yes, list provider (e.g. Red Cross, United Way, etc.), the amount received from each provider, frequency (monthly or one-time), and date received.	Total Other Received:

7. INCOME INFORMATION (Pre-COVID-19 related loss of job/income): Income includes: Wages, salaries and tips, alimony, child support, military income, part-time income, temporary income, TANF, Social Security, other benefits, other income for all household members over age 18. List ALL household members and their incomes. Attach a separate sheet if you need more space, or use the "Income Source" table provided immediately below.

FOOD STAMPS ARE NOT CONSIDERED INCOME- do not list food stamps.

Household Member Name	Source of Earned/ Employment Income (include employer name) If Applicable	Rate of Pay	Payment Basis (hourly, weekly, monthly, etc.)

Income Source (choose all that apply) Note: All PAY INTERVALS must be calculated as monthly frequency.	Frequency	Stated Income
☐ Earned/Employment Income	Monthly	
☐ Unemployment Insurance	Monthly	
☐ Supplemental Security Income (SSI)	Monthly	
☐ Social Security Disability Income (SSDI)	Monthly	
☐ Veteran's Service-Connected Disability Compensation	Monthly	
☐ Veteran's Non-Service-Connected Disability Pension	Monthly	
☐ Private Disability Insurance	Monthly	
☐ Worker's Compensation	Monthly	
☐ Temporary Assistance for Needy Families (TANF)	Monthly	
☐ General Assistance (GA)	Monthly	
☐ Retirement Income from Social Security	Monthly	
☐ Pension or retirement income from a former job	Monthly	
☐ Child Support	Monthly	
☐ Alimony/Other Spousal Support	Monthly	
☐ Other Sources (please specify):	Monthly	
☐ Declare no income ☐ Client Doesn't Know ☐ Client Refused	☐ Data not collected	

8. ASSET INFORMATION: Provide the requested information on any property you may own or assets you may have.

1. Do you own any other real estate?	☐ Yes ☐ No ☐ N/A
If yes, provide address, city and state of property(s), and current value:	
2. Do you have a mortgage on the home for which you request assistance?	☐ Yes ☐ No
If yes, what is the current balance owed on the mortgage?	

3. List below the types and sources of any household assets. Provide both the current cash value and the estimated annual income from the asset. (e.g. checking account, savings account, pension, money market account. Assets do no income owned, but non-income generating items, such as automobiles.)

Household Member Name	Type & Source of Asset	Cash Value of Asset	Annual Income From Asset

9. APPLICANT CERTIFICATION: Certify that all the information in the application is true, to the best of your knowledge. By signing this application, the applicant authorizes the state or any of its duly authorized representatives to verify the information contained herein.

I/We understand the information provided above is collected to determine if I/we are eligible to receive assistance under the Colorado Emergency Housing Assistance Program for households economically impacted by COVID-19.
I/We hereby certify that all the information provided herein is true and correct.
I/We understand that providing false statements or information is grounds for termination of housing assistance and is punishable under federal law.
I/We authorize the above-referenced Nonprofit Agency and any of its duly authorized representatives to verify all information provided in this application.
I/We understand that additional information will likely be required to move forward with this program.
I/We understand that I/We may be responsible to repay/return any duplicated benefits received in concert with this program or any of the other assistance received hereafter.
Please sign this application below certifying that you understand and agree that you may be responsible for repaying any other benefits that are determined to be duplicative of the assistance received from this program.

Typed Name of Applicant:	**Date**
Typed Name of Co-Applicant:	**Date**

Notice: Due to the nature of this program, and to avoid additional unneccesary contact, a typed name on this form will constitute the legal equivalent of your signature for the purposes of this application. An email must be included consenting to this application in writing.

Warning:
Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.

10. ELIGIBILITY RELEASE: It is required that you sign this form, which allows the Nonprofit Agency, State or Vendor to request information from Third Parties concerning your eligibility and participation in this program.	
Applicant Name:	
Applicant Address:	
Information Covered: Inquiries may be made about items including: Income (all sources including dependent income), Assets (all sources), Child Support, Rental Amount.	
Instructions to Applicant: Your signature on this Eligibility Release, and the signatures of each member of your household who is 18 years of age or older, authorizes the state or any of its duly authorized representatives to obtain information from a third party regarding your eligibility and continued participation in the Emergency Housing Assistance Program (COVID-19). Each adult member of the household must sign this Eligibility Release.	
Privacy Act Notice Statement: Nonprofit agency requires the collection of the information listed in this form to determine an applicant's eligibility for the Program. This information will be used to establish the level of benefits for which the applicant is eligible and to verify the accuracy of the information furnished. Information received from an applicant or as a result of verifying an applicant's eligibility may be released to appropriate Federal, State, and local agencies or, when relevant, to civil, criminal, or regulatory investigators, and to prosecutors. Failure to provide any information may result in delay or rejection of your eligibility approval. Subrecipient is authorized to ask for this information under the National Affordable Housing Act of 1990.	
NOTE: THIS GENERAL CONSENT MAY NOT BE USED TO REQUEST A COPY OF A TAX RETURN. If a copy of a tax return is needed, IRS Form 4506, “Request for a Copy of Tax Form", must be prepared and signed separately.	

Applicant's Authorization:

I authorize the above-named Nonprofit Agency, State or Vendor to obtain information about me and my household that is pertinent to determining my eligibility for participation in the Program. I acknowledge that:

(1) A photocopy of this form is as valid as the original; AND
(2) My printed name will act in lieu of a written signature for the purposes of this form; AND
(3) I have the right to review information received using this form; AND
(4) I have the right to a copy of information provided to the Subrecipient and to request correction of any information I believe to be inaccurate; AND
(5) All adult household members will sign this form and cooperate with the Subrecipient in the eligibility verification process.

