POSADA
Bringing Pueblo Home

Coronavirus Pandemic Community Utility Assistance Program Application Checklist

Attached to this checklist, is the formal application documents required for ALL persons seeking Utility Assistance through the Coronovirs Pandemic Community Utility Assitance Program. This checklist outlines all documents that are required for consideration of assistance. Documents must all be provided to Posada by the applicant, Posada is not responsible for acquiring any documents on behalf of the applicant.

To comply with program guidelines, applicant must submit the following to Posada:

- ☐ COHMIS paperwork for all members of the household
- ☐ COHMIS Client Consent and Release of Information form for all members of the household
- ☐ Collaborative Agencies Release Form
- ☐ Self Certification of Household Annual Income and COVID-19 Impact
- ☐ No Duplication of Benefits Statement
- ☐ Copy of entire utility bill (remittance statements alone will not be accepted)
- ☐ Copy of IDs and Social Security cards for all members of the household
- ☐ Copy of rental lease OR copy of mortgage statement

Applications are to be submitted in the drop box located at Posada's main office at
501 Belmont Ave, Pueblo, CO 81004.

For any questions or concerns regarding this application and required documents, please contact 719-545-8776 or email posada@posadapueblo.org.

EQUAL HOUSING OPPORTUNITY

COHMIS

Minimum Template Intake Form

Any Project in HMIS that Uses the Minimal Template

SOCIAL SECURITY NUMBER (SSN)	☐☐☐-☐☐-☐☐☐☐
QUALITY OF SSN	☐ Full SSN reported ☐ Approximate/partial SSN reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected
CLIENT NAME	
Last:	
First:	
Middle:	Suffix:
QUALITY OF NAME	☐ Full name reported ☐ Partial, street name, or code name reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected
DATE OF BIRTH (DOB) (MM/DD/YYYY)	☐☐-☐☐-☐☐☐☐
QUALITY OF DOB	☐ Full DOB reported ☐ Approximate/partial DOB reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected

GENDER

☐ Female
☐ Male
☐ Trans Female (MTF or Male to Female)
☐ Trans Male (FTM or Female to Male)
☐ Gender Non-Conforming (not exclusively male or female)
☐ Client doesn't know
☐ Client refused
☐ Data not collected

RACE

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ Client doesn't know
☐ Client refused
☐ Data not collected

ETHNICITY

☐ Non-Hispanic/Non-Latino
☐ Hispanic/Latino
☐ Client doesn't know
☐ Client refused
☐ Data not collected

VETERAN STATUS

☐ Yes
☐ No
☐ Client doesn't know
☐ Client refused
☐ Data not collected

RELATIONSHIP TO HEAD OF HOUSEHOLD

☐ Self (head of household)
☐ Head of household's child
☐ Head of household's spouse or partner
☐ Head of household's other relation member
☐ Other: non-relation member

PROJECT NAME	
PROJECT START DATE (MM/DD/YYYY)	

Has the client ever experienced homelessness before?

☐ No
☐ Yes
☐ Client doesn't know
☐ Client refused
☐ Data not collected

PRIOR LIVING SITUATION *(Where did the client sleep the night before entering this project?) (PICK ONLY 1)*

HOMELESS SITUATION

☐ Place not meant for human habitation (vehicle, anywhere outside)
☐ Emergency shelter, including hotel or motel paid for w/ emergency shelter voucher or RHY-funded host home
☐ Safe Haven

INSTITUTIONAL SITUATION

☐ Foster care home or foster care group home
☐ Hospital or other residential non-psychiatric medical facility
☐ Jail, prison or juvenile detention facility
☐ Long-term care facility or nursing home
☐ Psychiatric hospital or other psychiatric facility
☐ Substance abuse treatment facility or detox center

TRANSITIONAL & PERMANENT HOUSING SITUATION

☐ Residential project or halfway house with no homeless criteria
☐ Hotel or motel paid for without emergency shelter voucher
☐ Transitional housing for homeless persons (including homeless youth)
☐ Host Home (non-crisis)
☐ Staying or living in a friend's room, apartment, or house
☐ Staying or living in a family member's room, apartment, or house
☐ Rental by client, with GPD TIP subsidy
☐ Rental by client, with VASH housing subsidy
☐ Permanent housing (other than RRH) for formerly homeless persons
☐ Rental by client, with RRH or equivalent subsidy
☐ Rental by client, with HCV voucher (tenant or project)
☐ Rental by client in a public housing unit
☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with other ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ Owned by client, no ongoing housing subsidy

