LAKEWOOD Community Services Center

LAKEWOOD COMMUNITY SERVICES CENTER

APPLICATION FOR ESG ASSISTANCE

DATE: _____

In order to apply for funds, some preliminary information is required. Please note that your application for assistance does not guarantee receiving funds. Thank you.

HEAD OF HOUSEHOLD (HOH) INFORMATION				
LAST NAME	**FIRST NAME**	**M.I.**	**SUFFIX**	**SOCIAL SECURITY NUMBER**

DATE OF BIRTH	**GENDER** (Optional) ◯ Male ◯ Female ◯ Other	**MARITAL STATUS** ◯ Single ◯ Married ◯ Separated ◯ Legally Separated ◯ Divorced ◯ Widowed

ADDRESS	**LENGTH OF RESIDENCY**

MAIN PHONE NUMBER	**OTHER PHONE NUMBER**	**EMAIL**

DO YOU NEED AN INTERPRETER? ◯ YES ◯ NO	**WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?**	**WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?**

ARE YOU A VETERAN? ◯ YES ◯ NO	**ARE YOU DISABLED?** ◯ YES ◯ NO	**IF YES, WHAT IS YOUR DISABILITY?**

RACE (Optional) ◯ White/Caucasian ◯ Native ◯ American Indian/ Alaska Native ◯ Asian ◯ Black/African American Hawaiian/Other Pacific Islander ◯ Other	**ETHNICITY** (Optional) Hispanic? ◯ YES ◯ NO
WHO REFERRED YOU?	**HIGHEST SCHOOL GRADE COMPLETED**

HOUSEHOLD TYPE (Skip if Single Adult) ◯ Female Single Parent ◯ Male Single Parent ◯ Two Parent Family ◯ Foster Parent(s) ◯ Grandparent(s) & Child ◯ Non-Custodial Caregiver ◯ Couple with No Children ◯ Couple (Parent & Friend) and Child ◯ Other

Has there been a recent reduction in household income?	◯ YES ◯ NO
If yes, indicate reason:	
Is household receiving other rent/utility assistance?	◯ YES ◯ NO
If yes, please indicate source:	
Is household receiving food stamps?	◯ YES ◯ NO
If yes, how much each month?	
Does household have health insurance?	◯ YES ◯ NO
If yes, please indicate which type:	
Are any household members a domestic violence victim/survivor?	◯ YES ◯ NO
If yes, indicate when (and if fleeing):	

ADDITIONAL HOUSEHOLD MEMBERS									
FIRST NAME	LAST NAME	GENDER	DOB	SSN	RELATIONSHIP TO HOH	VETERAN Y/N	RACE	ETHNICITY	DISABILITY Y/N

DESCRIBE THE CIRCUMSTANCES THAT LED YOU TO SEEK ASSISTANCE (Presenting Problem):
WHAT TYPE OF ASSISTANCE DO YOU NEED RIGHT NOW:

ASSISTANCE REQUEST:	
Landlord Name:	Landlord Phone Number:
Amount of Rent Needed: $	Court-Ordered Eviction: ◯ Yes ◯ No

MONTHLY EXPENSES:				
Rent:	Gas:	Electric;	Phone:	Cable / Internet:
Water / Sewer:	Food:	Transportation:	Other:	Other:

CLEVELAND/CUYAHOGA COUNTY HMIS CONSENT AND RELEASE

When you request or receive services from the Cuyahoga County Continuum of Care (CoC), information is collected about you and your household. This information is then entered into the Cleveland/Cuyahoga Homeless Management Information System (CCHMIS), a.k.a. Clarity Human Services. The CCHMIS is used by over 40 local, social service agencies to coordinate service delivery.

What type of information is collected?

- Basic identifying information for you and each member of your household (may include name, SSN, date of birth, gender, race, ethnicity, household information, phone numbers, military veteran status, disability status)
- Income information (sources and amounts of household income, employment information, work skills)

What happens to the information collected?

- With your approval, information collected is shared with other service agencies participating in HMIS for the purpose of coordinating service delivery, identifying needs, and tracking outcomes.
- CCHMIS aggregate data (non-identifying) may be used for community reports and shared with Federal, State, and local agencies and other institutions for the purpose of research and analysis. Client information is only shared with authorized persons.

NOTE: CCHMIS uses many security protections to ensure confidentiality and only agencies that use CCHMIS can access this program. All partner agencies adhere to strict security policies to protect your privacy. HMIS software is highly secure.

Why should you agree to have your information shared with other agencies that use Cuyahoga County Clarity Humans Services? The benefits to sharing your information in HMIS are as follows:

- Reduce the number of visits to other agencies and forms completed;
- Identify other services or programs you may be eligible for;
- Better coordinate services for you and your household.

CLIENT INFORMED CONSENT/RELEASE OF INFORMATION AUTHORIZATION

You have the option to cancel access to personal information that you are providing about yourself and your minor children at any time. If you chose to cancel previous authorization, you must do so in writing. Please contact intake staff at the CoC Agency you're currently working with to formally rescind authorization. Please note that canceling authorization (rescinding authorization) will only impact future release of client information.