WARNING: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.

Signatures:	
Printed Name - Head of Household	*Date*
Printed Name - Other Household Member	*Date*
Printed Name -Other Household Member	*Date*
Printed Name -Other Household Member	*Date*
Printed Name -Other Household Member	*Date*

COHMIS Client Consent for Data Collection and Release of Information

This notice explains how information about you may be shared and used. It also tells you who can access your information. Please read it carefully and ask any questions you may have.

What is COHMIS?

The Colorado Homeless Management Information System (COHMIS) is a data system that stores information about homelessness services. The name of the software that stores this data is called Clarity Human Services. The purpose of COHMIS is to improve coordination of services that support people who are homeless or at risk of homelessness. To further ensure and navigate this coordination, data is shared statewide between the four Continuum of Care (CoC) bodies: MDHI (Metro Denver), Pikes Peak (El Paso County) Northern Colorado (Larimer and Weld Counties), and Balance of State (Remaining 54 Counties). Active agencies that participate in COHMIS are listed on https://cohmis.zendesk.com/hc/en-us.

What is the purpose of this form?

With this form, you can give permission to have information about you collected and shared with partner agencies that help provide housing and services. Partner agencies are required to protect the privacy of your identifying information.

You have rights regarding your information:

- You have the right to ask about who has seen your information.
- You have the right to see your information at any time and change it if it isn't correct.
- You have the right to change your authorization regarding the use of your data.
- You have the right to file a grievance if you feel your information has been misused. The Grievance Form may be requested at any time from any participating COHMIS agency.
- Right to refuse information while retaining rights of access to services.

The information to be collected and shared may include:

- Name, date of birth, gender, race, ethnicity, social security number, phone number, address
- Basic medical, mental health, substance use and daily living information
- Housing and program eligibility information
- Use of crisis services, Veteran services, hospitals and jail
- Employment, income, insurance and benefits information
- Services provided by partner agencies
- Results from assessments
- Photograph or other likeness (if included)

By signing this form:

- I authorize the CoC and Clarity to share COHMIS information with partner agencies, and the COHMIS information shared will be used to coordinate services. It will also be used to help evaluate the quality of community programs.
- I understand that the partner agencies may change over time and are always responsible for keeping my information private using reasonable best efforts for privacy policies.
- I understand that agencies must adhere to federal and Colorado laws regarding my protected information.
- I may revoke this consent at any time by returning a completed revocation of consent form, available upon request, to agency staff.
- I can receive a copy of this consent form.
- I understand this consent will expire 7 years from my last COHMIS recorded activity.

Printed Name of Client or Legal Guardian: _____

Printed Names of additional minor children covered by this release: _____

_____

Signature of Client or Representative: NOTE: Email this form along with your written consent. Your email will act as your electronic signature. If you cannot email the form, you can sign below or consent verbally. **Date:** _____

_____ **Date:** _____

_____*Initials of Client If Declining Consent*

FORM 1 – AFFIDAVIT OF LEGAL RESIDENCY

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

☐ I am a United States citizen, or

☐ I am a Permanent Resident of the United States, or

☐ I am lawfully present in the United States pursuant to Federal law.

I understand that this sworn statement is required by law because I have applied for a public benefit or I am a sole proprietor entering into a contract or purchase order with the State of Colorado. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit or prior to entering into a contract with the State. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under CRS §18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

_____

Signature

_____

Date

CENTENNIAL MENTAL HEALTH CENTER
Release of Information or Authorization
Mental Health and/or Substance Abuse

☒ This Release also serves as a Request For Information

Origin of Authorization: ☒ Internal ☐ External Direction of Authorization: ☒ Outgoing ☒ Incoming

I, _____ (Name of Client) _____ (DOB) **hereby authorize**

Centennial Mental Health Center (Name) 211 W. Main Street (Address) Sterling (City) 80751 (Zip)

AND Other Agency: _____ (Name) _____ (Address) _____ (City) _____ (Zip)

Landlord/ Mortgage Lender

_____ (Contact Person)

To Release the Following Information: (Check all that apply)

☐ All Clinical Records ☐ Evaluation/Assessment ☐ Physician's Records
☐ Lab Reports ☐ Service Plans ☐ Progress Notes
☐ Attendance / Participation / Progress ☐ Discharge/Transfer Summary ☐ Verbal Discussions
☒ Other Housing Assistance Only

For the Purpose of:

☐ Treatment (Internal & External) ☐ Operations (Administrative) ☒ Payment (Reimbursement)
☐ Other (Indicates HIPAA Authorization, use only when necessary) Specify: _____

Periods of Treatment: ☐ All Treatment Episodes ☒ Current Treatment Episode
☐ Specific Treatment Episode: Begin Date: _____ End Date: _____

If the purpose of this disclosure is marked as "Other" whether or not Treatment, Payment or Operations are checked, then this is a HIPAA Compliant Authorization. As such, the Center may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization and must provide me a copy.

I understand that my records or those of the individual listed above are protected under state and federal Substance Abuse and Mental Health confidentially regulations including 42CFR Part 2. Information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand and agree that this release form may be sent to the agencies and persons identified above. Copies of this form may be used in lieu of the original.

I understand there is potential for information disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken based upon it. This consent expires and cannot be used past the indicated date or event.

Expiration Date: _____ (Not more than one year) **OR** **Expiration Event:** _____

X _____ **CLIENT SIGNATURE** _____ Date

_____ Parent, Guardian or Authorized Representative Signature _____ Relationship/Authority _____ Date

_____ Staff Member Signature _____ Date

Consent revoked: _____ Client or Guardian Signature _____ Date

A COPY OF THIS RELEASE SHOULD BE PROVIDED TO THE CLIENT C010/03-03