



Agency Use: \_\_\_\_\_ Date Received: \_\_\_\_\_

Scanned by: \_\_\_\_\_

Assigned to: \_\_\_\_\_

# LFCAA Home Relief Pre-Application

## Primary Applicant Information

**Need Help With:**  
(Check all that apply)

**Rent:**

**Utilities:**

<b>Primary Applicant Name</b> (First, MI, Last, suffix)		
<b>Service Address</b> (Street, City, State and Zip) Is this your primary residence? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Mailing Address</b> (Street, City, State and Zip)
<b>Email Address</b>	<b>Phone Number</b>	<b>Preferred Contact Method(s)</b> <input type="checkbox"/> Phone <input type="checkbox"/> Email
<b>Gender</b>	<b>Social Security Number</b>	<b>Date of Birth</b>
<b>Ethnicity</b> <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Not Hispanic, Latino or Spanish Origins	<b>Race</b> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Not-reported <input type="checkbox"/> White	<b>Education</b> <input type="checkbox"/> Grade 0-8 <input type="checkbox"/> Grades 9-12/Non-Graduate <input type="checkbox"/> High School Grad/GED <input type="checkbox"/> 12+ Some Post-Secondary Education <input type="checkbox"/> 2 or 4 Year College Graduate <input type="checkbox"/> Graduate or other post-secondary school
<b>Is Primary Applicant Disabled?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Military Status</b> <input type="checkbox"/> Veteran <input type="checkbox"/> Active Military	<b>Is Primary Applicant a US Citizen?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Work Status</b> <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (short-term, 6 months or less) <input type="checkbox"/> Unemployed (long-term, more than 6 months) <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/not reported	<b>Health Insurance Type</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Employment Based <input type="checkbox"/> Self-Insured/Direct Pay <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> None	<b>Non-Cash Benefits</b> <input type="checkbox"/> Affordable Care Act Subsidy <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> HUD-VASH <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Public Housing <input type="checkbox"/> SNAP <input type="checkbox"/> WIC <input type="checkbox"/> Other: _____
<b>Household Size</b> (number of people): _____		<b>Dislocated Youth?</b> (Youth ages 14-24 who are neither working nor in school) <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Housing Status</b> <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Other: _____	<b>Family Type</b> <input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Two-Parent Household <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults/No Children <input type="checkbox"/> Non-related Adults with children <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Other: _____	<b>Building Type</b> <input type="checkbox"/> Mobile Home <input type="checkbox"/> Single Family <input type="checkbox"/> Multi-family low rise (3 stories or less) <input type="checkbox"/> Multi-family high rise (3 stories or more)



# LFCAA Home Relief Pre-Application

## Additional Household Member Information (Please include all household members. Use additional sheets if necessary.)

	1	2	3	4	5	6	7
Name							
SSN							
Date of Birth							
Relationship to Primary Applicant							
Race(s)							
Hispanic/Latino?							
Gender							
Veteran or Active Military							
Disability?							
Education							
Work Status							
US Citizen?							
Health Insurance							
Non-Cash Benefits							

## Additional Information Needed for Household Members with Disabling Conditions

Name	Disability of long duration that substantially limits the client's ability to live on their own (Please check all that apply)
	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic health condition <input type="checkbox"/> Mental health <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Drug abuse <input type="checkbox"/> Alcohol abuse
	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic health condition <input type="checkbox"/> Mental health <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Drug abuse <input type="checkbox"/> Alcohol abuse
	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic health condition <input type="checkbox"/> Mental health <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Drug abuse <input type="checkbox"/> Alcohol abuse
	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic health condition <input type="checkbox"/> Mental health <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Drug abuse <input type="checkbox"/> Alcohol abuse



# LFCOA Home Relief Pre-Application

## Housing Situation

Check the first correct answer and follow the arrows; note that rental and ownership are highlighted in the third box because people often miss them (please fill out separately for each adult if adults were living in different living situations)

Homeless Situations	
<input type="checkbox"/> Place not meant for habitation	
<input type="checkbox"/> Emergency shelter, including hotel or motel paid for <b>with</b> emergency shelter voucher, or RHY-funded Host Home shelter	
<input type="checkbox"/> Safe Haven	

Institutional Situations	
<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Long-term care facility or nursing home
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility
<input type="checkbox"/> Jail, prison, or juvenile detention facility	<input type="checkbox"/> Substance abuse treatment facility or detox center