AUTHORIZATION OF CONSENT: *All information may be shared with authorized personnel in participating and partner agencies relative to the CoC. Your release of information authorization is valid for three (3) years.*

SIGNATURE of Client, Guardian, or Head of Household | **PRINTED NAME** | **DATE**

REFUSAL OF CONSENT: *I understand that services will not be withheld if I refuse consent.*

SIGNATURE of Client, Guardian, or Head of Household | **PRINTED NAME** | **DATE**

ADDITIONAL HOUSEHOLD MEMBERS:

PRINTED NAME OF CLIENT **Relationship to HOH**

PRINTED NAME OF CLIENT **Relationship to HOH**

PRINTED NAME OF CLIENT **Relationship to HOH**

PRINTED NAME OF CLIENT **Relationship to HOH**

PRINTED NAME OF CLIENT **Relationship to HOH**

PRINTED NAME OF CLIENT **Relationship to HOH**

ESG COMPLAINT/GRIEVANCE/APPEAL PROCEDURES

A. GENERAL POLICY

It is the intent of agencies providing ESG assistance to respond quickly to complaints and appeals by the program participants. If the complaint is against Lakewood Community Services Center, please follow the following procedure.

- Submit written complaint to **Trish Rooney, Executive Director**
- She will investigate and recommend a solution

If the outcome of the agency's grievance process is not satisfactory to the client, a written complaint or appeal may be filed with the following agency:

Office of Homeless Services

310 West Lakeside Ave., Suite 595

Cleveland, Ohio 44113

B. PROCEDURES

Any complaint or appeal must be submitted in writing within 30 days of action or decision and include the following information:

- The nature of the complaint or reason for appeal
- The date of occurrence or termination
- The parties involved
- The desired outcome of the review/appeal
- A signed release of information (if we must speak with outside entities)

Appeal process and timeline:

- Appeal will be reviewed by the Executive Director at LCSC and a written decision will be provided within 3 working days.
- If, after going through the agency's complete internal grievance/complaint process, the participant is not satisfied with the agency or administering agency decision, they may appeal to the Office of Homeless Services (see above info).
- Upon receiving a request for an appeal, the Office of Homeless Services will convene a subcommittee of representatives to conduct and process the appeal within five working days.
- If after receiving the written response from the Office of Homeless Services, the complaint is dissatisfied, then a written appeal may be made to the HUD Columbus office.

_____ _____

Applicant/s Signature **Date**

THIRD PARTY VERIFICATION OF INCOME

APPLICANT(S) NAME: _____

Verifiable income includes but is not limited to:

- Earned Income before taxes and deductions (Gross).
- Fixed-monthly payments in lieu of earnings, such as SSDI, SSI, disability compensation, unemployment, and workers' compensation
- Monthly payments received from Social Security, annuities, retirement funds, pensions, disability and other similar types of periodic payments.
- Monthly income from government agencies excluding amounts designated for shelter, utilities, food stamps, WIC, and childcare.
- Alimony, child support, and foster care payments received from organizations, or persons, not residing in the household.
- All basic pay, special pay, and allowances paid to a member of the Armed Forces, excluding special pay for exposure to hostile fire.
- The net income earned from the operation of a business or self-employment.

Check only one box and complete that section

◯ I certify, under penalty of perjury, the following household income

Name: _____ Source: _____ Amount: _____ Frequency: _____

Name: _____ Source: _____ Amount: _____ Frequency: _____

Name: _____ Source: _____ Amount: _____ Frequency: _____

Name: _____ Source: _____ Amount: _____ Frequency: _____

_____ _____

Applicant/s Signature **Date**

◯ I certify, under penalty of perjury, that the household does not have any income at this time

_____ _____

Applicant/s Signature **Date**

THIRD PARTY VERIFICATION OF HOUSING STATUS

APPLICANT(S) NAME: _____

◯ Household without dependent children (complete one form for each adult in the household

◯ Household with dependent children (complete one form for household)

◯ Number of persons in the household: _____

This is to certify that the above individual, or household, is currently homeless, or at-risk of homelessness, based on the following indicated/verified information and criteria defined by HUD in 24 CFR § 576.2

Check any that apply:

◯ Currently homeless and lack a fixed, regular, and adequate nighttime residence (i.e. a car, park, abandoned building, bus station, airport, or campground)

◯ Victim(s) of domestic violence and fleeing from abuse.

◯ Being evicted, or displaced, from current housing and must leave within the next 21 days

◯ Moved because of economic reasons two or more times during the 60 days immediately preceding the application of homelessness prevention assistance

◯ Living in the home of another because of economic hardship

◯ Living in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or living in a larger housing unit in which there reside more than 1.5 persons per room.

◯ Exiting a publicly funded institution, or system of care (such as a health-care facility, mental health facility, foster care or youth facility, or correction program or institution)

◯ Living in a hotel, or motel, and the cost of the stay is not paid by charitable organizations or by Federal, State, or local programs for low-income individuals.

_____ _____

Applicant/s Signature **Date**

LCSC ESG TERMINATION FORM

To be completed upon receipt of Rental/Utility assistance

RECIPIENT NAME: _____

TOTAL ESG FUNDS RECEIVED: _____

ESG Recipient Signature:	Date:
Staff Signature:	Date:
Supervisor Signature:	Date:

*"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. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at **208 (a) (6), (7) and (8).** Violation of these provisions are cited as violations of 42 U.S.C. Section **408 (a) (6), (7) and (8).**"*