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| Chronicle Season of Sharing Fund | Intake Form  **Critical Family Needs/Housing Assistance** |

**THIS SECTION TO BE COMPLETED BY AGENCY REPRESENTATIVE**

**COUNTY:**  **Alameda  Contra Costa  Marin  Napa  S.F.  San Mateo  Santa Clara  Solano  Sonoma**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PROGRAM:**   **CFN  HA  CFN & HA Has applicant used program before?  YES, When:** | | | | | | | **No** |
| **Name:** | | | **D.O.B.:** | | **SSN:** | | |
| **Name:** | | | **D.O.B.:** | | **SSN:** | | |
| **Address:** | | **City:** | | **ZIP:** | **Tel #:** | | |
| **New Address:** | | **City:** | | **ZIP:** | **Tel #:** | | |
| **# Children under 18 (living in home):** | **Dates of birth:** | | | | | **Total in household:** | |

|  |
| --- |
| **Intake Criteria (check one):**  **Single Parent**  **Intact Family**  **Senior**  **Disabled**  **Senior & Disabled**  **Foster Youth** |

|  |
| --- |
| **Veteran  Domestic Violence  Pregnant 2nd/3rd Trimester** |

**Ethnicity/Race (check one):**  **Hispanic/Latino/Spanish**  **Not Hispanic/Latino/Spanish**

**If Not Hispanic/Latino/Spanish: (check one)**  **American Indian/Alaska Native**  **Asian**  **Black/African American**

|  |  |  |
| --- | --- | --- |
| **Native Hawaiian/Pacific Islander**  **White**  **Two or more races**  **Other** | |  |
| **If applicant has lived in country for less than 2 years, date moved to country:** | | |
| **Former Address/Country:** | | |
| **Monthly Net Income: $** | **Anticipated changes:** | |

|  |  |
| --- | --- |
| **Income Source:**  **Work**  **CalWORKS**  **CalFresh**  **SSI**  **SS**  **UIB**  **DIB**  **FC**  **Other** |  |

**Section 8 Voucher  Current Section 8  Homeless to Perm Housing  Shelter to Per Housing  Subsidized Housing**

|  |  |  |
| --- | --- | --- |
| **Referral agency: BCAC** | **Contact Person:** | **Email:** [**SOSBCAC@gmail.com**](mailto:SOSBCAC@gmail.com) |
| **Address 480 Military East 94510** | | **Tel #: (707)745-0900** |

|  |  |
| --- | --- |
| **Request:**  **Delinquent Rent/Mortgage**  **Deposit**  **First Month Rent**  **Other** |  |

|  |  |
| --- | --- |
| **Reason:  Disability/Illness  Unemployment  Family Separation  Public Assistance  Other** |  |

**Explanation (Please attach a separate sheet if necessary)**

|  |
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|  |

**What other action have been take to alleviate this need?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| **If approved, make check payable to (Landlord/Vendor):** | | | **Amount $** |
| **Address:** | **City:** | **ZIP:** | **Tel #:** |
| **If approved, make check payable to (Landlord/Vendor):** | | | **Amount $** |
| **Address:** | **City:** | **ZIP:** | **Tel #:** |
| **For (client’s name):** | | | |

**THIS SECTION TO BE COMPLETED BY APPLICANT**

I hereby give my permission to contact any agency/landlord who could be helpful in understanding my situation, and I give my consent to release any information necessary to receive assistance from the Chronicle Season of Sharing Fund (SOS). This form was completed in its authority by an authorized caseworker and approved by me prior to my signing.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

**CAMPAIGN**

I agree to interviewed and photographed for the SOS Campaign in the following media: San Francisco Chronicle / SFGate.com, SOS website and television. By agreeing to this, I understand that my photographs and videos are the property of the San Francisco Chronicle and can be used by the Season of Sharing Fund exclusively for future campaign materials, such as annual reports, in-paper ads and videos. **INITIAL HERE:**

**THIS SECTION TO BE COMPLTED BY CHRONICLE STAFF**

**CFN:**  **Denial**  **Approval $ HA:**  **Denial**  **Approval $**

**If assistance was denied, REASON:**

**Date Landlord Verified:**

**Authorized Signature: Phone: Date:**

**VERIFICATION REQUIREMENTS CHECKLIST**

These mandatory verification documents must be submitted before the screening committee will review your request. Documentation must be received within 5 working days after turning in application.

