AIDS FOUNDATION OF CHICAGO

Emergency Financial Assistance Policy and Procedures

Subject: **AFC Emergency Financial Assistance Application**
Date: **July 1, 2019**

I. PURPOSE

To set minimum eligibility criteria and standardize the process for distribution of multiple funding streams consistent with the guidelines established by those funding streams, which include Emergency Food and Shelter Program (EFSP), Housing Opportunities for People With AIDS (HOPWA STRMU), and Ryan White Part A. It is at the discretion of AFC staff along with the **guidelines established by the funding streams** to determine which funding source will be used in providing financial assistance to the client.

II. POLICY

The AIDS Foundation of Chicago receives funding from a variety of sources to assist low income residents who reside in the following counties: Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, McHenry and Will.

The principal purpose of this assistance is to stabilize individuals and families in their current home, to decrease the amount of time spent in shelters, and to help individuals and families secure and maintain affordable housing.

Additionally, these funds are not intended to provide continuous or long-term assistance. These funds are defined as being a "needs-based" assistance program – not an entitlement. Assistance from these funding streams is considered short-term help that is intended to promote long-term housing stability. AFC Emergency Financial Assistance is **based on funding availability** and is subject to the rules of the funding source. Additional forms may be required based on funding stream chosen. Those forms may be requested in the determination process.

III. ELIGIBILITY

AFC Emergency Financial Assistance offers **two options** to stabilize individuals and families in their current home, or to assist in moving to more affordable housing:

One-Time Emergency Assistance Payment	OR	Ryan White 90-Day EFA Program
For clients who have experiencing a temporary financial crisis to cover past due rent/mortgage, past due utilities, or first and last month's rent		For clients who have experienced a significant loss of income to cover past due rent and utilities for three months.

The application process is the same for either of these options. All applicants must meet certain eligibility criteria to be considered for assistance under either option. All approvals are at the discretion of AFC staff.

Eligibility Criteria:

1. Households in imminent danger of eviction;
   AND/OR
2. Households in imminent danger of homelessness;
   AND/OR
3. Households in imminent danger of foreclosure (Note: the household cannot already be in the foreclosure process);
   AND/OR
4. Households that are currently homeless. (Note: the household must provide documentation indicating their ability to afford rent and utilities in the future without this assistance.)

All households applying for assistance must be able to document a **temporary financial crisis** beyond their control. A crisis includes:

- → Loss of employment
- → Medical Disability or emergency
- → Loss or delay of a public benefit
- → Natural Disaster
- → Substantial change in household composition
- → Victimization by criminal activity (including Domestic Violence)
- → Illegal action by a landlord
- → Displacement by government or private action
- → Client is moving from homelessness into permanent housing
- → Obtain or maintain subsidized housing
- → Client is moving into more affordable housing that promotes long term stability

In addition, households must be able to document **the ability to sustain stable housing after receiving assistance**. This includes:

- → Proof of income or housing subsidy
- → Current lease or mortgage

Other Eligibility Requirements:

- → Households applying for emergency financial assistance through **HOPWA** or **Ryan White Part A** must also provide documentation indicating an HIV+ diagnosis.
- → Households applying for the **Ryan White Part A 90-Day EFA Program** must also provide documentation to demonstrate a significant loss of income (e.g., loss of employment, loss of benefits documentation, or other loss of income)

IV. FUNDING SOURCES

Emergency Financial Assistance payments will be drawn from one of three funding sources and are contingent on funds availability:

1. **Emergency Food and Shelter Program (EFSP)**
2. **Housing Opportunities for People with AIDS (HOPWA/STRMU)**
3. **Ryan White Part A** (Payer of last resort)

Any emergency financial assistance payment made cannot exceed a particular funding source's cap amount. Actual payment amounts will always be determined by the documentation submitted on the applicant's lease, eviction notice, utility bill or mortgage statement as provided in the application. The table below provides eligibility details for each of these three funding sources:

ELIGIBILITY DETAIL	FUNDING SOURCE		
	Emergency Food & Shelter Program (EFSP)	**Housing Opportunities for People with AIDS (HOPWA/STRMU)**	**Ryan White Part A** ***(Payer of last resort)***
Clients Living with HIV Only?	No - all households meeting eligibility criteria can apply	Yes – per funder requirements, households must have a documented HIV+ diagnosis and meet all eligibility criteria	Yes – per funder requirements, households must have a documented HIV+ diagnosis and meet all eligibility criteria
Capped Assistance Amount:	One month's rent ($1200 max)	Up to $1000 per payment	Up to $1000 per payment
Allowable Timeframe:	Clients may be eligible to receive assistance through EFSP once in a 12-month period. Crisis must be different from most recent crisis for which they received assistance.	Clients may be eligible to receive assistance through HOPWA/STRMU once in a 12-month period (see grant year cycle below). Crisis must be different from most recent crisis for which they received assistance.	Clients may be eligible to receive assistance through Ryan White Part A once in a 12-month period. Under the 90-Day EFA Program, clients may receive three consecutive monthly payments in a 12-month period (see grant year cycle below). Crisis must be different from most recent crisis for which they received assistance.
Grant Year Cycle:	Varies/based on fund availability	January 1 – December 31	March 1 – February 28

Eligible costs and expenses vary by funding sources. The table below indicates which costs and expenses are eligible for payment assistance under each funding source:

What Costs/Expenses are Eligible?	FUNDING SOURCE		
	Emergency Food & Shelter Program (EFSP)	**Housing Opportunities for People with AIDS (HOPWA/STRMU)**	**Ryan White Part A** ***(Payer of last resort)***
Past Due Rent	✓ Yes	✓ Yes (except for HUD subsidized programs)	✓ Yes
Past Due Mortgage	✓ Yes	✓ Yes	✗ No
First/Last Month's Rent	✓ Yes	✗ No	✓ Yes
Security Deposits	✗ No	✗ No	✗ No
Move-In Fees	✗ No	✗ No	✗ No
Utilities	✗ No	✓ Yes	✓ Yes

Additional Notes:

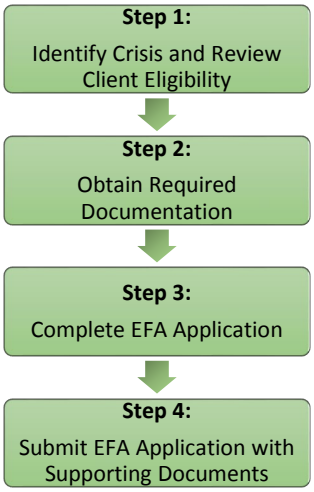
- Any payment made, regardless of how much it may be below the cap amount, will be counted as one payment.
- It is allowable for a client to obtain both a rent/mortgage assistance payment AND a utility assistance payment in the same month with one application IF the sum of both payments is still below the cap amount and they have submitted adequate supporting documentation.
- For one-time payment assistance: If a client requires assistance in an amount greater than a single source's cap in order to prevent homelessness, the use of two payments may be considered in the same application. The second payment MUST resolve the balance and MUST come from a different funding stream.

Determining Funding Source:

AFC staff will determine, based on the application provided by the Service Provider, which funding source will be used to assist the client. AFC will first determine if the client's application meets the requirements for EFSP in order to receive funds. If EFSP funds are determined to be an ineligible source or if EFSP funds have been exhausted for the given period, AFC staff will then review HOPWA/STRMU as an alternate funding option. If HOPWA/STRMU funds are determined to be an ineligible source or if HOPWA/STRMU funds have been exhausted for the given period, AFC staff will then review Ryan White Part A ***payer of last resort funding requirements in order to assist the client's application.***

V. PROCEDURE FOR OBTAINING ASSISTANCE

Clients must complete the **Step by Step** application process with their assigned Service Provider and submit to the AIDS Foundation of Chicago for review.



Step One: Prior to completing any application forms the Service Provider must review the client for eligibility. At this time, the Service Provider and client should agree upon which of the eligible temporary financial crisis they are striving to document. Use the attached guide **"Documenting the Crisis"** to help determine eligibility. If it appears that the client is experiencing one of the eligible temporary financial crisis and will be able to document it, they should move on to step two.

Step Two: The client must present the Service Provider with all of the documentation that supports the temporary financial crisis that is being experienced. The attached guide **"Documenting the Crisis"** will help the Service Provider inform the client what must be submitted.

Step Three: All application forms should be completed along with the Service Provider writing a narrative that describes the temporary financial crisis that is supported by the documentation.

Step Four: The completed application may be submitted to the AFC Housing staff for review. Submitting an application does not guarantee approval. Once an application is reviewed the Service Provider will be notified within 72 hours if it is approved, denied or incomplete with a confirmation letter. If the application is considered incomplete, the Service Provider and client must submit supplemental documentation to AFC Housing Staff within 14 business days to potentially move it forward for review.

VI. PROCEDURE FOR APPEALING A DENIAL

AFC's decisions for approval or denial are based on two factors:

1. The narrative provided in the application; and
2. The supporting documentation submitted.

Step One: If the client is unable to present supporting documentation of an eligible temporary financial crisis, or the narrative in the application does not sufficiently explain the financial crisis, the application will be denied, and AFC will provide an official denial letter.

Step Two: The denial letter from AFC will state all reasons for the application denial. The Service Provider should share the denial letter with the client and explain if necessary.

Step Three: If the client is dissatisfied with the Service Provider's explanation, they should be given the contact information of the Server Provider's supervisor. The supervisor should further explain how the denial decision was made based on the ineligibility of the application or the lack of supporting documentation**.**

Step Four: Clients who are dissatisfied with the process or results of their application for the AFC Housing and Utility Assistance Program will be provided the name and number of the AFC Director of Housing Stabilization, Alma Arroyo, and (312) 334-0966.

VII. RESPONSIBILITIES OF CLIENT, SERVICE PROVIDER, AND AFC

Responsibilities of Client/Applicant:

- All applicants for AFC Housing and Utility Assistance must be enrolled in the central client registry at AFC.
- Applicants must provide adequate documentation that they are experiencing a temporary financial crisis beyond their control.
- Applicants are not to engage in physically and/or verbally threatening behavior toward their Service Provider or AFC staff at any time. Physical or verbal threats will be cause for application denial.
- Discriminatory remarks and harassment in regard to, but not limited to, matters of race, color, national origin, creed, gender, sexual orientation or religion **will be considered verbal threats** and will be cause for application denial.

Responsibilities of Service Provider:

- The Service Provider will work with the client to submit all required forms and supporting documentation.
- The Service Provider will complete all pending incomplete applications within 14 business days of receiving the letter confirming an incomplete application from AFC Housing Staff.
- The Service Provider will offer comprehensive services regardless of race, color, creed, sex, ethnicity, national origin, marital status, sexual orientation, citizenship status, spoken language, physical/mental disability, age, economic status or religion.