☐ Client doesn't know
☐ Client refused
☐ Data not collected

LENGTH OF STAY IN PRIOR LIVING SITUATION *(How long did the client stay in that situation?)*

☐ One night or less
☐ Two to six nights
☐ One week or more, but less than one month
☐ One month or more, but less than 90 days
☐ 90 days or more, but less than one year
☐ One year or longer
☐ Client doesn't know
☐ Client refused
☐ Data not collected

APPROXIMATE DATE HOMELESSNESS STARTED
*(for the client's **current** episode of homelessness)*

MONTH DAY YEAR

Number of times the client has been on the streets, in ES, or Safe Haven in the past three years including today *(Regardless of where they stayed last night)*

☐ One time
☐ Two times
☐ Three times
☐ Four or more times
☐ Client doesn't know
☐ Client refused
☐ Data not collected

Total number of months homeless on the streets, in ES, or SH in the past three years

☐ One month (first time)
☐ Two months
☐ Three months
☐ Four months
☐ Five months
☐ Six months
☐ Seven months
☐ Eight months
☐ Nine months
☐ Ten months
☐ Eleven months
☐ Twelve months
☐ More than 12 months
☐ Client doesn't know
☐ Client refused
☐ Data not collected

DISABLING CONDITION	
☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

Would you like to share the reasons or factors you feel contributed to your homelessness?	☐ No	☐ Yes*

***If YES please indicate all reasons that apply**

☐ Abuse or violence in my home	☐ Lost a job, could not find work
☐ Alcohol or substance use problems	☐ Medical Expenses
☐ Asked to leave or evicted	☐ Mental health condition
☐ Bad credit	☐ Moved to find work
☐ Client Choice	☐ Problems with public benefits
☐ COVID-19	☐ PTSD
☐ Disabling conditions	☐ Reasons related to my race or ethnicity
☐ Discharged from foster care	☐ Reasons related to my sexual orientation or gender identity
☐ Discharged from jail	☐ Relationship problems or family breakup
☐ Discharged from prison	☐ Traumatic brain injury
☐ Family member or personal illness	☐ Unable to pay rent or mortgage
☐ Language barrier	☐ Unable to pay utilities
☐ Legal problems	☐ Other reason (Please specify:_____)

CONTACT INFORMATION (Optional – entered on the **Contacts** tab)	
Phone number	
Email	

ADDRESS (Optional – entered on the **Locations** tab)			
Street			
City			
State		Zip Code	

Signature of applicant stating all information is true and correct

Date

COHMIS

Child Intake Form

For all non-RHY funded projects

SOCIAL SECURITY NUMBER (SSN)	☐☐☐-☐☐-☐☐☐☐
QUALITY OF SSN	☐ Full SSN reported ☐ Approximate/partial SSN reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected
CLIENT NAME	
Last:	
First:	
Middle:	Suffix:
QUALITY OF NAME	☐ Full name reported ☐ Partial, street name, or code name reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected
DATE OF BIRTH (DOB) (MM/DD/YYYY)	☐☐-☐☐-☐☐☐☐
QUALITY OF DOB	☐ Full DOB reported ☐ Approximate/partial DOB reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected

GENDER

☐ Female
☐ Male
☐ Trans Female (MTF or Male to Female)
☐ Trans Male (FTM or Female to Male)
☐ Gender Non-Conforming (not exclusively male or female)
☐ Client doesn't know
☐ Client refused
☐ Data not collected

RACE

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ Client doesn't know
☐ Client refused
☐ Data not collected

ETHNICITY

☐ Non-Hispanic/Non-Latino
☐ Hispanic/Latino
☐ Client doesn't know
☐ Client refused
☐ Data not collected

RELATIONSHIP TO HEAD OF HOUSEHOLD

☐ Head of household's child
☐ Head of household's spouse or partner
☐ Head of household's other relation member
☐ Other: non-relation member

PROJECT NAME	
PROJECT START DATE (MM/DD/YYYY)	☐☐-☐☐-☐☐☐☐

DISABLING CONDITION

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

PHYSICAL DISABILITY

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Physical Disability**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

DEVELOPMENTAL DISABILITY

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

CHRONIC HEALTH CONDITION

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Chronic Health Condition**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

HIV/AIDS

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

MENTAL HEALTH PROBLEM

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Mental Health Problem**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

SUBSTANCE ABUSE PROBLEM

☐ No
☐ Alcohol abuse
☐ Drug abuse
☐ Both alcohol and drug abuse

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Substance Abuse Problem**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

HEALTH INSURANCE		
Covered by Health Insurance?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Covered by Health Insurance – Indicate all sources that apply**

☐ Medicaid	☐ Health Insurance Obtained Through COBRA
☐ Medicare	☐ Private Pay Health Insurance
☐ State Children's Health Insurance Program	☐ State Health Insurance for Adults
☐ Veteran's Administration (VA) Medical Services	☐ Indian Health Services Program
☐ Employer-Provided Health Insurance	☐ Other Health Insurance (Specify source:_____)

Signature of parent/guardian stating all information is true and correct

Date

COHMIS Client Consent for Data Collection and Release of Information

This notice explains how information about you may be shared and used. It also tells you who can access your information. Please read it carefully and ask any questions you may have.

