Subject: **AFC Emergency Financial Assistance Program**
Date: **June 1, 2020**

How to use the RW EFA Application Packet

The following application is intended for use by case managers in order to secure rental and utility assistance for clients. It is our goal to maintain client confidentiality throughout the application process, and thus, here are some basic rules to follow when completing this application.

- The completed application includes personal health information (PHI) and must be treated confidentially, if it is emailed it must be emailed securely.

- Case managers are to complete the application on behalf of the client and only send clients pages that require a client signature.

- At no time should the entire application be sent to a third party unless requested by the client. If the entire application is requested by a client, the case manager should request and document a verbal consent to email any document that may have client information or organizational information.

    - *If the entire application is requested by a client, be sure to send it securely via encrypted email or fax, or mail with a plain envelope without agency affiliation*

- Any forms to be completed by the client's Landlord should be sent directly to the Landlord or client to send to their Landlord. New confidential forms have been created that do not any reference HIV or AIDS, these forms should be used.
    - *Please note that these forms do not have any language including the agencies name to protect the privacy of the clients*
    - *All email correspondence regarding Landlord forms should be sent via an email address that does not disclose the client's health status. For example aidschicago.org*

- If you have any questions, please contact us for further guidance

EFA POLICY & PROCEDURE

Subject: **AFC Emergency Financial Assistance Program**
Date: **June 1, 2020**

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

AFC 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 permanent housing:

One-Time EFA Payment	OR	90-Day EFA Program
For clients who have experienced 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 or foreclosure (Please Note: Should not currently be in advanced stages of foreclosure or eviction)
   AND/OR
2. Households in imminent danger of homelessness
   AND/OR
3. Households that are currently homeless.

All households applying for assistance must be able to document a **temporary financial crisis** beyond their control. An eligible 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 maintain 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 **90-Day EFA Program** must also provide documentation to demonstrate a significant loss of income (e.g., loss of employment, loss of benefits, 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 funding 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 funding source's cap amount. Actual payment amounts will always be determined by the supporting documentation submitted (i.e. Lease, eviction notice, utility bill or mortgage statement). 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 ($1000 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. 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. Crisis must be different from most recent crisis for which they received assistance. **RWA is Payer of Last Resort**
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	✓ Yes	✓ Yes	✓ Yes

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.***

NO PAYMENTS CAN BE MADE DIRECTLY TO THE CLIENT/APPLICAT

V. PROCEDURE FOR OBTAINING ASSISTANCE

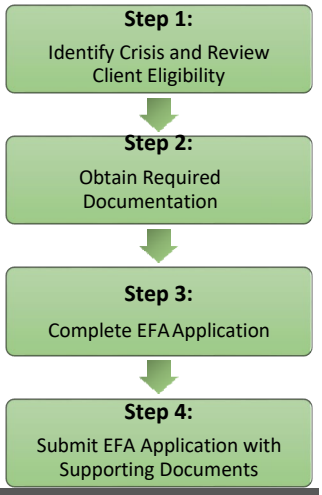
Clients must complete the **Step by Step** application process with their assigned Service Provider and submit to AFC for review.

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 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. Applying 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 Service 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 Emergency Financial Assistance Program may contact the AFC Director of Housing Stabilization, Alma Arroyo, (312) 334-0966.

VII. RESPONSIBILITIES OF CLIENT, SERVICE PROVIDER, AND AFC

Responsibilities of Client/Applicant:

→ All applicants of the AFC Emergency Financial 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 regarding, 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:

→ AFC will determine approval and approval amount on each application based on the supporting documentation submitted, funding availability and prioritization of client needs.

→ AFC will inform Service Provider of approval status, and for which assistance option the application was approved. An approval confirmation letter will be sent to the service provider. The letter will include: Amount Approved, Service Month Covered and Check Date.

