HOME STRETCH
HOUSING ASSISTANCE FUND APPLICATION

SERVICE PROVIDER INFORMATION

Name of Referring Service Provider: _____
(First, Middle, Last, Suffix)

Name of Referring Service Agency: _____

Name of Referring Service Program: _____

Service Provider Phone Number: _____

Service Provider E-mail Address: _____

Service Provider Address: _____
(Number, Street, City, Zip Code)

_____

APPLICANT INFORMATION

Name of Applicant: _____
(First, Middle, Last, Suffix)

Social Security #: _____ Applicant's Date of Birth: _____

Applicant's Phone Number: _____ Applicant's E-mail Address: _____

Is the applicant currently experiencing homeless or have they exited homelessness within the last 60 days? Yes ☐ No ☐

Is the applicant a resident of Alameda County Yes ☐ No ☐

An Alameda County HMIS Release of Information, HMIS Client Profile form, and HMIS Intake Form must be attached to this application in order for the application to be complete. If this information is already in HMIS and is up-to-date, you may print these pages and write "updated" with the date the information was verified and the provider's signature.

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HOUSING HISTORY

Qualifying and planned/current future living situation after receiving assistance. Please check **ONE** box for **qualifying** and **ONE** box for **Planned/Current.** The qualifying living situation is the living situation the applicant is in currently that qualifies them for assistance or the living situation they were in prior to move in (within the last 60 days) that qualifies them for assistance. The planned/current living situation is the permanent housing situation they are moving into or have moved into within the last 60 days.

Qualifying	Planned/ Current	Living Situation*	Qualifying	Planned/ Current	Living Situation
		Place not meant for habitation			Permanent housing (other than RRH) for formerly homeless persons
		Emergency shelter including hotel/motel paid for with voucher			Rental by client, no ongoing housing subsidy
		Safe Haven			Rental by client, with VASH subsidy
		Interim Housing			Rental by client, with GDP TIP subsidy
		Foster care home or foster care group home			Rental by client with other housing subsidy (including RRH)
		Hospital or other residential non-psychiatric medical facility			Residential project or halfway house with no homeless criteria
		Jail, prison or juvenile detention center			Staying or living in a family member's room, apartment or house
		Long-term care facility or nursing home			Staying or living in a friend's room, apartment or house
		Psychiatric hospital or other psychiatric facility			Transitional housing for homeless persons
		Substance Use Treatment Facility or Detox			Client doesn't know
		Hotel or motel paid for without emergency shelter voucher			Client Refused
		Owned by client, no ongoing housing subsidy			Other:

***** *A list of definitions for these living situations is available. If you are not sure of the correct response, please contact the Home Stretch Office.*

HOUSING HISTORY AND HOUSING PLAN INFORMATION

1) Please briefly describe the applicant's current situation 2) The Home Stretch Housing Assistance Fund is meant to be one time and have a lasting impact. Please describe the applicant's plan to maintain this housing moving forward. Are there any additional resources or supports that are needed? Please add pages if needed.

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RENTAL/HOUSING INFORMATION

Please include a copy of the lease, rental agreement or intent to rent with the application.

What is the size (studio, 1 bedroom etc.) of the applicant's current/proposed unit? _____

How many people will live there? _____

What is the total rent the client will pay? _____

What is the total rent for the unit: _____

Is there a subsidy like a Housing Choice Voucher, VASH, Shelter + Care? If so, which one? _____

Has the unit passed a housing authority inspection? Yes ☐ No ☐

*Note that a copy of the inspection report or verification that the unit passed inspection must be submitted with the application if the unit is subsidized by a housing authority.

HOUSING UTILITY COSTS – IF APPLICABLE

Please include a copy of the utility bill with the applicant's account number.

What is the amount owed? _____

Is the applicant required to pay a deposit in order to establish service? If so, how much? _____

What is the total amount requested? _____

In order to increase affordability of utility costs associated with PG&E, please learn more about the CARE or FERA programs. You can visit this link www.pge.com/care or call 1-866-743-2273 for more information.

HOME FURNISHINGS AND HOUSEHOLD ITEMS – IF APPLICABLE

What is the estimated total cost of all items requested? $_____

List address where the items should be delivered: _____

_____

(Number, Street, City, Zip Code)

Will the applicant use an approved vendor and Home Stretch will order directly or is the service provider's organization going to use a different vendor and pay for the items directly then request reimbursement?

*Note that all requests must be fully completed and all payments made/items ordered within 90 days of move in.

Home Stretch approved vendor ☐ Service provider's organization will request reimbursement ☐

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UNIT MODIFICATIONS AND MEDICAL EQUIPMENT – IF APPLICABLE

Please enclose verification of medical necessity from a medical professional, as well as verification that the applicant attempted to obtain any requested medical equipment through their health insurance.

Are you requesting any unit modifications? If so, what modifications are needed? _____

_____

_____

_____

Verification of need must be provided for anything listed in this section.

What is the estimated cost of the unit modifications? _____

Has the landlord agreed to the unit modifications? Please include with paperwork. Yes ☐ No ☐

Are you requesting medical equipment? If so, what is needed? _____

_____

Verification of need as well as verification of an attempt to obtain the requested equipment utilizing health insurance must be included.

What is the estimated cost of the equipment?_____

Address where the items should be delivered:_____

_____

(Number, Street, City, Zip Code)

OTHER ALLOWABLE EXPENSES – MOVING SERVICE – IF APPLICABLE

For Other Allowable Expenses (i.e. Moving Service etc.):

Please keep in mind that the amount of funding needed must be determined in advance. This means that a moving service with rates based on mileage is not an allowable expense.

Please write an explanation of what is needed: _____

_____

_____

_____

_____

_____

What is estimated cost? _____

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HOME STRETCH HOUSING ASSISTANCE FUND REQUEST SUMMARY

For the funds requested, place the estimated dollar amount(s) next to each expense. If no funding is requested for a specific line, please write "$0." The individual amounts should add up to the total amount of funds requested.

Rental Assistance:

First Month's Rent (tenant's portion only) Amount = $_____

Security Deposit Amount = $_____

Total Requested: Total Amount = $_____

Move In Assistance:

Utility Start-Up Costs Amount = $_____

Estimated Home Furnishings & Household Items Amount = $_____

Estimated Moving Services Amount = $_____

Estimated Total Requested: Total Amount = $_____

Safety and Accessibility:

Medically Necessary Items (such as a hospital bed) Amount = $_____

Unit Modifications Amount = $_____

Estimated Total Requested: Total Amount = $_____

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HOME STRETCH HOUSING ASSISTANCE FUND AGREEMENT

I have requested assistance from the Home Stretch Housing Assistance Fund to help me access housing or stay housed. I understand that I have certain obligations that come with receiving this assistance.

✓ I agree to complete the application with my service provider and to provide accurate and truthful information.

✓ I agree to work with my service provider and others in my support system on my housing plan.

I have read, understood and accepted the above agreement and verify my application contains truthful and accurate information.

Applicant Signature: _____ Date: _____

Print Name of Applicant: _____

As the service provider working with this applicant, I agree to support the applicant in working on their housing plan and confirm that the information on this form is correct based on the knowledge I have. This includes verifying that the person is currently experiencing homelessness or has exited homelessness in the last 60 days. I attest that I do not have any personal financial interest in the properties or vendors associated with the application.

Service Provider Signature: _____ Date: _____

Print Name of Service Provider: _____

FOR HOME STRETCH PROGRAM USE ONLY – DO NOT WRITE BELOW

- ☐ Application Approved
- ☐ Application incomplete
- ☐ Application Denied (reason in notes)

Reviewer's Signature: _____ Date: _____

Notes:

_____

_____

_____

_____

_____

_____