Applicant's representative may rely upon the applicant's verbal, email or text affirmation to complete the application.

APPLICATION COVER PAGE

Agency:_____

Address: _____
Street City State Zip Code

Medical Case Manager /Housing Counselor _____
(Print Name)

Phone: _____

Fax: _____Email: _____

I attest the information and documentation submitted is accurate and verified by me.

_____
(MCM signature) (Supervisor Name & Email)

Date: _____

Fax the application to 215-985-2099. Attn: EFA COORDINATOR
This is a secured fax number, do NOT use any other PHMC fax number for this purpose.
DO NOT SEND the application via MAIL

Place a √ next to the application pages to be submitted. Please review Program Guide and make sure all required documentation is included with the application.

☐ Page 2, Applicant Demographic & Personal Data	☐ Page 6, Statement of Back Rent Form
☐ Page 3, Insurance & Applicant's Residence	☐ Page 7, Vendor Information
☐ Page 4, Household Members	☐ Page 8, Consent for Service Form
☐ Page 5, Intent to Rent Form	

Public Health Management Corporation

DATE OF APPLICATION: _____

APPLICANT NAME: _____

ADDRESS: _____
STREET/APT#/CITY/STATE/ZIP CODE

_____
STREET/APT#/CITY/STATE/ZIP CODE

COUNTY OF RESIDENCE: _____

DATE OF BIRTH: _____ SSN: _____

GENDER (check one): ☐ Male ☐ Female ☐ Unknown
☐ Transgender (please circle one): male to female female to male
Biological sex of applicant at birth (check one): ☐ Male ☐ Female

RACE & ETHNICITY: (Please note that both race and ethnicity are required of the applicant, this is based on the applicant's self-report. An applicant's response is sufficient for this purpose).

RACE (check all that apply): ☐ American Indian/ Alaska Native ☐ Asian ☐ Black /African American
☐ Native Hawaiian/Other Pacific Islander ☐ White

If applicant answered Asian, please specify the following (check all that apply):
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

If applicant answered Native Hawaiian/Other Pacific Islander, please specify the following (check all that apply):
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

ETHNICITY (check one):
☐ Hispanic/Latino(a)/Spanish Origin ☐ Non-Hispanic/Latino(a)/Spanish Origin

If applicant answered Hispanic/Latino(a)/Spanish Origin, please specify the following (check all that apply):
☐ Mexican/Mexican American/Chicano(a) ☐ Puerto Rican ☐ Cuban
☐ Another Hispanic/Latino(a)/Spanish Origin

HIV RISK (check all that apply): ☐ MSM ☐ IDU ☐ Heterosexual Contact
☐ Hemophilia/Coagulation Disorder ☐ Perinatal Transmission ☐ Blood Transfusion
☐ Not Reported or Not Identified

MEDICAL INSURANCE (check one):
☐ Private Employer
☐ Private Individual
☐ Medicare
☐ Medicaid, CHIP or Other Public Plan
☐ No Insurance/Uninsured
☐ Other
☐ Unknown
☐ Veterans Health Administration (VA), Military Health Care (Tricare), & Other Military Health Care
☐ Other Plan (Client has an insurance type other than listed above)

CURRENT LIVING ARRANGEMENT (check one):

☐ Renting (unsubsidized) ☐ Permanently living with family/friends ☐ Institutional setting ☐ Substance abuse treatment facility or detox center ☐ Foster care home or foster care group home ☐ Temporarily staying with family/friends ☐ Temporary placement in institution ☐ Jail/ prison/juvenile/detention ☐ Hotel, or motel (paid with a government voucher) ☐ Emergency shelter or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a vehicle, an abandoned building, a bus/train/subway station/airport, or anywhere outside	☐ Own home/ apartment ☐ Subsidized housing ☐ Psychiatric hospital or other psychiatric facility ☐ Hospital ☐ Transitional housing for homeless individuals ☐ McAuley House, Good Shepherd, Calcutta ☐ Hotel or motel (paid w/o a government voucher)

How long have you lived there? _____

SUBSIDY INFORMATION:

Do you receive a housing subsidy?
☐ Yes ☐ No Source: _____

Do you receive low income housing?
☐ Yes ☐ No Source: _____

HOUSEHOLD COMPOSITION:

Family size: _____(This is the number of family members who live together, including the applicant. An applicant living alone (or with **only** non-relatives) counts as a family of one.

