

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)

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's income at or below 40% of the Area Median Income? Yes ☐ No ☐

Is/was the applicant staying in Alameda County when experiencing homelessness? Yes ☐ No ☐

Is the identified permanent housing unit in Alameda County*? Yes ☐ No ☐

* Households are not required to stay in Alameda County to be eligible for this resource. If moving to another county, applications must be approved, and registries submitted within 30 days to maintain eligibility. Additionally, the housing plan section of the application must address plans for any needed supports in the new area.

Please use the application checklist found on our webpage and linked here to ensure that all required documents are included when submitting an application. Missing or incomplete documents can lead to delays in processing.

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HOUSING HISTORY

Please check **TWO total** boxes on the chart below.

In the “qualifying” column (far left), please check **ONE** box that reflects the applicant’s living situation that qualifies them to apply for this assistance (either where they are currently experiencing homelessness or where they were staying immediately prior to moving into housing).

In the “planned/current” column, please check **ONE** box that describes the permanent housing situation the household is planning to move into (or has 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 homestretchfund@acgov.org.

HOUSING HISTORY AND HOUSING PLAN INFORMATION

The Home Stretch Housing Assistance Fund is meant to be used one time and have a lasting impact. Please briefly describe: 1) the applicant’s qualifying situation, and 2) 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 (if subsidized, what is the tenant portion)? _____

What is the total rent for the unit: _____

Is there a rental subsidy (Housing Choice Voucher, VASH, Shelter + Care)? Yes ☐ No ☐

*Note that if there is a rental subsidy, applications must include confirmation of subsidy approval, including identified tenant portion of rent.

The next four (4) sections may or may not be required, depending on what kinds of funds are being requested. Complete all relevant sections, then proceed to HAF Request Summary (p5).

HOME FURNISHINGS AND HOUSEHOLD ITEMS – IF APPLICABLE

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

Address where the items should be delivered (explain if requesting delivery anywhere other than lease address):

(Number, Street, Unit Number, City, Zip Code)

List any instructions that may be helpful for finding unit at time of delivery: _____

HOUSING UTILITY COSTS – IF APPLICABLE

If applying for utility start-up costs, 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.

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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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HOUSING ASSISTANCE FUND REQUEST SUMMARY

Enter the estimated dollar amount(s) being requested for each expense type. If no funding is requested for a specific line, please write “\$0” or leave blank. The grand total should add up to the amount of all funds being requested.

Rental Assistance:

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

Security Deposit Amount = \$ _____

Total Rental Assistance Requested: Total Amount = \$ _____

Household Assistance:

Utility Start-Up Costs Amount = \$ _____

Estimated Home Furnishings & Household Items Amount = \$ _____

Estimated Moving Services Amount = \$ _____

Estimated Total Household Assistance Requested: Total Amount = \$ _____

Safety and Accessibility:

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

Unit Modifications Amount = \$ _____

Estimated Total Safety and Accessibility Requested: Total Amount = \$ _____

Total funds requested in all categories Grand Total= \$ _____

HOUSING ASSISTANCE FUND APPLICATION

HOME STRETCH HOUSING ASSISTANCE FUND AGREEMENT

I have requested assistance from the Housing Assistance Fund to help me access housing. 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:
