

COVID-19 Financial Hardship Application for Assistance



U.S. Department of Housing and Urban Development
 CARES Act /CDBG /CDBG-CV /HOME Programs
 administered by/on behalf of the City of Killeen, Texas

Place a CHECK MARK in the box indicating the type of assistance requested.
 You may select one or both categories for assistance.

- Utility Assistance
- Rental Assistance-Killeen Rental Property

STAFF ONLY

COVID-19 REF# _____
 CD STAFF _____ DATE _____

Applicant / Solicitante				Co-Applicant / Co-Solicitante			
NAME /NOMBRE (Please Print)		Head of Household?		NAME (Please Print)		Head of Household?	
		<input type="checkbox"/> YES/ SI <input type="checkbox"/>				<input type="checkbox"/> YES / SI <input type="checkbox"/>	
Texas DL /State ID #		Other ID#		Texas DL/ State ID#		Other ID#	
Current Address / Dirección Actual:				Current Address / Dirección Actual:			
City /Ciudad	State / Estado TX	Zip Code / Código		City /Ciudad	State / Estado TX	Zip Code / Código	
Currently receiving Federal housing assistance?		YES / SI <input type="checkbox"/> NO <input type="checkbox"/>		Currently receiving Federal housing assistance?		YES / SI <input type="checkbox"/> NO <input type="checkbox"/>	
If YES, please indicate which type of housing assistance: you receive:				If YES, please indicate which type of housing assistance: you receive:			
Public Housing <input type="checkbox"/>		Housing Choice Voucher/Section 8 <input type="checkbox"/>		Public Housing <input type="checkbox"/>		Housing Choice Voucher/Section 8 <input type="checkbox"/>	
Email / Electrónico		Telephone / Teléfono:		Email / Electrónico		Telephone / Teléfono:	

FAMILY MEMBER INFORMATION					Ethnicity – mark Y or N if you are of Hispanic origin.		MONTHLY FAMILY INCOME					
LIST EACH FAMILY MEMBER LIVING IN THE HOUSEHOLD	AGE	Gender (M)ale (F)emale	DATE OF BIRTH MM/DD/YYYY	RELATION TO APPLICANT	Race – mark the number that identifies your Race		Enter the MONTHLY DOLLAR AMOUNT for each category of income listed; If none then enter zero "0"					
					ETHN	RACE	Employment/ Unemployment/Workers Comp	Social Security/ SSDI VA Disability	TANF/WIC	Pension, Retirement, VA Benefits, Pension	Other Income- Alimony, Child Support, COVID19 Payroll Program Payments	
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
AMI 0-30% >30-50% >50-80% Over 80%							Calculated Total Monthly Income All Sources \$					

Race—select one (1) category applicable to each person in the family . Write the number next to the name of each person indicating that person's RACE.

- 11 White 12 Black/African American 13 Asian 14 American Indian/Alaska Native 15 Native Hawaiian / Other Pacific Islander
 16 American Indian/Alaska Native & White 17 Asian & White 18 Black/African American & White
 19 American Indian/Alaska Native & Black/African/American 20 OTHER MULTI-RACIAL

HOUSING & EMPLOYMENT INFORMATION			
Name of Apartment Complex	<input type="checkbox"/> NA	Employer Name/ City	
Property Manager/ Company Name		Supervisor Name	
Telephone		Telephone	
Lease Start / End Date		Last Date Worked / # Hours	
UTILITY ACCOUNTS & CHILD CARE PROVIDER INFORMATION			
Killeen Utilities (Water) Account #		Child Care Provider Name	<input type="checkbox"/> NA
Gas Company Name/Account #		City/Location	
Electric Co Name/ Account #			

By checking one of the statements below—You may be required to provide proof to document the statement. **CHECK ALL THAT APPLY**

- A Household Member tested positive for COVID-19 by a source authorized by the State of Texas.
- A Household Member was required to quarantine because of close contact exposure to someone who tested positive for COVID-19



FINANCIAL HARDSHIP QUESTIONNAIRE/SCREENING QUESTIONS

Please complete the requested information and place a check mark next to the statement that most closely reflects your current situation since the COVID-19 Disaster Declaration

EMPLOYMENT COMPLETE REQUESTED INFORMATION AND CHECK ALL THAT APPLY

A determination of financial hardship due to lost employment or income either permanently or temporarily due to the effects of the COVID-19 pandemic.

I was employed in a position working full time (40 hours/week) part time (less than 40 hours/week) when COVID-19 restrictions were imposed by the Texas Governor. My position at my employer prior to COVID-19 restrictions were put into place was *(describe position)* _____.

1. My employer has guaranteed my return to employment once the COVID-19 restriction are lifted and I am receiving unemployment compensation.
2. My employer has contacted me to return to work on May 18, 2020 and has guaranteed return to my previous position and scheduled hours.
3. My employer has not guaranteed my return to employment once the COVID-19 restriction are lifted; and, I am not receiving unemployment compensation.

HOUSING (*Rental Assistance*) COMPLETE REQUESTED INFORMATION AND CHECK ALL THAT APPLY

A determination of housing crisis due to lost employment or income either permanently or temporarily due to the effects of the COVID-19 pandemic.

