APPLICATION COVER SHEET – DEPOSIT ASSISTANCE

Waterloo Households Only

Black Hawk County Office	Buchanan County Office	Grundy Center Office
1535 Lafayette St. Box 4120	1827 1st St. W, Ste D	1606 G Avenue
Waterloo, IA 50704	Independence, IA 50644	Grundy Center, IA 50638
319-291-2065	319-334-6081	319-824-3460

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Email: _____ Phone: _____ Last 4 of Social Security #: _____

1. Have you applied for or are you receiving Section 8 Housing Assistance? Yes No
2. Have you applied for any other assistance to help with this need? Yes No
   If Yes, where did you apply? _____
3. How much assistance do you need? _____

SUBMIT THE FOLLOWING INFORMATION WITH YOUR APPLICATION.

- ✓ Complete The Basic Intake Form
- ✓ Proof Of Income From All Sources (See Income Attachment)
- ✓ Last 6 Months Of Checking And Last 3 Months Of Savings
- ✓ Proof you have signed up for or are receiving Section 8
- ✓ Consent To Release & Exchange Information
- ✓ Copy of a Lease
- ✓ Social Security Card Copies (If Not Previously Provided To OT)

QUESTIONS? CALL US OR EMAIL CRISIS@OPERATIONTHRESHOLD.ORG

My signature below certifies that the income on this application is true and correct to the best of my knowledge. I understand any false information may disqualify me for assistance.

APPLICANT SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY: Application Status: Approved Denied Reason: _____

Amount Paid by OT: _____ Agency/Vendor to Pay: _____

CONSENT TO RELEASE, OBTAIN OR EXCHANGE INFORMATION

Participant Name: _____ **Date of Birth:** _____

Address: _____

FROM:	**TO:**
Name: 1535 Lafayette Street Waterloo, IA 50703 PH (319) 291-2065 FAX (319) 232-6484	Agency: Contact Person: Address: Phone: FAX:

CONSENT TO OBTAIN OR EXCHANGE THE FOLLOWING CHECKED ITEMS

HOUSING ASSISTANCE ☐ Rent ☐ Deposit ☐ Mortgage ☐ Homelessness	**UTILITY ASSISTANCE** ☐ Water ☐ Gas ☐ Electric ☐ Fuel	**EMPLOYMENT EXPENSES** ☐ Equipment ☐ Clothing
BILL ASSISTANCE ☐ Landline Phone ☐ Cell Phone	**EXPENSES** ☐ Medical Bills ☐ Dental Bills	**EDUCATION** ☐ Books ☐ Materials
ASSISTANCE FOR CHILDREN ☐ Internet for School ☐ School Uniforms/School Clothing ☐ Child Care	**TRANSPORTATION** ☐ Bus Pass ☐ Vehicle Registration	
HOUSEHOLD ASSISTANCE ☐ Household Items ☐ Personal Hygiene ☐ Food ☐ Personal Protective Equipment (PPE)	**OTHER:**	

Briefly explain the purpose for this release of information	**To communicate with Vendor/Agency who will receive payment by verifying any necessary information for the above selected program assistance.**

Please read before signing below.

•I understand that the consent to Release, Obtain or Exchange Information form is limited to the agencies, groups or persons named, and this information is not to be passed on to anyone else or to be used for any purpose other than those specified.

•I understand that I have the right to see this information at any time. I can revoke my consent by writing to both the persons giving and the persons receiving the information. But any information already released may be used as stated on this consent. I understand the information is needed to plan services or to determine eligibility for services. This consent is not automatically renewable. It expires automatically at the end of the period specified unless revoked sooner. I have read this release form, or it has been read to me and I understand its content.

•Federal and/or State law specifically requires that any disclosure or re-disclosure of AIDS-related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____**X**__ **This authorization is a one-time disclosure and is valid for 90 days from the date of signature**
_____ **This authorization becomes invalid one year from date of signature or when case is closed**

See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

_____ _____
Participant Signature Effective Date

_____ _____
Staff Signature Date

Please check and initial one of the below:

☐ I declined a copy of this release: _____ ☐ I received a copy of this release: _____
Participant Initials Participant Initials

CC: Original to case file; copy to participant/legal representative 8/2020

INCOME ATTACHMENT:
WHAT INCOME DOCUMENTATION DO I NEED TO PROVIDE?

Please provide documentation for all income types that you have, including your Bank Account Checking/Savings history. It is the responsibility of the applicant to obtain and submit the required income documentation with the application.

If you have no income, you must request a Minimal Income Verification Form from our staff.