Responsibilities of AFC:

- No payments will be made directly to the client; all payments will be made directly to a third party/vendor (property Management Company, utility company, building owner or mortgagor.
- AFC will make decisions on each application on a case-by-case basis, based on funding availability and prioritization of client needs.
- AFC will inform Service Provider of approval status, and for which assistance program the application was approved.
- AFC will inform the Service Provider where the payment will be made from along with the date the check will be issued. The issue date is determined by the AFC Finance Department.
- AFC will provide services regardless of race, color, creed, sex, ethnicity, national origin, marital status, sexual orientation, citizenship status, spoken language, physical/mental disability, age, economic status or religion

AIDS FOUNDATION OF CHICAGO

Emergency Financial Assistance Application

Service Provider: This document is designed to assist you in submitting a complete application with all necessary documentation. This sheet should be attached to the front of the completed EFA application and all supporting documents.

APPLICANT INFORMATION:

Complete the applicant information below. Including the AFC Client ID or Ryan White ID is not required, but will help expedite the application process and coordination of services.

First Name:	Last Name:	AFC Client ID:	Ryan White ID:

Birthdate:	Social Security Number:
__ __ / __ __ / __ __ __ __	__ __ __ - __ __ - __ __ __ __ ☐ Don't know/Don't Have

APPLYING FOR *(check only one)*:

☐	**One-Time Emergency Assistance Payment** For clients who have experiencing a temporary financial crisis to cover past due rent/mortgage, past due utilities, or first and last month's rent	**OR**	☐	**Ryan White 90-Day EFA Program** For clients who have experienced a significant loss of income to cover past due rent and utilities for three months.

DOCUMENTATION CHECKLIST

All relevant supporting documents must be included with the Emergency Financial Assistance application to be considered for approval. In the list below, please place a check mark in the box next to each item included with your application.

APPLICATION

☐ **Emergency Financial Assistance Application : Documentation Checklist (pg. 1)**

Client Demographics Form (pg. 2-3)
Client Household Info/Consent to Enroll in Client Database Form (pg. 4)
Client Budget Form (pg. 5)
Narrative and Temporary Financial Crisis (pg. 6)
AFC Client Rights/Responsibilities and Grievance Form (pg. 7)
AFC Consent to Release Information (pg. 8)

SUPPORTING DOCUMENTS

☐ **Temporary Financial Crisis <u>Supporting Documentation</u>** *(e.g. letter from unemployment, police report, letter of homelessness, proof of subsidy etc.)*

☐ **Current Lease or Current Rental Agreement Form or Mortgage Payment Statement** *(The rental agreement form included in this packet may be used in place of a formal lease agreement)*

☐ **Notice of Eviction <u>OR</u> Landlord Statement Form** *(The Landlord Statement form included in this packet may be used in place of a formal notice of eviction)*

☐ **Copies of Past Due Utility Bills/Shut-off Notices** *(Bills cannot exceed 30 days from issue date)*

☐ **Documentation of Household's Current Income** *(e.g., full month of paycheck stubs, current benefits statement, current unemployment assistance statement)*

☐ **Copy of the Client's State/Govt Issued ID**

☐ ***P*roof of HIV Status** *(If labs indicate an undectable viral load, additional proof may be requested)*

☐ **Proof of Ownership from Landlord** *(Only for Private Market Lanlords: e.g. property tax statement)*

☐ **Federal W9 and EIN Verification Letter** *(Please use attached Landlord Letter for guidance)*

RELEASES AND AUTHORIZATIONS

☐ **Signed Chicago Department of Public Health HOPWA Authorization to Use and Disclose Confidential Information**

☐ **Signed Illinois Department of Public Health Ryan White Part B Authorization for Release of Health Information**

SIGNATURE

Print Service Provider Name	Service Provider Signature	Service Provider Agency	Date

AIDS FOUNDATION OF CHICAGO

Emergency Financial Assistance Application

Application Date:	__ __/__ __/__ __	Application Completed by:	
Client First Name:		Client Last Name:	

1. Birthdate: __ __/__ __/__ __ __ __

2. Social Security Number: __ __ __- __ __-__ __ __ __ ☐ Don't know/Don't Have

CLIENT INFORMATION

3. Mailing Address:

4. Address Line 2:

5. City:

6. State:

7. Zip Code:

8. Okay to send mail? ☐ Yes ☐ No

9. Best Contact Number: (__ __ __) __ __ __- __ __ __ __ ext. _____

10. Contact Type: ☐ Home ☐ Work ☐ Mobile

11. Message Type: ☐ Any ☐ Discreet ☐ None

12. Alternate Contact Number: (__ __ __) __ __ __- __ __ __ __ ext. _____

13. Contact Type: ☐ Home ☐ Work ☐ Mobile

14. Message Type: ☐ Any ☐ Discreet ☐ None

15. Gender: Do you consider yourself to be:
- ☐ Male
- ☐ Female
- ☐ Genderqueer
- ☐ Non-binary/nonconforming/third gender
- ☐ Prefer to self-describe:_____
- ☐ Prefer not to say

16. Do you identify as transgender?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

17. Sexuality: Do you consider yourself to be:
- ☐ Straight/Heterosexual
- ☐ Gay or Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Asexual
- ☐ Prefer to self-describe _____
- ☐ Prefer not to say

18. Race (Check all that apply):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Don't know
- ☐ Refused

19. Ethnicity:
- ☐ Hispanic/Latinx/a/o
- ☐ Non-Hispanic/Latinx/a/o
- ☐ Don't know
- ☐ Refused

20. Are you a veteran?
- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

21. Are you pregnant?
- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

22. Country of Origin:

23. Primary or Preferred Language:

24. Do you need translation services? ☐ Yes ☐ No

25. Emergency Contact Name(s):	Relationship to Client:	Home phone number:	*IF LIVING WITH HIV*: Aware of client's diagnosis?
		(__ __ __) __ __ __- __ __ __ __	☐ Yes ☐ No
		(__ __ __) __ __ __- __ __ __ __	☐ Yes ☐ No
		(__ __ __) __ __ __- __ __ __ __	☐ Yes ☐ No