→ 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

EFA 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 Supporting Documentation** *(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 OR 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**

☐ **Proof of HIV Status** *(If labs indicate an undetectable viral load, additional proof may be requested)*

☐ **Proof of Ownership from Landlord** *(Only for Private Market Landlords: e.g. property taxs tatement)*

☐ **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

EFA 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:	10. Contact Type:	11. Message Type:
(_____)_____-_____ext. _____	☐ Home ☐ Work ☐ Mobile	☐ Any ☐ Discreet ☐ None

12. Alternate Contact Number:	13. Contact Type:	14. Message Type:
(_____)_____-_____ext._____	☐ Home ☐ Work ☐ Mobile	☐ 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

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

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
	☐ 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

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 or 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 regarding 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 crises 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 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 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. Applying 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 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
Ryan White Part B Program

Authorization for Release of Health Information

First Name (print)	Middle Initial	Last Name (print)

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, inclusive of any and all federal funding utilized including Housing Opportunities for Persons with AIDS (HOPWA), and/or successor programs in which you participate or to which you apply for services.

1. I certify that the information I provide to the Program is true and accurate to the best of my knowledge. I understand that I may be disqualified from the Program and/or prosecuted for willfully providing false information.
2. I understand that the information requested by the Program is for the purpose of determining my eligibility for a state and federally funded program to which funding is limited and may expire at any time without extended or alternate funds being available.
3. I understand that eligibility approval does not mean I will receive all services offered by the Program. I understand each service may require additional information, and that I must provide this information for verification before provision of said services.
4. If I am enrolled in the Program, I will be granted an eligibility period of no more than six months. Upon the conclusion of my eligibility period, I will be required to reapply and must 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 Case Manager (if applicable) notify the Program of any change in circumstances affecting my participation in, or eligibility for, the Program within thirty (30) days of the change. This includes any changes in income, address or insurance coverage. I understand changes in my situation will be periodically evaluated to determine continued eligibility for the Program.
6. I understand that all mailed correspondence sent by the Program will be sent to the address I have on file with the program only if I have consented to receive mail.
7. I authorize the Program to release my enrollment, eligibility, service utilization, and any other information necessary to facilitate my enrollment in the program and the provision of services to my physicians on file, program service providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, and\or other 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.
8. 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.
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 Program 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) become null and void.

14. I authorize the Program to release information related to my enrollment, eligibility, service utilization, and any other information the program determines necessary to facilitate my enrollment into the program and the provision of services to the following entities:

    a. Case Management providers funded by the Program. This includes but is not limited to both medical and non-medical case management providers, medical benefit coordinators/benefit specialists, client representatives, and peer navigators.

    b. Certified Application Counselors (CAC) licensed under the authority of the Program.

    c. Members of my medical care team including, but not limited to, the physicians, physician assistants, nurses, nurse practitioners, mental health providers, substance abuse providers, oral health care providers, and any professional staff working under their authority.

    d. Entities with a grant or contractual relationship with the Program, including the grantee or contractor's sub-recipients/sub-contractors in contractual relationships to carry out activities covered by the Program. This includes the Program's regional lead agencies, contracted community-based organizations, contracted dispensing pharmacy, and contracted third party payer for insurance premiums and client out of pocket medical costs.

    e. Individuals or entities listed on my eligibility assessment as assisting me with my enrollment and eligibility.

    f. IL Department of Insurance (insurance coordination), Employment Security (income verification), Health and Family Services (Medicaid verification), the Centers for Medicare & Medicaid Services and other program/sections within the IL Department of Public Health per Illinois Statute 410 ILCS 305.

    g. Any grantee or subrecipient of any part of the Ryan White Care Act for the purposes of service coordination and to prevent duplication of information and services.

    h. Entities employed or authorized by the IL Department of Public Health to conduct reengagement and outreach activities in instances when I may have a break in my enrollment to ensure I have not fallen out of medical care. These activities will take place during the 24 months covered by this authorization.

With my signature, I authorize the Program and the entities identified in item 14 of this document to share my information with the additional entities listed below and I understand that I must list these contacts on each submission of this form in order to allow the Program to continue to share my information with them.

_____

Individual Name

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

Telephone

_____

Individual Name

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

Telephone

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

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