Annual family income: _____ (This is the sum of income of all family members who live together. It includes pre-tax money or "cash" income [earnings; unemployment compensation; Social Security; public assistance; veteran payments; survivor benefits; pension or retirement income; interest; dividends; rents; royalties; income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources]. It excludes non-cash benefits including food stamps, housing subsidies and capital gains or losses).

Did you experience a loss of income as a result of COVID 19 (during the Stay-at-Home Order or after)?
☐ Yes
☐ No

Public Health Management Corporation

HOUSEHOLD MEMBERS:

Name of household member ____

DOB ______________________________

Race (check all that apply): ☐American Indian/ Alaska Native ☐Asian ☐Black /African American ☐Native Hawaiian/Other Pacific Islander ☐White

Ethnicity (check one): ☐Hispanic/Latino(a)/Spanish Origin ☐Non-Hispanic/Latino(a)/Spanish Origin

Relationship to Applicant (check one): ☐Domestic Partner/Lover ☐Husband ☐Wife ☐Mother ☐Father ☐Son ☐Daughter ☐Sister ☐Brother ☐Other ____________________

Name of household member ____

DOB ______________________________

Race (check all that apply): ☐American Indian/ Alaska Native ☐Asian ☐Black /African American ☐Native Hawaiian/Other Pacific Islander ☐White

Ethnicity (check one): ☐Hispanic/Latino(a)/Spanish Origin ☐Non-Hispanic/Latino(a)/Spanish Origin

Relationship to Applicant (check one): ☐Domestic Partner/Lover ☐Husband ☐Wife ☐Mother ☐Father ☐Son ☐Daughter ☐Sister ☐Brother ☐Other ____________________

Name of household member ____

DOB ______________________________

Race (check all that apply): ☐American Indian/ Alaska Native ☐Asian ☐Black /African American ☐Native Hawaiian/Other Pacific Islander ☐White

Ethnicity (check one): ☐Hispanic/Latino(a)/Spanish Origin ☐Non-Hispanic/Latino(a)/Spanish Origin

Relationship to Applicant (check one): ☐Domestic Partner/Lover ☐Husband ☐Wife ☐Mother ☐Father ☐Son ☐Daughter ☐Sister ☐Brother ☐Other ____________________

Name of household member ____

DOB ______________________________

Race (check all that apply): ☐American Indian/ Alaska Native ☐Asian ☐Black /African American ☐Native Hawaiian/Other Pacific Islander ☐White

Ethnicity (check one): ☐Hispanic/Latino(a)/Spanish Origin ☐Non-Hispanic/Latino(a)/Spanish Origin

Relationship to Applicant (check one): ☐Domestic Partner/Lover ☐Husband ☐Wife ☐Mother ☐Father ☐Son ☐Daughter ☐Sister ☐Brother ☐Other ____________________

Use an additional page if needed

Public Health Management Corporation

INTENT TO RENT LETTER

The tenant_____ will rent
(name of applicant)

property located at_____. The

landlord_____ _____ and tenant have
(name of landlord)

entered an agreement prior to the lease for 1st month's rent $_____ last month's rent

$_____ or security deposit $_____ for a total of $

_____

in order for the tenant to occupy the above property.

NOTE: The security deposit must be returned to the Public Health Management Corporation. Please initial one of the statements below

_____Landlord will return the security deposit to the Public Health Management Corporation upon termination of lease.

_____Tenant will return the security deposit to the Public Health Management Corporation upon termination of lease.

_____Tenant is responsible for security deposit. These funds will NOT be used for this purpose.

Signatures:

_____ _____
Landlord – Print Name Tenant – Print Name

_____ _____
Landlord – Signature Tenant – Signature

_____ _____
Date Date

_____
Landlord Phone Number and Email

Public Health Management Corporation

STATEMENT OF BACK RENT

The tenant _____ is currently
(name of applicant)

behind in rent. The landlord _____ and tenant have entered into a
(name of landlord)

repayment agreement, by which both parties have agreed to bring the tenant's rental account current.