26. Have you ever experienced domestic violence?
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

If Yes:

27. When did the experience occur?
- ☐ Currently experiencing
- ☐ Within the past 3 months
- ☐ Three to six months ago
- ☐ Six months to one year ago
- ☐ Over one year ago
- ☐ Don't know
- ☐ Refused

28. Are you CURRENTLY fleeing a domestic violence situation?
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

AIDS FOUNDATION OF CHICAGO

Emergency Financial Assistance Application

UNIVERSAL DATA ASSESSMENT

1. Have you experienced homelessness before?

☐ Yes ☐ No

2. Current Residence: What is your current living situation?

Homeless Situations
- ☐ Place not meant for habitation
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Safe Haven
- ☐ Interim Housing

Institutional Situations
- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, prison or juvenile detention facility
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center

Transitional & Permanent Housing Situations
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with VASH subsidy
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Transitional housing for homeless persons (incl. homeless youth)

Other
- ☐ Don't know
- ☐ Refused

3. Current Residence: For how long have you stayed there?

☐ One night or less ☐ One week or less ☐ One month or more, but less than 90 days ☐ One year or longer
☐ Two to six nights ☐ More than one week, but less than one month ☐ 90 days or more, but less than one year ☐ Don't know
☐ Refused

4. What is the number of times you have been on the streets, in Emergency Shelter, or Safe Haven in the past three years, including today?

☐ One time ☐ Three times ☐ Don't know
☐ Two times ☐ Four or more times ☐ Refused

5. Total number of months homeless (on the street, in ES or SH) in the past three years:

_____ months ☐ Don't know ☐ Refused

HEALTH INSURANCE/PRIMARY CARE PROVIDER

1. Insurance Type:

☐ Medicare ☐ Indian Health Insurance ☐ Military Insurance ☐ Other Public
☐ Medicaid ☐ State Children's Health Insurance Program (S-CHIP) ☐ Private – Employer ☐ Other
☐ State-Funded ☐ Combined Children's Health Insurance/Medicaid Program ☐ Private – Individual ☐ No Insurance

2. Insurance Provider/Managed Care Organization (MCO) Name:

3. Policy Number:

4. Is this primary? ☐ Yes ☐ No

5. Are medications covered? ☐ Yes ☐ No

6. Policy Status: ☐ Active ☐ Pending/Applied

7. Date applied for: __ __/ __ __/ __ __ __ __

8. Policy Start Date: __ __/ __ __/ __ __ __ __

1. Do you have a Primary Care Physician (PCP)? ☐ Yes ☐ No

If No: **2.** Why do you not have a PCP?

If Yes: **3.** What is your PCP's name?

4. With what institution is your PCP affiliated?

CLIENT HEALTH

1. Have you been diagnosed as HIV positive? ☐ Yes ☐ No

If Yes: **2.** Date of HIV Diagnosis: __ __/ __ __/ __ __ __ __

3. Have you been diagnosed as positive for AIDS? ☐ Yes ☐ No

If Yes: **4.** Date of AIDS Diagnosis: __ __/ __ __/ __ __ __ __

5. Do you have a Ryan White Case Manager? ☐ Yes ☐ No

If Yes: **6.** Have you seen your case manager in the last 6 months? ☐ Yes ☐ No

AIDS FOUNDATION OF CHICAGO

Emergency Financial Assistance Application

HOUSEHOLD INFO.

Name, DOB, SSN:	Relation to Head of Household:	Gender:	Race and Ethnicity:
First Name: Last Name: Birthdate: __ __ / __ __ / __ __ __ __ ☐ Full DOB ☐ Approx./Partial DOB Social Security Number: __ __ __ - __ __ - __ __ __ __ ☐ Full SSN ☐ Approx./Partial SSN	☐ Child ☐ Partner or Spouse ☐ Other Family ☐ Other Non-Family	☐ Male ☐ Female ☐ Genderqueer ☐ Non-binary/third gender ☐ Prefer to self-describe: ______ ☐ Prefer not to say Identify as Transgender? ☐ Yes ☐ No ☐ Prefer not to say	Race (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Doesn't Know ☐ Refused Ethnicity: ☐ Hispanic/Latinx/o/a ☐ Non-Hispanic/Latinx/o/a
First Name: Last Name: Birthdate: __ __ / __ __ / __ __ __ __ ☐ Full DOB ☐ Approx./Partial DOB Social Security Number: __ __ __ - __ __ - __ __ __ __ ☐ Full SSN ☐ Approx./Partial SSN	☐ Child ☐ Partner or Spouse ☐ Other Family ☐ Other Non-Family	☐ Male ☐ Female ☐ Genderqueer ☐ Non-binary/third gender ☐ Prefer to self-describe: ______ ☐ Prefer not to say Identify as Transgender? ☐ Yes ☐ No ☐ Prefer not to say	Race (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Doesn't Know ☐ Refused Ethnicity: ☐ Hispanic/Latinx/o/a ☐ Non-Hispanic/Latinx/o/a
First Name: Last Name: Birthdate: __ __ / __ __ / __ __ __ __ ☐ Full DOB ☐ Approx./Partial DOB Social Security Number: __ __ __ - __ __ - __ __ __ __ ☐ Full SSN ☐ Approx./Partial SSN	☐ Child ☐ Partner or Spouse ☐ Other Family ☐ Other Non-Family	☐ Male ☐ Female ☐ Genderqueer ☐ Non-binary/third gender ☐ Prefer to self-describe: ______ ☐ Prefer not to say Identify as Transgender? ☐ Yes ☐ No ☐ Prefer not to say	Race (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Doesn't Know ☐ Refused Ethnicity: ☐ Hispanic/Latinx/o/a ☐ Non-Hispanic/Latinx/o/a

CLIENT SIGNATURE, CONSENT TO ENROLL IN CENTRAL DATABASE, AND APPLICATION COORDINATION

☐ ______ I certify that the information I have provided in this application is accurate to the best of my knowledge.