I am experiencing a housing crisis and facing potential homelessness due to loss of income when COVID-19 restrictions were imposed by the Texas Governor. My monthly rent payment is \$_____ and is due on *(day of month)*_____.

1. I was behind on my rent payments before COVID-19 restrictions were imposed by the Texas Governor. I owe back rent for a total of _____ months.
2. I owe late fees for back rent owed.
3. I am at risk of losing my current housing as ordered by an eviction notice from my landlord/property manager dated _____ and effective _____.
4. I am not at risk of losing my current housing and I am able to pay my rent.

UTILITIES

A determination of hardship and inability to pay for basic utilities due to lost employment or income either permanently or temporarily due to the effects of the COVID-19 pandemic. Basic Utilities include: Water, Electric, Gas CHECK ALL THAT APPLY

1. I am experiencing a financial hardship and am unable to pay for basic utilities for my current housing.
2. I am able to pay for basic utilities for my current housing.

CHILDCARE

A determination of hardship and inability to pay for proper child care due to lost employment or income either permanently or temporarily due to the effects of the COVID-19 pandemic. Childcare is for a child/children age 0-12 years of age. COMPLETE REQUESTED INFORMATION AND CHECK ALL THAT APPLY

Prior to the restrictions associated with the COVID-19 pandemic I had proper childcare for my child/children and paid a after school only daily weekly bi-monthly monthly rate of \$_____. I

f I were to return to work when the COVID-19 restrictions are lifted:

1. I will need short term assistance to pay for proper childcare for my child/children.
2. I will not need assistance to pay for proper childcare for my child/children.

FOOD

A determination of financial hardship and inability to pay for an adequate amount food due to lost employment or income either permanently or temporarily due to the effects of the COVID-19 pandemic. CHECK ALL THAT APPLY

1. I am currently unable to pay for sufficient food to meet family needs.
2. I am able to pay for sufficient food to meet family needs.

TRANSPORTATION

A determination of hardship and inability to pay for fuel to access certain necessary services due to lost employment or income either permanently or temporarily due to the effects of the COVID-19 pandemic. Necessary services include: grocery stores, pharmacies, child care, employment. CHECK ALL THAT APPLY

1. I own my vehicle and can make the monthly payment.
2. I access public transportation to meet my transportation needs.
3. I need transportation assistance.

HEALTH/MEDICAL/PRESCRIPTIONS

A determination of hardship and inability to pay for medical/prescriptions due to lost employment or income either permanently or temporarily due to the effects of the COVID-19 pandemic. Childcare is for a child/children age 0-12 years of age. CHECK ALL THAT APPLY

- | | | |
|---|--|---|
| 1. <input type="checkbox"/> I have health insurance. | 2. <input type="checkbox"/> Enrolled in Medicare and/or Supplemental Insurance | |
| 3. <input type="checkbox"/> Enrolled in Affordable Care Act | 4. <input type="checkbox"/> No Health insurance | 5. Prescription Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO. |



COVID-19 has affected my household in the following way:

(Describe the need for assistance and how the household has been affected by the COVID-19 pandemic.)

Authority for Release of Information

To Whom It May Concern:

I hereby authorize investigation by a duly accredited representative of the City of Killeen, Texas on behalf of the U.S. Department of Housing and Urban Development bearing this release, or a copy thereof, within one year of its date, to obtain any information from schools, residential management agents, employers, utility providers, criminal justice agencies, U.S. Citizenship and Immigration Services, or individuals, relating to an application for assistance relative to financial hardship as the result of the COVID-19 pandemic on my household. This information may include, but is not limited to, academic, residential, employment history, wages and attendance, income, personal history, status of utility accounts, immigration status, and arrest and conviction records. I hereby direct you to release such information upon request of the bearer. I understand that the information released is for official use and may be disclosed to such third parties as necessary in the fulfillment of responsibilities related to application for program(s) funded in whole or in part by the U.S. Department of Housing and Urban Development or other Federal agency.

I hereby release any individual, including record custodians, from any and all liability for damages of whatever kind or nature which may at any time result to me on account of compliance, or any attempts to comply, with this authorization. Should there be any questions as to the validity of this release, you may contact me as indicated below.

**AUTHORIZATION FOR RELEASE OF INFORMATION
 SELF CERTIFICATION STATEMENT OF ANNUAL INCOME BY BENEFICIARY
 All household members age 18 years and over**

1. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone/Teléfono:	Date
2. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone /Teléfono:	Date
3. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone /Teléfono:	Date
4. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone/Teléfono:	Date
5. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone/Teléfono:	Date
6. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone/Teléfono:	Date
7. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone /Teléfono:	Date
8. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone /Teléfono:	Date
9. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone /Teléfono:	Date
10. Signature/ Firma	Print Full Legal Name/ Imprima su nombre legal	Telephone /Teléfono:	Date

WARNING: The information provided in this application form is subject to verification by HUD at any time, and Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making a false or fraudulent statement to a department of the United States Government, and may be fined not more than \$10,000 or imprisoned for not more than five years, or both. This information will be used to establish a level of benefit for HUD and other Federally funded program(s); To protect the government's financial interest; and to verify the accuracy of information furnished. It may be released to appropriate Federal, State, and Local Agencies when relevant to civil, criminal or regulatory investigators, and prosecutors. Failure to provide any information may result in a delay or rejection of eligibility or approval.