Temporary and Permanent Housing Situations	
<input type="checkbox"/> Residential project or halfway house with no homeless criteria	<input type="checkbox"/> Permanent housing (other than Rapid Rehousing Programs) for formerly homeless persons
<input type="checkbox"/> Hotel or motel paid for <b>without</b> emergency shelter voucher	<input type="checkbox"/> Rental by client, with Rapid Rehousing or equivalent subsidy
<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/> Rental by client, with Housing Choice Voucher (Section 8: tenant or project based)
<input type="checkbox"/> Host Home (non-crisis)	<input type="checkbox"/> Rental by client in a public housing unit
<input type="checkbox"/> Staying or living in a friend's room, apartment or house	<input type="checkbox"/> Rental by client, no ongoing housing subsidy
<input type="checkbox"/> Staying or living in a family member's room, apartment or house	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
<input type="checkbox"/> Rental by client, with GPD TIP subsidy	<input type="checkbox"/> Owned by client, with housing subsidy
<input type="checkbox"/> Rental by client, with VASH housing subsidy	<input type="checkbox"/> Owned by client, no housing subsidy

**DID THE CLIENT STAY LESS THAN 90 DAYS?**

<input type="checkbox"/> No (Skip to next page)	<input type="checkbox"/> Yes
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**LENGTH OF STAY IN INSTITUTION**

<input type="checkbox"/> 1 night or less	<input type="checkbox"/> 2 to 6 nights
<input type="checkbox"/> 1 week or more, but less than 1 month	<input type="checkbox"/> 1 month or more, but less than 90 days

**DID THE CLIENT STAY LESS THAN 7 DAYS?**

<input type="checkbox"/> No (Skip to next page)	<input type="checkbox"/> Yes
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**LENGTH OF STAY IN HOUSING SITUATION**

<input type="checkbox"/> 1 night or less	<input type="checkbox"/> 2 to 6 nights
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**LENGTH OF STAY IN LITERALLY HOMELESS SITUATION**

<input type="checkbox"/> 1 night or less	<input type="checkbox"/> 1 week or more, but less than 1 month	<input type="checkbox"/> 90 days or more, but less than 1 year
<input type="checkbox"/> 2 to 6 nights	<input type="checkbox"/> 1 month or more, but less than 90 days	<input type="checkbox"/> 1 year or longer

<p><b>On the previous night, did the client stay on the streets, in an Emergency Shelter, or in a Safe Haven?</b></p> <input type="checkbox"/> No (Skip to next page) <input type="checkbox"/> Yes
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**LENGTH OF TIME HOMELESS** Include time on the streets, in emergency shelter, and in safe haven.

Including this and any previous sheltered stays or unsheltered episodes, what is the approximate date that the client became homeless? (month / day / year)	/ /
Including today, what is the number of times the client has been on the street, in ES or SH in the past 3 years? (Institutional stays of less than 90 days are not a break. Stays less than 7 days in other places are not a break.)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more
What is the total number of months the client has been homeless on the street, in ES or SH in past 3 years?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 or more



# LFCAA Home Relief Pre-Application

## Covid Impact Statement

A State of Emergency has been declared in the United States of America and the State of Ohio due to the COVID-19 global pandemic. There is no person in the country that is not affected by COVID-19. I, like thousands of others across the state, am requesting assistance to my pay my rent, mortgage and/or utility payment(s) in part or in full. I, and/or other residents in my home, have experienced the following circumstances due to the Global Pandemic and State of Emergency it has caused:

- Loss of Work / Decrease in Available Hours at Work
- Forced Work Closure
- Inability to Access or Get to Work
- Unpaid wages or Other Unpaid Compensation Ordinarily Received
- Increase in Childcare Costs
- Forced to Take Off Work due to School Closure or Childcare Change
- Self-Quarantined at Home under Government or Medical Recommendation
- Stay at Home or Shelter in Place Order by any level of Government Authority
- Forced to Take Off Work to Care for a Family Member
- Personal or Family Experiencing Illness, Disability, or Mental Health Issues
- Lack of Access or Delayed Access to Healthcare
- Experience of Food Insecurity, Shortages, or Delayed Benefits
- Increase in Family Expenses due to Pandemic or Emergency Preparedness
- Unemployment Insurance Unavailable, Insufficient, or Delayed
- Emergency Assistance Unavailable, Insufficient, or Delayed
- Loss of Social, Financial, or Health Safety Net
- Fear and Concern of Future Economic and Health Insecurity and Instability
- If I Pay for Rent Now, I Will Not be Able to Meet My or My Family's Basic Needs

OTHER: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_







# LFCAA Home Relief Pre-Application

## Release of Information

*(Note: Completing these Releases now may help save time later, but you may also wait and complete or add releases as necessary while working with your Case Manager. Use additional pages if necessary)*

I, \_\_\_\_\_, give **Lancaster-Fairfield Community Action Agency** consent to obtain from or provide to the following agencies pertinent information relating to my application for benefits and/or services. In granting such permission I understand that such information will remain confidential and that such information will be used for the benefit of the person named above and his/her family. This consent is valid for a period of 90 days.

LFCAA may contact the following organization and agencies to discuss my application. Information that may be provided includes: Name and Contact Information, Application Status, Amount Owed, Monthly Payments Required, Employment Status, Assistance Received, and Amounts of Potential Assistance.

### Complete all that apply:

Referral Source: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Landlord: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Lender: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Utility: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Utility: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Other: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Once Income Documentation is Received, LFCAA may contact Employers to verify Employment Status and Income Amounts.

Employer: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Employer: \_\_\_\_\_ Contact Information: \_\_\_\_\_

I release Lancaster-Fairfield Community Action Agency and its staff from any legal liability for disclosing and acquiring information which I have permitted by signing this form. I also release the above named persons and/or agencies from any legal liability for giving information to Lancaster-Fairfield Community Action Agency for the period stated above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# LFCAA Home Relief – Countable Income Worksheet

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Household Member Name <i>Report income information for yourself and all adults in your household (18 and over)</i>	Total Amount Received	Period Received (30, 90, or 365 days)
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	

Income Category		Amount	Frequency (Weekly, Bi-Weekly, Monthly, or Yearly)	Total 30 Day Amount
Fixed Countable Income	Supplemental Security Income (SSI)			\$ _____
	Social Security Disability Insurance (SSDI)			
	Social Security Retirement (SS)			
	Pension (government, military and private)			
	Widow/Widower's Benefit			
	Alimony			
	Black Lung Pension			
Earned Countable Income	Wages (salary, tips, commission, bonuses, etc.)			\$ _____
	Active Military Pay			
Other Earned Countable Income	Seasonal Employment			\$ _____
	Self-Employment			
Supplemental Countable Income	Unemployment			\$ _____
	Utility Assistance			
	Workers' Compensation			
	Employment Disability Payouts			
	Strike Benefit			
Other Countable Income	Cash withdraws from: Individual Retirement Accounts, Annuities, Other investments			\$ _____
	Lump sum payout from: Estate & Trust settlements, Divorce settlements, insurance payout, lottery winnings			
	Interest Income			
None (must complete Zero Income Form)				\$ _____
<b>Total</b>				<b>\$ _____</b>





## LFCAA Home Relief – Countable Income Worksheet

Deductible Income	Amount	Frequency (Weekly, Bi-Weekly, Monthly, or Yearly)	30 Day Total
Health Insurance Premiums			\$ _____
Short and Long-Term Disability Premiums Prescription Plans			
Health Care Spending Accounts Medicaid Spend Down (deductibles) Medicare Premiums			
Child Support paid-out			
Attorney fees for estate or trust settlements			
Self-employment IRS allowable business expenses Reimbursement for work expenses			

<b>Total Household Income (Countable Income – Deductions)</b>	<b>\$</b> _____
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Excluded Income	Amount	Frequency (Weekly, Bi-Weekly, Monthly, or Yearly)	30 Day Total
Agent Orange Pension			\$ _____
Veterans affairs, service related disability			
Handicapped income (i.e. work programs for the blind or disabled)			
Title V wages (i.e. senior employment programs)			
Volunteers in Service to America Stipend (VISTA)			
Work allowances (work requirement to receive OWF assistance)			
Income earned by dependent minors			
Tax refunds/rebates			
Education assistance (grants stipends for tuition/books)			
Stipends for foster care			
Military allowances for subsistence			
Ohio waiver program (Medicaid benefit for caregiver)			
Prevention retention and contingency (i.e. emergency services, rental asst.)			
transportation allowances (WIOA)			
Proceeds from reverse mortgage			
FEMA, cash payments			
Title III Disaster relief emergency assistance			
Child Support Received			
Ohio Works First			
Temporary Assistance for Needy Families (TANF)			