☐ ______ I consent to enroll in the centralized client database established by the AIDS Foundation of Chicago (the "Database") to assist and monitor the enrollment of persons receiving financial assistance through the AFC Housing and Utility Assistance application.

In connection with my enrollment in the Database, I hereby allow the following information to be furnished to the AIDS Foundation of Chicago for entry into the Database: my name (where applicable), date of birth, any positive or negative HIV status and other demographic data. In addition, depending on funding source, services or financial assistance received may be reported. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, avoiding duplication of services and coordinating a system for service delivery to persons with or at risk of HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

☐ ______ I give consent to my Provider to contact my landlord for the purpose of completing AFC Housing and Utility Assistance Application, following the same confidentiality requirements identified in this application. I can terminate this consent by submitting a written request to my housing navigation agency.

______________________	______________________	______________________
Client Signature	Print Client Name	Date
______________________	______________________	______________________
Service Provider Signature	Print Service Provider Name	Date

AIDS FOUNDATION OF CHICAGO

Emergency Financial Assistance Application

CLIENT INCOME

1. Do you receive cash income?	
☐ Yes *(complete table 3 below)*	☐ No

2. Do you receive non-cash benefits?	
☐ Yes *(complete table 4 below)*	☐ No

3. CASH INCOME

Please list all sources of client income, including monthly amounts, in the table below:

Income Source	Monthly Amount
Earned Income (Employment)	$
Unemployment Insurance	$
Supplemental Security Income	$
Social Security Disability Income	$
Veteran's Disability Payment	$
Private Disability Insurance	$
Worker's Compensation	$
TANF	$
General Assistance	$
Retirement (Social Security)	$
Veteran's Pension	$
Other Pension	$
Child Support	$
Alimony/spousal support	$
Family Support	$
AABD	$
Targeted Work Initiative	$
Other Household Income	$
Other Income	$
TOTAL:	**$**

4. Non-Cash Benefits

Please list all sources of non-cash benefits, including monthly amounts, in the table below:

Income Source	Monthly Amount
Food Stamps/SNAP	$
WIC (Supplemental Nutrition Program for Women, Infants, and Children)	$
Veteran's Administration Medical Services	$
TANF Child Care Services	$
TANF Transportation Services	$
Other TANF-Funded Services	$
Other Source	$
TOTAL:	**$**

CLIENT EXPENSES

1. Have you had any expenses in the past 30 days?	
☐ Yes (complete table 2 below)	☐ No

2. Monthly Expenses

Please list all expenses, including monthly amounts, in the table below:

Expense	Comments/Description	Monthly Amount
Car Payment		$
Electric		$
Rent/Mortgage		$
Car Insurance		$
Gas		$
Transportation		$
Water		$
Food & Personal		$
Sewer		$
Cleaning/Laundry		$
Phone		$
Legal Actions (Court)		$
Day Care		$
Medical/Insurance		$
Miscellaneous		$
	TOTAL:	$

TEMPORARY FINANCIAL CRISIS AND PREVENTION SERVICES

1. Narrative *(To be completed by Service Provider)*: Please provide a brief narrative detailing the situation that caused the client's temporary crisis. Describe the impact the assistance will have moving forward:

2. Emergency/Crisis Situation: *(Check only one)*

☐ **Loss of Employment** (Termination letter from employer; unemployment application/ documentation that shows final date of employment)

☐ **Medical disability or emergency** (Bill from hospital or care provider; signed note from care provider)

☐ **Loss or delay of a public benefit** (PA, VA, or SS Letters)

☐ **Natural Disaster** (Fire or flood report or other similar documentation)

☐ **Substantial change in household composition** (Proof of death of household member or other similar documentation)

☐ **Victimization by criminal activity** (with police report)

☐ **Domestic violence situation** (with police report)

☐ **Illegal action by a landlord**

☐ **Displacement by government or private action** (Signed letter from landlord or other authority informing individual/household of need to move)

☐ **Client is moving from homelessness into permanent housing**

☐ **Obtain or maintain subsidized housing**

☐ **Client is moving into more affordable housing that promotes long-term stability**

3. Reason for Assistance: *(Check only one)*

☐ To maintain current residence ☐ To move from current residence to other permanent housing ☐ To move from homelessness to permanent housing

4. Assistance Requested: Enter the requested assistant amount(s) into the appropriate boxes below:

First and Last Month's Rent:	$ _____
Past Due Rent:	$ _____
Past Due Mortgage:	$ _____
Past Due Utility:	$ _____

Responsibilities of Client/Applicant:

- All applicants for AFC Housing and Utility Assistance must be enrolled in the central client registry at AFC.
- Applicants must provide adequate documentation that they are experiencing a temporary financial crisis beyond their control.
- Applicants are not to engage in physically and/or verbally threatening behavior toward their Service Provider or AFC staff at any time. Physical or verbal threats will be cause for application denial. Discriminatory remarks and harassment in regards to but not limited to matters of race, color, national origin, creed, gender, sexual orientation or religion **will be considered verbal threats** and will be cause for application denial.

The following **Step by Step** application process with my assigned Service Provider has been explained to me:

Step One: Prior to completing any application forms the Service Provider must review the client for eligibility. At this time, the Service Provider and client should agree upon which of the eligible temporary financial crisis they are striving to document. Use the attached guide **"Documenting the Crisis"** to help determine eligibility. If it appears that the client is experiencing one of the eligible temporary financial crisis and will be able to document it, they should move on to step two.

Step Two: The client must present the Service Provider with all of the documentation that supports the temporary financial crisis that is being experienced. The attached guide **"Documenting the Crisis"** will help the Service Provider inform the client what must be submitted.

Step Three: All of the application forms should be completed along with the Service Provider writing a narrative that describes the temporary financial crisis that is supported by the documentation.

Step Four: The completed application may be submitted to the AFC Housing staff for review. Submitting an application is not a guarantee of approval. Once an application is reviewed the Service Provider will be notified within 48 hours if it is approved, denied or incomplete with a confirmation letter. If the application is considered incomplete the Service Provider along with the client will have 14 business days to submit supplemental documentation to AFC Housing Staff to potentially move it forward for review.

Process for Grievance/Appeal of Decision

AFC's decisions for approval or denial are based on two factors:

1. The narrative provided in the application; and
2. The supporting documentation submitted.

Step One: If the client is unable to present supporting documentation of an eligible temporary financial crisis, or the narrative in the application does not sufficiently explain the financial crisis, the application will be denied, and AFC will provide an official denial letter.

Step Two: The denial letter from AFC will state all reasons for the application denial. The Service Provider should share the denial letter with the client and explain if necessary.

Step Three: If the client is dissatisfied with the Service Provider's explanation, they should be given the contact information of the Server Provider's supervisor. The supervisor should further explain how the denial decision was made based on the ineligibility of the application or the lack of supporting documentation**.**

Step Four: Clients who are dissatisfied with the process or results of their application for the AFC Housing and Utility Assistance Program will be provided the name and number of the AFC Director of Housing Stabilization, Alma Arroyo, and (312) 334-0966.

I understand my rights and responsibilities and the grievance procedure. I also understand that this policy is specifically related to the AFC Housing and Utility Assistance application and it is not intended the replace the Grievance Procedure at my Case Management agency.

Client Signature	Print Client Name	Date
Service Provider Signature	Print Service Provider Name	Date

Client: Please keep a copy of this form for your records.

Subject to the limitations and conditions set forth below, I, _____ hereby consent to _____("Service Provider"), acting through its employees or agents, to use and/or disclose my health information and medical records to the AIDS Foundation of Chicago (AFC), and/or any subcontracted agencies that provide services through them, as follows: (i) in connection with my participation in the centralized client database established by AFC (the "Client Track Database") and the operation of the client database; (ii) to allow sharing of my case management agency with my housing navigator. (iii) To allow sharing of my housing services/assistance with my case management agency. (iv) to enable AFC and the Ryan White Case Management Cooperative to conduct quality assurance programs for individuals receiving services through the Cooperative; (iiv) to avoid duplication of services by agencies; and (vi) in connection with the submission of reports and other data to funding sources.

In connection with my enrollment in the Database, I hereby give my consent for the following information to be furnished to AFC for entry into the Database: my name, date of birth, and other demographic data. In addition, verification of HIV positive status, viral load/CD4 counts, and dates of HIV medical services and case management services will be released to the AIDS Foundation. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, for development and monitoring of a housing and healthcare cascade, avoiding duplication of services and coordinating a system for service delivery to persons with HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

I further allow the program staff of AFC and its designated Oversight Committee and Ryan White Cooperative to review my individual service records as part of the funder's quality assurance program. For the purposes of this consent, I acknowledge and agree that my service records include any and all records generated by any of the Provider agencies that participate in the Ryan White Northeastern Illinois Cooperative, AFC Supportive Housing Programs or Financial Assistance Programs.

I further understand that any information I provide for the purposes of receiving services will be disclosed to the Illinois and/or Chicago Department of Public Health department for purposes of surveillance, or any purpose for continuity of obtaining health care, housing, financial assistance or social services, (1) with my consent, (2) as required by law, or (3) if necessary, to prevent a serious attempt to inflict harm on myself or others. Security precautions will be maintained to prevent unauthorized access to the Database by anyone other than the program staff of AFC.

I give further consent to allow AFC to report information that I provide in connection with my enrollment in the Database and in connection with my receipt of services to the federal grant programs that support AFC. I understand that such information may be provided either in the aggregate or on an individualized basis.

I further understand that should I receive service funded under Part A and B of the Ryan White CARE Act or IDPH HOPWA, certain information will be reported to the Direct Services Unit of the Illinois Department of Public Health and the Chicago Department of Public Health, including: Demographic information, including but not limited to name, gender, race, ethnicity, and birth date; service utilization information; HIV/AIDS diagnosis and treatment information, if any; and mental health and/or substance use diagnosis, treatment, and service information, if any.

I understand that this information will be shared for the purposes of evaluating Part A and B and HOPWA service utilization patterns, on-site service reviews, and when necessary to coordinate services.

I can terminate this consent by submitting a written request to my housing navigation agency indicating that I no longer desire to receive services through the Cooperative or AFC's housing programs, or my written revocation of this authorization, whichever occurs first.

I understand that I have the right to receive a copy of this consent. I further understand that I may revoke this consent at any time by providing written notice of my intent to revoke this consent to Provider. This consent cannot be revoked to the extent that action has already been taken based on this consent.

This consent is valid for a period of two years from the date of the actual client signature below.