CHECKLIST (for Office Use only)	DOCUMENTATION TO SUBMIT WITH APPLICATIONS	
	IF YOU HAVE THIS INCOME	**YOU NEED TO PROVIDE THIS DOCUMENTATION….**
	Employment/ Wages	Last **THREE Months** of pay stubs for each employed person in the Household, 18 and over.
	Checking Account	Last **SIX Months** of Statements. Must not black out any part of bank statement.
	Savings Account	Last **THREE Months** of Statements. Must not black out any part of bank statement.
	Social Security / SSI / SSDI	Attach your most recent benefit letter for the current year
	Welfare Assistance / FIP	Attach verification for any public assistance programs
	Alimony / Child Support	Child support (amount received in the last **THREE Months**) and documentation of Alimony from court order
	Unemployment, Severance, Workers Comp	Verification of past **THREE Months**
	VA/IPERS/ Civil Service/ IRA/ Annuities	Attach the most recent benefit for the **current year**
	Rental Property Income	Last **TWO Years** of income tax statements (certified copy from IRS or Tax Preparer)
	Pensions	Attach the 1099 form from pension providers for the **last year**
	Gifts	Attach documentation for financial assistance received from an individual
	Income from a Business	Attach tax statements from the business for the past **TWO years**
	Other Real Estate	Indicate address and value of the asset
	Life Insurance	Cash Value Only
	Retirement, 401k, Keogh Accounts	Attach statement showing current value
	Other	Attach any copies of other income or asset verification

If you have questions about what type of information to provide, please contact our office or 319-291-2065 or email Crisis@operationthreshold.org

INCOMPLETE APPLICATIONS WILL BE DELAYED / DENIED

DUPLICATION OF BENEFITS CERTIFICATION

This certification must be completed by all applicants that will receive assistance from the CDBG-CV funded Crisis Assistance programs, offered by Operation Threshold. CDBG-CV funds follow The Robert T. Stafford Disaster Relief and Emergency Assistance Act, (42 U.S.C. 5121-5207) (Stafford Act) Section 312 which prohibits federal agencies from providing assistance to any person, business concern or other entity for "any part of such loss as to which one has received financial assistance under any other program or from insurance or any other source." 42 U.S. C. 5155(a) and Economic Security Act.

Please identify any other assistance funds that you have received or anticipate receiving for this need. Sources of funds include but are not limited to Federal, State, and local government, church, or nonprofit assistance programs.

I/We have received the following recovery assistance funds:

ASSISTANCE / AGENCY	AMOUNT	USE OF FUNDS

☐ No members of the household have received any type of assistance for this need in the past three months.

I hereby certify that:

1. I/We have received no other assistance funds for this assistance request, together than those set forth above.
2. If I/We receive duplicated benefits, I/we will repay the duplicated benefits.
3. I/We certify under penalty of perjury that all information provided as part of this application si true and correct to the best of My/Our knowledge.

Printed Name **Signature**

Date: _____

BASIC INTAKE FORM

HEAD OF HOUSEHOLD CONTACT INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL		COUNTY	
STREET ADDRESS		CITY		STATE		ZIP CODE	
MAILING ADDRESS		CITY		STATE		ZIP CODE	
HOME PHONE NUMBER		CELL NUMBER		EMAIL ADDRESS			

HOUSEHOLD MEMBER INFORMATION (A legend for completing this section is at the bottom of the page)

NAME (FIRST AND LAST) **USE ROW 1 FOR PERSON LISTED ABOVE**	RELATION TO HEAD OF HOUSEHOLD	Marital Status	DATE OF BIRTH	GENDER (circle one)	SOCIAL SECURITY NUMBER OR I-94 NUMBER	DISABILITY (circle one)	HEALTH INSURANCE	HISPANIC, LATINO, OR OF SPANISH ORIGIN?	RACE	MILITARY STATUS (circle one)	HIGHEST LEVEL OF EDUCATION	EMPLOYMENT (work status)	INCOME PERIOD
1	HEAD OF HOUSEHOLD			MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
2				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
3				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
4				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
5				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
6				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
7				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			
8				MALE FEMALE OTHER		YES NO UNKNOWN		YES NO		VETERAN ACTIVE NONE UNSURE			

HOW MANY HOUSEHOLD MEMBERS ARE: A U. S. Citizen _____ Homebound _____ **A disconnected youth (age: 14-24) who is neither working or in school _____**

LEGEND FOR COMPLETING THE HOUSEHOLD MEMBER SECTION

RELATION TO HH	DOB	MARITAL STATUS	SS NUMBER OR 1-94 NUMBER	HEALTH INSURANCE	RACE	HIGHEST LEVEL OF EDUCATION	EMPLOYMENT (WORK STATUS)
• Head of Household • Spouse • Child • Foster Child • Grandchild • Sibling • Parent • Grandparent • Other Relative • Not Related	• Date Format 99/99/99	• Married • Single • Divorced • Widowed	• Social Security Number Format: 999-99-9999 • I-94 Format (11 numbers) 999999999 99 **INCOME PERIOD** • Weekly • Bi-Weekly • Semi-Monthly • Monthly • Quarterly • Annually	• Medicaid • Medicare • State Children's Health Insurance Program • State Health Insurance for Adults • Military Health Care • Direct Purchase • Employment Based • None	• American Indian • Alaska Native • Asian • White • Black or African American • Native Hawaiian and Other Pacific Islander • Other • Multi-Race	• 0-8th Grade • 9th-12th Grade/non-graduate • High School Graduate (or equivalency diploma) • 12th Grade + some post-secondary school • College Graduate (2 or 4 year) • Graduate of other post-secondary school	• Employed (Full-Time-FT) • Employed (Part-Time-PT) • Migrant Seasonal Farm Worker • Unemployed (short-term, 6 months or less) • Unemployed (long-term, more than 6 months) • Unemployed (not in labor force) • Retired

3. HOUSEHOLD TYPE (check one)

	Single Person		Single Parent Female		Single Parent Male		Two Parent Household
	Two Adults No Children		Multi-Generational Household		Non-Related Adults with Children		Other

4. HOUSEHOLD INCOME SOURCES (check all that apply)

For each household income source you check, you must include proof of income documentation with this application. For EMPLOYMENT INCOME, provide copies of your check stubs for the 30 days preceding this application, or provide a copy of your federal income tax return. For SELF-EMPLOYMENT INCOME or FARM INCOME, provide a copy of your federal income tax return.