The amount of the tenant's arrears is $_____ for _____

_____
(specify months and year)

_____ _____
Landlord – Print Name Tenant – Print Name

_____ _____
Landlord – Signature Tenant – Signature

_____ _____
Date Date

Please note: The tenant is responsible for all late fees and service charges.

Landlord's Address: _____

Phone Number and Email (__) _____

Public Health Management Corporation

VENDOR INFORMATION FORM

GRANT REQUEST: ☐ Back Rent ☐ 1st & Last Month Rent ☐ Mortgage ☐ 1ST Month & Security Deposit ☐ Heating Oil ☐ Essential Utilities ☐ Pharmaceutical		**PAYMENT DELIVERY:** ☐ Mail Check ☐ Pick Up Check ☐ ACH (Landlords ONLY)
VENDOR COMPANY:		
CONTACT:		
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
TELEPHONE NO:	**FAX NO:**	**EMAIL:**
ACCOUNT NUMBER:	**AMOUNT REQUESTED $**	
GRANT REQUEST: ☐ Back Rent ☐ 1st & Last Month Rent ☐ Mortgage ☐ 1ST Month & Security Deposit ☐ Heating Oil ☐ Essential Utilities ☐ Pharmaceutical		**PAYMENT DELIVERY:** ☐ Mail Check ☐ Pick Up Check ☐ ACH (Landlords ONLY)
VENDOR COMPANY:		
CONTACT:		
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
TELEPHONE NO:	**FAX NO:**	**EMAIL:**
ACCOUNT NUMBER:	**AMOUNT REQUESTED $**	
TOTAL GRANT AMOUNT REQUESTED: $		

Public Health Management Corporation

CONSENT FOR SERVICE FORM

I,_____(print full name) am applying for Emergency Financial Assistance (EFA). I agree to cooperate with referring and administering agency staff in providing additional information, as required, to complete the application. I have answered the questions on the application form and have submitted all necessary documentation to support my request for assistance.

I consent to the agency's assessment of my financial need. The assessment is to identify possible resources to meet my needs in an ongoing way.

Applications are considered by the requirements outlined in the EFA Program Guide. Agency staff will provide any assistance needed by applicants in the application and appeal process.

CONFIDENTIALITY STATEMENT

Assigning an "individual identification number" to the application and maintaining records in a locked file assures the applicant's privacy. Records are maintained for seven years and then destroyed. Application forms are open to inspection only to those professionals who are licensed or fund the activities of the EFA program and for internal contract review, when necessary. Neither this agency nor its representatives will reveal the applicant's personal health or medical information to anyone without a release form in accordance with Pennsylvania Act 59 and the HOPWA Confidentiality User Guide, November 2013.

The Provider agency reserves the right to deny or limit service based on its professional judgment of needs. A negative decision will be discussed with you. You have the right to appeal this decision. The agency will make every effort to provide satisfactory service in every respect; however, if you should experience an unusual difficulty, please contact the agency's Executive Director who will act promptly to assist you. In regards to any of the above items, you may request a detailed copy of the agency's relevant appeals process. You may also request to appeal the decision by contacting the Health Information Helpline at 1-800-985-2437 or 215-985- 2437.

This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or if authorization by the confidentiality of HIV-related information Act, 35 P.S. Section 7601. Et Seq. A general authorization for the release of medical or other information is not sufficient for this purpose.

APPLICANT STATEMENT

I have been offered, read and signed a copy of the agency's release form in accordance with Pennsylvania Act 59 and the HOPWA Confidentiality User Guide that will allow the agency to contact other organizations, companies or agencies that will allow this agency to collect information that may be required to complete my application.

I have read this application in full. All the information given to the agency concerning this emergency grant is correct to the best of my knowledge. If any information provided is found purposely inaccurate or false, I am responsible for paying back the money given to me, and I will not be able to re-apply for emergency funding.

Applicant's Signature_____ Date_____

Case Manager's Signature _____ Date_____