

Am I Eligible For Assistance?

- Have you experienced financial hardship due directly, or indirectly, to the coronavirus pandemic?
- Does anyone in your household qualify for unemployment benefits?
- Have you experienced a reduction in household income?
- Are you late paying your rent?
- Do you have a pending eviction?
- Are you homeless?
- Is your combined household income for ALL household members age 18 and over, at or below 80% of the Area Median Income (AMI)? **Income eligibility will be determined during the application process and calculated using the most recent (30 day) income documentation*

If you answered “**Yes**” to any of the **questions** listed above, **you may be eligible** to receive assistance from the American Rescue Plan Home Relief Grant (ARPHRG).

TO REQUEST ASSISTANCE:

Carefully read and thoroughly complete ALL DOCUMENTS in this packet **and**

RETURN ALL REQUIRED DOCUMENTS to:

600 W. Main St – HEAP Drive-thru

Hours: Monday-Friday, 8:00 a.m.-5:00 p.m.

After hours drop off in mail slot located on HEAP building

FOR MORE INFORMATION: **Call (937) 325-8366** or
email: help@oicofclarkco.org

- **Failure to provide all required documentation when submitting this application, will result in your request for assistance to be delayed and possibly determined ineligible for assistance.**
- **A copy of our Client Appeal Process can be picked up at the HEAP Drive-thru and is also located on our website: www.oicofclarkco.org**

APPLICATION CHECKLIST

- Copy of your Driver's License or Picture ID
- Copy of Social Security cards for all household members
- Copy of Birth Certificates if available for all household members
- Non-Citizen documentation may be required
- Completed Assistance Request Form – Signed & Dated
- Completed Hardship Form - Signed & dated and include any of the below supporting documentation that applies to your situation:
 - Documentation of hardship
 - Copy of health care document showing test results
 - Documentation of quarantine
 - Documentation from employer of time off
 - Paystubs that support reduction in pay
 - **Any additional documentation that may be needed by Case Manager to process application**
- Signed Duplication of Benefits Statement
- Signed Permission to Share Information document
- Proof of Income for past 30 days for all household members 18 years or older (see attached Income types)

Client #:
Case Manager:



American Rescue Plan Home Relief Grant (ARPHRG)
YOU MUST LIST ALL MEMBERS LIVING IN YOUR HOUSEHOLD
AND RETURN THIS DOCUMENT WITH YOUR PACKET
PLEASE PRINT CLEARLY

Applicant's Name: _____

Current Address: _____

City, State, Zip Code: _____

Cell Phone Number: _____

Other Contact Phone Number: _____

Email address: _____

Household Member's Name	Birth Date	Social Security Number	Is Household Member employed?
<i>APPLICANT</i>			<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Household Member</i>			<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Household Member</i>			<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Household Member</i>			<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Household Member</i>			<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Household Member</i>			<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Household Member</i>			<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Household Member</i>			<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Household Member</i>			<input type="checkbox"/> yes <input type="checkbox"/> no

*****Does any household member receive:**

- SSI/SSDI Yes No
- SNAP Yes No

I (enter your name →) _____ verify to that the household I am requesting assistance for, or any of this household's members, have NOT received rent or utility assistance from another source for the time period that I am requesting to be covered.

Signature: _____ **Date:** _____

American Rescue Plan Home Relief Grant Assistance Request Related to Coronavirus Pandemic

American Rescue Plan Act of 2021, Emergency Rental Assistance (ERA2) is available for necessary expenditures for households who have one or more individuals within the household that have qualified for unemployment benefits or experienced a reduction in household income, incurred significant costs, or experienced other financial hardship during or due, directly, or indirectly, to the coronavirus pandemic.

I, and/or other residents in my home, have experienced the following circumstances due to the coronavirus pandemic:

- 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: _____



Opportunities for Individual Change, OIC of Clark County
920 West Main Street, Springfield, Ohio 45504
Telephone: (937) 323-6461 www.oicofclarkco.org

AUTHORIZATION TO RELEASE INFORMATION

I _____

Print Name

Located at:

Address

City

State

Zip Code

Here by give OIC of Clark County permission to share my information with other agencies for the purpose of completing the necessary requirements to receive emergency assistance through the American Rescue Plan Home Relief Grant

Signature of Applicant

Date



Opportunities for Individual Change, OIC of Clark County
920 West Main Street, Springfield, Ohio 45504
Telephone: (937) 323-6461 www.oicofclarkco.org

Duplication of Benefits

I _____
Print Name

Address

City **State** **Zip Code**

Have you received previous assistance from OIC or another agency? Yes No

If so, agency(s) name and number of months of assistance.

*****By signing this document, you verify that the household I am requesting assistance for, or any of this household's members, have NOT received rent or utility assistance from another source for the time period that you are requesting to be covered. *****

Signature of Applicant

Date

Types of Income Required

Income documentation for everyone in the household over 18 years of age:

- 30 days of Paystubs (*name needs to be on the paystub and the gross amount*)
- SNAP (*if received- name needs to be on document*)
- TANIF (*if received- name needs to be on document*)
- Child Support documentation (*if received- name needs to be on document*)
- SS/SSI/ SSDI Award Letter for 2023 benefits (*if received- name needs to be on document*)
- **If no income:** Complete Self-Declaration of Income Document included in application if not worked in the last 30 days. **Each person 18 and older will need to provide a Self-Declaration form if no income claimed.** If assistance has been received to pay bills, a letter must be signed by the person helping to include dates, amounts and what was paid.
- Copy of 2022 1040 if taxes were filed.



Self-Declaration of Income Support

Applicant Information:

First Name	Last Name	Telephone Number (include area code)
Address		

If you have no other way to document your income and/or household situation, please complete all sections below. An incomplete worksheet may delay the processing of your application.

Monthly Household Income Amount:	\$	Annual Household Income:	\$
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Describe how you have been able to pay your bills, including food, shelter, clothing etc.:

Monetary Support section:

If you are receiving help paying your bills and/or expenses from a non-household member, please list their name(s), address, and phone number(s) below. If you have a note from the person providing assistance, please include the signed and dated note with your application. If additional space is required (you have more than one person assisting you) use the back of this form to list their information and have them provide a signed and dated notes, if available.

First Name	Last Name	Telephone Number (include area code)
Address		
How much is given: \$	How Often: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Paid to me <input type="checkbox"/> Paid to bill directly

Does your household receive any of the following?	Yes or No	Amount per Month
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.		\$

Describe how your household was financially impacted by COVID-19:

By signing below, I declare under penalty of perjury that the information submitted on this worksheet is true and correct. I further certify that my household is experiencing homelessness or housing instability.

Signature: _____

Date: _____

Verified by: _____

Date: _____

Appendix VI: Employment Verification

Employment Verification Form

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.

Please submit information to local Energy Assistance Provider:

****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, if providing 12 months of employment attach a separate document with that information.

Date paycheck issued:	Gross pay amount:	Medical/Child Support/Dental/ Vision/HSA Deductions:

Employer Address: _____

Employer Name (print): _____

Contact Phone Number: _____

Employer Signature (required): _____ Date: _____