☐ Employment Income (salary/wages)	☐ SSI (Supplemental Security Income)	☐ Private Disability Insurance	☐ SSDI (Social Security Disability Income)
☐ Self-Employment or Farm Income	☐ Worker's Compensation	☐ Alimony or Spousal Support	☐ Social Security Retirement Income
☐ VA Service Connected Disability Compensation	☐ Child Support	☐ General Relief/Assistance	☐ Unemployment Insurance/Benefits
☐ VA Non-Service Connected Disability Compensation	☐ Pension	☐ TANF/FIP Assistance	☐ No Income
☐ Other:			

Does your household have savings over $50,000 (include: all savings and checking accounts, CDs, and other investments)? ☐ YES ☐ NO

Did anyone in your household file a tax return and receive the EITC (Earned Income Tax Credit) benefit last year or this year? ☐ YES ☐ NO

HOUSEHOLD NON Cash Benefits (Check all that apply)

☐ WIC (Women, Infants & Children) ☐ Public Housing ☐ Permanent Supportive Housing ☐ LIHEAP ☐ Affordable Care Act Subsidy ☐ SNAP (Food Stamps)

☐ Housing Choice Voucher (HCV) ☐ HUD-VASH Veteran's Affair Supportive Housing ☐ Child Care Voucher ☐ Other_____

HOUSING STATUS (check one) ☐ OWN ☐ RENT ☐ OTHER PERMANENT HOUSING ☐ HOMELESS (if homeless, what is your housing status?) ☐ OTHER **What are your Mortgage or Rent costs per month? $**

- If you rent, are your heating costs included in your rent? ☐ **Yes** ☐ **No**
- If you Rent, do you receive RENT assistance? ☐ **Yes** ☐ **No**
- If you Rent, if your rent based on a percentage of your income? ☐ **Yes** ☐ **No**

HOUSING TYPE

☐ **House** ☐ **Mobile Home** ☐ **Rent a Room** ☐ **2, 3, or 4 Unit Apt.** ☐ **5 or more Unit Apt.** ☐ **Other**

IF YOUR HEAT IS INCLUDED IN YOUR RENT, YOU MUST INCLUDE A COPY OF YOUR LEASE.

LANDLORD/COMPLEX INFORMATION

NAME		ADDRESS		PHONE	

MAIN SOURCE OF HOME HEATING **You must include copies of your most recent Heating Bill and Electric Bill.**

☐ Natural Gas ☐ Electric ☐ Propane (LP) ☐ Fuel Oil ☐ Wood/Coal/Corn ☐ Other

*** If propane or fuel oil, do you have an empty tank (20% or less or in the red)?** ☐ Yes ☐ No

DO YOU HAVE A DISCONNECT NOTICE? ☐ **YES** ☐ **NO**

ARE YOU CURRENTLY DISCONNECTED? ☐ **YES** ☐ **NO**

*** Please provide copy of disconnect notice with application.**

HOUSEHOLD HEATING AND ELECTRIC COMPANIES

Heating Vendor		Electric Vendor	
Account Name		Account Name	
Account Number		Account Number	

CERTIFICATION STATEMENT

I certify under penalty of perjury the above information is true. I give permission to the agency processing this application to acquire additional information and to share information with other organizations for the purposes of providing services to assist my household. This sharing of information is to be conducted with maximum respect for the confidentiality of the information contained in this application.

I am hereby making application for assistance to Operation Threshold for any of the following programs: LIHEAP, CSBG, CDBG, HOME, EFSP. **I further certify the following:** I declare that I am the only person in the household who has or will apply for this program(s). I understand that this information will be used, upon request, in determining eligibility for other agency programs or services. Any willful misrepresentation of the information on this form is subject to a penalty of law. I assure that any payments received will be used solely for the needs stated on my application and verified by Operation Threshold Staff. I understand that by signing (either in written form or electronically) this application, I am authorizing the assistance to be provided and vendor to be paid.

I hereby give permission to the State of Iowa, the U.S. Department of Energy, U.S. Department of Health and Human Services, U.S. Department of Housing and Urban Development and the agency processing this application to obtain additional information as relevant to completing and verifying my application for assistance. This includes permission to the State of Iowa to release application information to my energy supplier and to provide details about my account and energy use to the LIHEAP and Weatherization Assistance Program.

I understand this statement.

_____ _____

APPLICANT SIGNATURE **DATE**