Provider will not use or disclose personal health information beyond the scope of this authorization without your written consent or authorization. Please note that, subject to applicable law, disclosed information may be subject to re-disclosure by the recipient, and may no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

_____	_____	_____
Signature of Client or Client's Legal Representative	Print Name	Date

_____

Relationship (if signed by person other than client)

Chicago Department of Public Health
STI/HIV Division -- HIV Housing Programs
Housing Opportunities for Persons with AIDS (HOPWA) Program

Authorization to Use & Disclose Confidential Information

Client Name: _____

I, _____ (*Name*), hereby authorize

_____ (Provider) to disclose to AIDS Foundation of Chicago (*Delegate Agency*), to disclose my full name and date of birth (or, if I am signing below as a Personal Representative, the full name and date of birth of the above-named Client, whose Personal Representative I am) to the Chicago Department of Public Health (CDPH), for the following purposes:

- To enable the CDPH to collect names of individuals receiving HIV Housing services through the HOPWA program; and
- To enable CDPH to match names with CDPH HIV surveillance data in order to assess if HOPWA clients are linked to care, retained in care, and in Anti-Retroviral Therapy (ART) treatment in connection with the submission of reports and other data to funding sources.

This authorization is valid for one year from the date signed and witnessed.

I understand that: I may revoke this authorization at any time by providing written notice to the above-named Delegate Agency. Such revocation shall have no effect on uses or disclosures made prior to the revocation. The Delegate Agency may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations.

_____ _____
Client Signature / Date Witness Signature / Date

_____ _____
Print Client Name Print Witness Name

_____ _____
Personal Representative's Signature / Date Witness Signature / Date

_____
Personal Representative's relationship to Client
(i.e., authority to act on client's behalf)

_____
Print Personal Representative's Name

ILLINOIS Department of Public Health

Authorization for Release of Health Information

Ryan White Part B Program

First Name	Middle Initial	Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)
	/ /

Please read all statements and sign in the space provided to certify that you have read and understand this authorization. All references to "Program" or "Programs" refers to the Illinois Department of Public Health, Ryan White Part B Program and/or successor programs in which you participate or to which you apply for services.

1. I certify that the information in this application is true and accurate to the best of my knowledge. I understand that I may be disqualified from this program(s) and/or prosecuted for willfully providing false information.
2. I understand that the information requested on this application is for the purpose of determining my eligibility for a state and federally funded program. The funding is limited and may expire at any time without extended or alternate funds being available.
3. If I am considered eligible for services, my information will be utilized with our contractual partners for the reasons explained in this document. Eligibility approval does not mean I will receive or be enrolled in all services. I understand each service may require additional information, and that I must provide this information for verification before enrollment into said services.
4. Upon approval, my eligibility will expire after six months. Upon the conclusion of my six months, I will be required to reapply and provide updated eligibility information to continue accessing services. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my Recertification Application every (6 months) as per Federal Guidelines.
5. I agree to notify, or to have my Medical Case Manager notify the program(s) of any circumstances affecting my participation in, or eligibility for, the program(s). I agree to notify the program(s) within thirty (30) days of a change in address and understand that all program correspondence will be sent to the address I have on file with the program(s). I understand changes in my situation will be periodically evaluated to determine continued eligibility for the program(s).
6. I authorize the program to release my enrollment, eligibility and service utilization records and other information necessary to facilitate the provision of program services to my physicians, other providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, or entities that are under contract with the program with the understanding that my status will never be disclosed to entities not affiliated with the Ryan White Part B Program in the bullet point list below.
7. If I experience discrimination because of the release or disclosure of medical related information, I may contact the Illinois Department of Human Rights at (217) 785-5100 or (312) 814-6200. This agency is responsible for enforcing the Illinois Human Rights Act which provides certain protections for persons with disabilities.
8. If I request enrollment into Medical Case Management or request any service that requires coordination with a Medical Case Manager, my information will be shared with the Medical Case Management provider that the Care Connect Regional Lead Agent who is administering this program in my area assigns to me.
9. I acknowledge that my health insurance premiums (if applicable) are being paid by the program via a contractual third party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the IDPH for any unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.
10. I agree to indemnify and hold the Illinois Department of Public Health (IDPH) harmless from any and all claims for making premium reimbursement payments directly to the IDPH or any entity under contract with the IDPH in connection with Program Services. I agree to indemnify and hold the IDPH, or any entity under contract with the IDPH in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from IDPH or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program(s).
11. I agree to reimburse IDPH for any and all premium reimbursement payments that are paid to me in error during my enrollment.
12. I understand that my records are protected under the Health Insurance Portability and Accountability Act, Pub.L 104-491, 110 Stat. 1936, enacted August 21, 1996, and Illinois Statute 410 ILCS 305 relating to confidentiality of medical information, and cannot be disclosed to any other entity except those referenced herein without my written consent. I do not have to consent to the release of this information. However, if I refuse to sign this authorization, I will be ineligible to receive services through this program.
13. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of **24 months** from the date this form is signed, or until such time as I inform the administrator of the Program(s), in writing, of my wish to terminate services in the Program(s). I also understand that I will still be required to sign a new authorization form every 6 months to continue Ryan White Services. I also understand that each time I sign a new reauthorize on a 6 month basis for renewal purposes that any and all previous authorization(s)

PLEASE RETURN THIS PAGE

REQUIRED PAGE

become null and void.

a. This authorization refers to authorizing the release for a validity period spanning 24 month period from the date this form is signed for those instances when I may step away from care after a 6 month certification, which this authorization will provide permission for reengagement activities to take place by designee(s) of the Department not to exceed the 24 months from the date of signature.