## LFCAA Home Relief – Countable Income Worksheet

Expense Type	Total Monthly Expense Amount
Food	\$
Shelter	\$
Child Care	\$
Transportation	\$
Utilities	\$
<b>Total</b>	<b>\$</b>

<b>Total Number of People in Household (Adults and Children)</b>	
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I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Documentation of all income is required (employment verification form, pay stubs, award letters, etc.).*

*Additional forms are required to document self-employment, seasonal employment, and zero income. These forms will be provided by your Case Manager as necessary.*

*For Completion by Staff:*

a. Monthly Household Income	\$
b. Household Size (double check with Intake Form/Pre-Application)	
c. ____% Federal Poverty Guidelines for Household Size (from table)	\$
d. ____% Area Median Income for Household Size (from table)	\$
<b>Percent of Federal Poverty Guidelines (From OCEAN)</b>	<b>%</b>
<b>Percent of Area Median Income (From OCEAN)</b>	<b>%</b>

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_



# LFCAA Home Relief – Zero Income Self-Declaration Worksheet

**Primary Applicant Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Monetary Support section:** If you are receiving help paying your bills and/or expenses from a non-household member(s), please list their name(s), address(es), and phone number(s) below, also include a signed statement from that person(s). The statement should note how much money is provided, how often, and if the money is given to you or paid directly to your creditors. If additional space is required (you have more than three (3) people assisting you) use the back of this form to list their information and have them provide the required signed statements.

Supporter 1 - First Name	Last Name	Telephone Number (include area code)
Address		
Supporter 2 - First Name	Last Name	Telephone Number (include area code)
Address		
Supporter 3 - First Name	Last Name	Telephone Number (include area code)
Address		

**Explain how the following expenses are paid (Write N/A to any that do not apply):**

Bill	Monthly Amount	Gift / Loan (if Other, please explain)		
Rent/Mortgage	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:
Food	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:
Gas	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:
Electric	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:
Phone/Cell	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:
Car Payment/Insurance	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:
Cable/Internet	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:
Personal Expenses	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:
Bulk Fuels (i.e. propane, fuel oil/coal)	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:
Other Expenses	\$	<input type="checkbox"/> Gift	<input type="checkbox"/> Loan	<input type="checkbox"/> Other:

Does your household receive any of the following?	Yes or No	Amount
Food Stamps		\$
Rental Assistance (i.e. Section 8, HUD, Metropolitan Housing)		\$
Utility Allowance (HUD) – Please note if this is paid directly to the utility companies.		\$

**Income Comments section:**


By signing below, I declare under penalty of perjury that the information submitted on this worksheet is true and correct.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



# LFCOA Home Relief – Self-Employment Income and Expense Form

**Primary Applicant Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

*Examples of self-employment include: Owning your own business, babysitting, day care, home partysales, odd jobs, Ohio Electronic Child Care, etc.*

If you do not file a Form 1040 with the IRS, you must provide an **IRS Verification of Non-Filing Letter** (if applicable), along with this completed form.

Name of Self-Employed Person: \_\_\_\_\_

Name of Business: \_\_\_\_\_

Type of Business: \_\_\_\_\_

Business Address: \_\_\_\_\_

Itemized Business Income			Itemized Business Expenses		
Date	Source	Amount	Date	Source	Amount
<b>12-month Income Total</b>			<b>12-Month Expense Total</b>		
<b>Total Business Income (Income minus Expenses):</b>					

*Attach additional pages as necessary.*

I certify under penalty of perjury, that this income and expenditure information is true and correct to the best of my knowledge.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



# LFCAA Home Relief – Employment Verification Form

Primary Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please return completed form to *Lancaster-Fairfield Community Action, 1743 E Main St., Lancaster, OH 43130*

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_

Business Name (please print): \_\_\_\_\_

Employee Signature: \_\_\_\_\_

***If pay stubs are not available, the client's employer must complete the box below.***

**\*\*To be completed by the Employer Only\*\***

Please complete the below information, sign and return to the agency listed above.

Your assistance is appreciated.

Date employment began: \_\_\_\_\_ Date first paycheck issued: \_\_\_\_\_

Date employment ended (if applicable): \_\_\_\_\_ Date last paycheck was issued: \_\_\_\_\_

Gross amount of last pay: \_\_\_\_\_

Provide the information below for the last 30 days or 12 months of employment or attach a copy of paystubs to this form.

Date paycheck issued:	Gross pay amount:	Medical Deductions:

Employer Address: \_\_\_\_\_

Employer Name (print): \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Employer Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