**INCOMPLETE PACKETS ARE SUBJECT TO DENIAL**

**MUST BE A SOLANO RESIDENT OF 6 MONTHS** (Benicia, Dixon, Fairfield, Rio Vista, Vacaville & Vallejo)

1. California Picture ID’s (adults 18+ & over)

2. Social Security Cards for all in household

3. Monthly income of all adults in the household (2 Current Pay Stubs)

If employment is pending, we need a letter from the employer (with letterhead) identifying the client

as a new employee, verifying starting date, rate of pay and hours to be worked with phone number to

contact.

4. Unemployment/Workers Comp (current pay stub) or status pending letter

5. SS/SSI/SSDI, TANF/AFDC award letters (must show income or pending income)

6. Present rental agreement (must show names, terms, amount, signature & date)

7. If moving to a new place, we need the New Rental Agreement and/or

Sec 8 Housing Assistance (which tells the landlord, all in household and Section 8 terms)

8. If renting from a private owner (we need tax assessor statement showing address/name of

owner with a parcel number)

9. Verification of Situation. Must provide documents showing why you

need assistance, and What was the cause (If rent is due, current 3-day notice)

10. Budget Sheet (Completely filled out) 3 months of budgeting with one month

showing why you need assistance

**ADDITIONAL VERIFICATION MAY BE REQUESTED BASED ON INDIVIDUAL CASES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Authorized Signature:** |  | **Date:** |  |

**SEASON OF SHARING – RENTAL ASSISTANCE PROGRAM**

THE NEXT PAGE MUST BE SIGNED BY YOUR **LANDLORD** OR **APARTMENT COMPLEX MANAGER**.

IF THEY ARE A PRIVATE LANDLORD, WE MUST HAVE THEIR TAX ASSESSORS STATEMENT SHOWING **PROOF OF OWNERSHIP WITH PROPERTY TAX ID NUMBER AND ADDRESS OF PROPERTY.**

**SEASON OF SHARING – RENTAL ASSISTANCE PROGRAM**

To Whom It May Concern

|  |  |
| --- | --- |
| This is to confirm that | and family |

is renting/buying/leasing an apartment or house from

|  |
| --- |
|  |

(Name of owners or Mortgage Company that checks are made out to)

The residence is located at:

|  |  |  |
| --- | --- | --- |
|  | City | Zip |

in Solano County. The amount of security deposit or one month’s rent or mortgage is $.

The amount currently needed to obtain or maintain the residence is $ (including: overdue rent/mortgage payments/late fees/deposits). I agree to accept Season of Sharing funds. Any balance left will be **PAID BY THE RESIDENT IN** full or monthly payments. Should this money be paid, I agree to allow the tenant(s) to remain in the residence for a **minimum of 30 days** according to the terms of our rental/lease/mortgage agreement. Under no circumstances, will the funds be paid to the client(s) either directly or through the landlord/mortgage company.

**IF A PRIVATE LANDLORD,**

Client must have landlord provide **A COPY OF** his/her **TAX ASSESSOR STATEMENT**

showing property address and proof of ownership.

|  |
| --- |
| **Back Rent / Security Deposit Payment Plan** |

|  |  |  |
| --- | --- | --- |
| Total amount owed to landlord |  | $ |
| Amount Client will pay to landlord |  | $ |
| \*Are you willing to accept monthly payments? |  |  |
| Amount to be paid in monthly payments |  | $ |
| Amount to be paid in full |  | $ |
| **Total** |  | **$** |

***The information contained in this letter is true and correct to the best of my knowledge. Any attempt to falsify information or provide fraudulent information will constitute an unlawful act and the appropriate law enforcement officials will be notified.***

**LANDLORD:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Landlord Name: | |  | | | | |
| Address: |  | | | | | |
| Email: |  | | | | | |
| Landlord Telephone #: | | | |  | | |
| Landlord Signature: | | |  | | Date |  |

**CLIENT:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Print Name: | |  | | |
| Signature: |  | | Date |  |

VERIFICATION OF ELIGIBILITY

|  |  |  |  |
| --- | --- | --- | --- |
| Name(s) |  | Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Address: |  | Phone |  |

|  |
| --- |
| 1. Household Members: (Children) (Others) |

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Birthdates | Social Security #s | Relationship |
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| 1. Household Income: Include AFDC, Social Security, S.S.I., Wages, Child Support, etc. |

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Source | Amount | Verification |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |

1. I am requesting **$** to help with

|  |  |  |  |
| --- | --- | --- | --- |
| Total Net Income (Take Home) | **$** | Maximum Rent You Can Afford | **$** |

|  |
| --- |
| 1. Applicant(s) Work History: approx. 3 years, starting with most recent |

|  |  |  |  |
| --- | --- | --- | --- |
| Employer & Address | Dates: mo./yr. | Earnings | Verification |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
|  |  | **$** |  |
| 1. Bank Accounts: | | | |

Bank & Address Balance Verification

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CHECKING

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SAVINGS

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| 1. Outstanding Debts: Loans, charge accounts, etc. |

Owed to: Name & Address Balance Verification

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| 1. Rental History: Approx. 3 yrs. Starting with most recent |

Address Dates Landlord & Address Verification

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1. Personal/Community assistance you have applied for: Give names, reasons not available

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| Family: |

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| Friends: |

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| Family: |

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| Friends: |

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1. Why are you in need of this help? (supply as many supporting verifications as possible)

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1. How will you avoid this situation from happening again?

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1. Other information you think helpful to your application

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SIGNATURE:

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(Applicant)

|  |  |  |
| --- | --- | --- |
| Chronicle Season of Sharing Fund | **Name:** |  |
|  |  |
| **Date:** |  |

Budget Form

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Section 1: Monthly income** | | | | | |
|  | **Last month** | **This month** | | | **Next month** |
| Applicant's take home pay | $ | $ | | | $ |
| Spouse's take home pay | $ | $ | | | $ |
| Unemployment/disability income | $ | $ | | | $ |
| Other sources of income - | $ | $ | | | $ |
|  |  |  | | |  |
| **Total monthly income** | **$** | **$** | | | **$** |
| **Section 2: Monthly expenses** | | | | | | |
|  | **Last month** | | **This month** | **Next month** | | |
| Rent or mortgage | $ | | $ | $ | | |
| Taxes (homeowner) | $ | | $ | $ | | |
| Utilities: PG&E | $ | | $ | $ | | |
| Utilities: Water & Garbage | $ | | $ | $ | | |
| Telephone/cell phone | $ | | $ | $ | | |
| Food/Toiletries (not covered by food stamps) | $ | | $ | $ | | |
| Health Insurance | $ | | $ | $ | | |
| Medical needs (prescriptions, doctor visits, etc.) | $ | | $ | $ | | |
| Car payment | $ | | $ | $ | | |
| Auto insurance | $ | | $ | $ | | |
| Transportation (bus, gas, tolls, Parking) | $ | | $ | $ | | |
| Child care | $ | | $ | $ | | |
| Clothing | $ | | $ | $ | | |
| Cleaning/laundry | $ | | $ | $ | | |
| Installment payments (credit cards, loans) | $ | | $ | $ | | |
| Cable television | $ | | $ | $ | | |
| Miscellaneous (cigarettes, entertainment, etc.) | $ | | $ | $ | | |
| Other Expenses - | $ | | $ | $ | | |
| Other Expenses - | $ | | $ | $ | | |
| **Total monthly expenses** | **$** | | **$** | **$** | | |
| **Section totals** | | | | | | |
| **Total income (from Section 1)** | $ | | $ | $ | | |
| **Less total expenses (From Section 2)** | $ | | $ | $ | | |
| **Monthly balance** | **$** | | **$** | **$** | | |

|  |  |
| --- | --- |
| Solano County | Solano County Season of Sharing |

**Declaration Under Penalty of Perjury**

|  |  |  |
| --- | --- | --- |
| Case Name | Case Number | Worker |

|  |  |  |  |
| --- | --- | --- | --- |
| I, |  | residing at |  |

|  |  |
| --- | --- |
| Hereby declare under penalty of perjury that: |  |

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I declare under penalty of perjury that the foregoing statements are true and correct, and I am aware that if I present any material matter as true which I know false, I may be subjected to penalties prescribed for perjury under the Penal Code of the State of California in accordance with Section 11054 of the Welfare and Institutions Code.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| EXECUTED AT | **BENICIA,** | CALIFORNIA, THIS |  | DAY OF | **, 20** |

|  |  |
| --- | --- |
|  | CLIENT’S SIGNATURE |

\* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \*

|  |  |  |
| --- | --- | --- |
| I have explained to |  | the purpose of this declaration |

Client’s Name

and how it affects his/her eligibility.

|  |  |  |  |
| --- | --- | --- | --- |
| SUBSCRIBED AND SWORN TO ME THIS |  | DAY OF | **, 20** |

|  |  |  |
| --- | --- | --- |
| BY |  | NAME AND TITLE |