The agencies listed below are utilized to coordinate and verify eligibility for all services, and for treatment and care coordination with other program(s) within IDPH, following the same confidentiality requirements identified above in statements 1-13:

- System Software Vendor *
- Premium Assistance Payment Vendor*
- Pharmacy Benefits Manager Vendor*
- Quality Assurance & Compliance Vendor*
- Centers for Medicare & Medicaid Services
- IL Department of Insurance
- DIS Outreach Specialists employed by IDPH and/or local Health Departments
- Chicago Department of Public Health
- IL Department of Employment Security (Income Verification Services)
- IL Department of Health and Family Services (Medicaid Verification Services)
- IL Department of Public Health programs per Illinois Statute 410 ILCS 305
- IL Department of Public Health's Office of Health Protection Sections/Programs
- All Ryan White funded Providers

* Specific vendor information can be requested at: https://www.wh1.ioc.state.il.us

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact listed below, and understand that I will be required to list this contact on each submission of this form.

_____

Alternate Contact Person Name **(You do not have to list your Case Manager)**

_____

Street Address

_____

City State Zip Code

(_____) _____ - _____ Is this person aware of your + status? ☐ Yes ☐ No

Telephone

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact listed below, and understand that I will be required to list this contact on each submission of this form.

_____

Alternate Contact Person Name **(You do not have to list your Case Manager)**

_____

Street Address

_____

City State Zip Code

(_____) _____ - _____ Is this person aware of your + status? ☐ Yes ☐ No

Telephone

_____ / /

Client Signature (age 12 and older) **Date**

_____ / /

Parent/Guardian (if under 12) or Legal Representative **Date**

PLEASE RETURN THIS PAGE

REQUIRED PAGE

EMERGENCY FINANCIAL ASSISTANCE
Rental Agreement Form

Date:	__ __/ __ __/ __ __ __ __

RENTAL AGREEMENT:

Agreement between _____, Owner(s),
Print Owner(s) Name(s)

and _____, Tenant(s)
Print Tenant(s) Name(s)

for a dwelling located at:

Address:	Address Line 2:

City:	State:	Zip Code:

Tenant(s) agree to rent this dwelling on a month-to-month basis for $_____ per month,
Monthly rent amount

Payable in advance on the _____ day of the calendar month,
Monthly due date

Beginning on __ __/ __ __/ __ __ __ __.
Start date of rental agreement

ADDITIONAL EXPENSES/FEES:

The first month's rent for this dwelling is: $_____

Tenant is responsible for making direct payments to utility companies for the following utilities:		
Electric:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent
Heating:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent
Cooking:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent
Water:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent
Garbage Removal:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent

SIGNATURES:

_____
Print Tenant Name

_____
Print Landlord Name

_____
Tenant Signature

_____
Landlord Signature

_____
Date

_____
Date

EMERGENCY FINANCIAL ASSISTANCE
Landlord Statement Form

Date:	__ __/ __ __/ __ __ __ __

TENANT INFORMATION:

Tenant's First Name:	Tenant's Last Name:

Tenant's Address:	Address Line 2:

City:	State:	Zip Code:

Total Amount Due:	$

LANDLORD INFORMATION:

Owner's Name or Management Company Name:	

Mailing Address:	Mailing Address Line 2:

City:	State:	Zip Code:

Contact Person (Owner or legal representative of property):	

Contact Number:	(__ __ __) __ __ __ - __ __ __ __ ext. _____

LANDLORD SIGNATURE:

By signing below, I certify that I am the owner, or legal representative of the owner, of the property listed under "Tenant's Address" above, and that the information provided is true and accurate to the best of my knowledge.

_____ _____

Landlord Signature Print Landlord Name

AFC OFFICE USE ONLY:

SERVICE MONTH(S) APPROVED:

AMOUNT APPROVED: $

FOR:
☐ *PAST DUE RENT*
☐ *1ST & LAST MONTHS RENT*

NOTES:

AFC STAFF APPROVAL (INITIALS):

AFC HOUSING PROGRAM: EMERGENCY FINANCIAL ASSISTANCE

Dear Landlord or Property Manager,

You are receiving this letter because a **current or potential tenant** has requested assistance from the AFC Housing Program which provides Emergency Financial Assistance. The purpose of the AFC Housing Program: Emergency Financial Assistance is to stabilize individuals and families in their current home, to decrease the amount of time spent in shelters, and to help individuals and families secure and maintain affordable housing.

In order to be in compliance with our state/federal funders and The Internal Revenue Service (IRS), we are required to collect the following documentation:

For Private Market Landlord:

If the landlord is a private market landlord, the Tax ID number will be a Social Security number or an Individual Tax Identification Number (ITIN). A Copy of your social security card or ITIN card/letter must be attached for verification.

If the landlord is a private market landlord, proof of property ownership must be submitted. A current copy of the property tax bill or copy of the property deed must be attached for verification.

For Property Management Company or Business:

If the landlord is a property management company, the Tax ID number will be the Employer Identification Number (EIN) for the business. A Copy of the EIN Verification letter or state business verification print out must be attached for verification.

Unable to locate?

If you are unable to locate your federal Tax ID forms, you can visit www.irs.gov or www.mytaxillinois.gov

If you are unable to locate property proof of ownership, you can visit www.cookcountytreasurer.com or www.cookrecorder.com

This information is gathered exclusively for the purpose of making payments to landlords so that the tenant can remain stably housed. Your information will never be used for any other purpose and your privacy will be respected at all times.

If you would like to fax these documents directly to AFC Housing Programs, please fax to: (312)-334-0977
ATTN: AFC Housing Program/EFA
Or mail to:
AFC Housing Program/EFA
PO BOX 1022
Chicago, IL 60690

For any additional questions or concerns that you may have please reach out to the Director of Housing Stabilization, Alma Arroyo at (312)-334-0966.

Thank you very much for your cooperation and for your commitment to providing safe and affordable housing for your tenants!

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ►

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►