What is COHMIS?

The Colorado Homeless Management Information System (COHMIS) is a data system that stores information about homelessness services. The name of the software that stores this data is called Clarity Human Services. The purpose of COHMIS is to improve coordination of services that support people who are homeless or at risk of homelessness. To further ensure and navigate this coordination, data is shared statewide between the four Continuum of Care (CoC) bodies: MDHI (Metro Denver), Pikes Peak (El Paso County) Northern Colorado (Larimer and Weld Counties), and Balance of State (Remaining 54 Counties). Active agencies that participate in COHMIS are listed on https://cohmis.zendesk.com/hc/en-us.

What is the purpose of this form?

With this form, you can give permission to have information about you collected and shared with partner agencies that help provide housing and services. Partner agencies are required to protect the privacy of your identifying information.

You have rights regarding your information:

- You have the right to ask about who has seen your information.
- You have the right to see your information at any time and change it if it isn't correct.
- You have the right to change your authorization regarding the use of your data.
- You have the right to file a grievance if you feel your information has been misused. The Grievance Form may be requested at any time from any participating COHMIS agency.
- Right to refuse information while retaining rights of access to services.

The information to be collected and shared may include:

- Name, date of birth, gender, race, ethnicity, social security number, phone number, address
- Basic medical, mental health, substance use and daily living information
- Housing and program eligibility information
- Use of crisis services, Veteran services, hospitals and jail
- Employment, income, insurance and benefits information
- Services provided by partner agencies
- Results from assessments
- Photograph or other likeness (if included)

By signing this form:

- I authorize the CoC and Clarity to share COHMIS information with partner agencies, and the COHMIS information shared will be used to coordinate services. It will also be used to help evaluate the quality of community programs.
- I understand that the partner agencies may change over time and are always responsible for keeping my information private using reasonable best efforts for privacy policies.
- I understand that agencies must adhere to federal and Colorado laws regarding my protected information.
- I may revoke this consent at any time by returning a completed revocation of consent form, available upon request, to agency staff.
- I can receive a copy of this consent form.
- I understand this consent will expire 7 years from my last COHMIS recorded activity.

Printed Name of Client or Legal Guardian: _____

Printed Names of additional minor children covered by this release: _____

_____

Signature of Client or Representative: _____ **Date:** _____

Signature of Agency Witness: _____ **Date:** _____

_____ *Initials of Client If Declining Consent*

Collaborate Agencies Release Form

I am aware that Posada, Pueblo Community Health Center, Spanish Peaks Mental Health Center, Pueblo Rescue Mission and the YWCA all work together to provide services to the homeless population. In order for these agencies to assist me, I understand that it is often necessary to exchange limited information, which I have provided to these agencies.

By initialing below, I authorize exchange of information with:

Day Care Providers	Health Solutions
Educational Institutions	Los Pobres
Employers	Parole/Probation
Employment Agencies	Pueblo Housing Authority
Job Training Services	Veteran's Services
Landlord/Rental Management Company	YWCA
Law Enforcement	Pueblo Rescue Mission
Catholic Charities	PCHC
Cooperative Care Center	Other _____

I understand that all of the information exchanged between agencies will be handled with confidentiality and will be subject to each agency's conflict of interest policies. This authorization is valid for one year from the date of the signature.

I may revoke this authorization at any time by submitting a written statement to Posada, the Pueblo Community Health Center, Pueblo Rescue Mission, Health Solutions or YWCA.

_____	_____
Client Signature	**Date**
_____	_____
Spouse/Other Adult Signature	Date
_____	_____
Staff Signature	Date

Consent Revoked: (Sign below ONLY TO REVOKE consent)
I revoke consent for release of information.

_____	_____
Client Signature	Date

POSADA
Bringing Pueblo Home

Coronavirus Pandemic Utility Assistance Program Self-Certification of Annual Income & COVID Impact

INSTRUCTIONS:

Please complete one form and include the requested information for all persons in the household. Complete an additional form if the applicant needs more space. The adult head of household must sign and date the form. This form is valid for use between **April 10, 2020 - December 31, 2020.**

PART I: ELIGIBILITY

Funds are limited to income eligible families whose annual income does not exceed 80 percent of the area median income, as determined by HUD. Assistance is limited to (a) applicants who have an economic hardship as a result of COVID-19 and do not have the financial ability to make payment of utility expenses without leaving them unable to make necessary purchase of good and service and to (b) live within the City of Pueblo, CO.

Household Size	1	2	3	4	5	6	7	8
80% Limits	$39,800	$45,450	$51,150	$56,800	$61,350	$65,900	$70,450	$75,000

To comply with program guidelines, applicant must indicate which eligibility category applies to household.

Check All that Apply:

☐ Permanent loss of Job directly related to COVID-19

☐ Temporary loss of employment directly related to COVID-19

☐ Loss of Wages due to diagnosis of COVID-19

☐ Decrease in income or unable to work as indirect result of COVID-19 (please explain)_____

_____

_____

By signing below I, _____, attest that I was directly or indirectly financially impacted by COVID-19 and this financial loss has negatively impacted my ability to independently support my housing. I agree to provide Posada with the necessary documentation to support my statement of financial impact. My signature below is only valid until December 31, 2020 and I have the right the relinquish my signature to this agreement at any time.

_____

Participant Signature

_____

Date

EQUAL HOUSING OPPORTUNITY

PART II: HOUSEHOLD INFORMATION

Enter legal address (where the applicant currently lives) and contact information below.

	Legal Address	Mailing Address (if different from legal)
Street, Apt./Unit #		
State, City, Zip Code		
Phone Number(s)		
Email(s)		

Enter all household information below and indicate if any member is or will be a part-time/full-time student in the next 12 months. Do not include live-in-aides, children of live-in-aides, foster children, or foster adults.

Household Member #	**Name** ***(Last, First, MI)***	**Relationship to the Head of Household (co-head, spouse, child, etc.)**	**Birth Date** ***(mm/dd/ yyyy)***	***Student (Part/Full-time, Neither)**	****Disabled (Y/N)**
1		Head of Household			
2					
3					
4					
5					
6					

*Note for Applicant: Students do not qualify for HOME assistance unless the individual meets one of the exemptions below. Check all that apply:

☐ Over age 24 ☐ Veteran of the US Military ☐ Married ☐ Has dependent child/ren

☐ Member is part of a household that is low-income

**Note for Administrator: the "Disabled" column is not required and only provided if deductions under adjusted income at 24 CFR 5.611 will be applied for tenant-based rental assistance programs.

PART III: ANNUAL INCOME

Report all current income and income expected to be received in the next 12 months including long-term **unemployment compensation and all hazard pay**. **DO NOT INCLUDE:** IRS Economic Impact Payments (stimulus checks), Federal Pandemic Unemployment Compensation (the additional $600 per week), income of a live-in-aide, children of live-in-aides, foster children, foster adults, or the income of minors.

Section A: For each household member (HH Mbr#) below, anticipate annual income for the next 12 months by converting current income to annual figures. Convert wages/income by multiplying it by the frequency in which it is received and factor in amounts that will terminate before the end of the next 12 months. Multiply weekly income by 52; Bi-weekly income (received every other week) by 26; Semi-monthly income (received twice each month) by 24; and Monthly income by 12. A full-time student, 18 years or older (excluding the head of household or spouse) should exclude earnings in excess of $480 for annual income. Leave blank those that do not apply. To determine the total income for the household, add up all columns on the last row of this chart.

Income Sources	HH Mbr# 1	HH Mbr# 2	HH Mbr# 3	HH Mbr# 4	HH Mbr# 5	HH Mbr# 6
Unemployment Compensation (include regular unemployment, Pandemic Unemployment Assistance and Pandemic Emergency Unemployment Compensation) (exclude Federal Pandemic Unemployment Compensation)						
Wages, salary, overtime, hazard pay, commissions, fees, tips, bonuses (before payroll deductions)						
Net income from business and self-employment (include income from independent contractors, Gig economy jobs such as Etsy, Amazon, eBay, Uber, Lyft, Instacart, Grubhub, etc.)						
Interest, dividends, and other net income of any kind from real or personal property (include rental income)						
Social Security (include disability/Supplemental; include gross amount prior to any Medicare premiums)						
Retirement/Pension/Insurance policy/Annuities						
Disability or Death Benefits (disability compensation)						
Worker's Compensation and Severance pay						
Welfare Assistance Payments (Temporary Assistance to Needy Families)						
Regular Pay, special pay, and housing allowance for the Armed Forces (exclude military hazard pay)						
Veterans Administration (VA) Benefits (exclude deferred disability benefits)						
Adoption Assistance Payments (exclude amount in excess of $480)						
Alimony or Child Support (include only amounts expected)						
Re-occurring cash gifts from private/nonprofit/charity or friends/family who will not reside in the unit						
Other (please describe): _____						
Total for each HH Member						
Section A: Total Income for Household						

EQUAL HOUSING OPPORTUNITY

Section B - Income From Assets: Annual income includes income derived from assets to which household members have access. Interest or dividends earned are counted as income even when the earnings are reinvested. Using the categories below, report the (a) type of asset(s) held by each member of the household, (b) cash value of asset(s), and (c) the income derived from the assets **(report annual figures only)**. If the asset does not generate income, report zero. If the household member does not have assets, leave blank. Calculate the totals on the last row of this chart.

Household Member #	**Assets Categories:** Checking, Savings, Mutual funds, Money Market Acct. Equity in Rental Property, Retirement and Pensions, 401(K), Stocks, Bonds, Treasury Bills, Certificate of Deposit, Annuities, Revocable Trust, Mortgages or Deed of Trust, Whole Life Insurance policy, Lump sum- inheritance, Lottery Winnings, Insurance Settlements, Personal property held as an investment (e.g., antiques, gems, etc.)	Cash Value of Asset	Interest/Dividends Earned on the Assets
1			
2			
3			
4			
5			
6			
Household Member #	**Disposed Assets:** Assets given away for less than the fair market value in the last 24 months with value greater than $1,000, (e.g. sale of a home)	Cash Value of Disposed Asset	Income from Disposed Asset
		Box (B1) Total Value of Assets	**Box (B2)** Total Income from Assets

*****To be completed by Program Administrator*****	
If the amount in Box (B1) is greater than $5000, calculate the imputed value of the assets by multiplying Box (B1) by the Passbook Savings rate of (.06%)	**Box (B3) Value of Imputed Asset**
	$
Section B: Total Income from Assets (greater of box (B2) or (B3)	$
Total Household Annual Income (Sections A + B)	$

EQUAL HOUSING OPPORTUNITY

PART IV: APPLICANT CERTIFICATION

I certify under penalty of perjury that the above information is complete and accurate to the best of my knowledge. I understand that Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony and assistance can be terminated for knowingly and willingly making a false or fraudulent statement to a department of the United States Government. I agree to provide any additional documentation required by the program administer to document my/our household income.

HEAD OF HOUSEHOLD		
Signature	**Printed Name**	**Date**
OTHER ADULT HOUSEHOLD MEMBERS		
Signature	**Printed Name**	**Date**
Signature	**Printed Name**	**Date**
Signature	**Printed Name**	**Date**
Signature	**Printed Name**	**Date**
Signature	**Printed Name**	**Date**

POSADA
Bringing Pueblo Home

Coronavirus Pandemic Community Utility Assistance Program
No Duplication of Benefits Statement

The City of Pueblo, in partnership with Posada, offer Coronavirus Pandemic Community Utility Assistance Program for eligible Pueblo City residents. The program funded through CARES Act has a goal to assist Pueblo residents who were financially impacted by COVID-19 to maintain stable housing and remain self-sufficient following the support period. Funds that are distributed to participants, are only available to the participant on a one-time basis. Following initial assistance, no more assistance provided to the participant from the Coronavirus Pandemic Community Utility Assistance Program.

These funds are not to be provided to the participant in duplication to other utility assistance per Section 3 of the contract executed between Posada and the City of Pueblo which states:

"Applicant must disclose other local, state, and federal utility assistance received and agree to repay any utility assistance provided under the Utility Assistance Program if duplicate benefits are received"

By completing this form, the participant certifies that they have NOT received any utility assistance in duplication. The participant will be responsible for reimbursing Posada for any utility assistance received through the Coronavirus Pandemic Community Utility Assistance Program should there be any discovered duplication of benefits for utility assistance for the participant.

Check All that Apply:

☐ I have NOT received any utility assistance through CARES Act funding.

☐ I have received utility assistance through CARES Act funding. (If this box is checked, list ALL utility assistance provided, who the assistance was provided through and the date which the assistance was received)_____
_____
_____
_____

I, _____ (the participant), certify that my signature below is only valid until December 31, 2020 and I have the right the relinquish my signature to this agreement at any time.

_____
Participant Signature

_____
Date

EQUAL HOUSING OPPORTUNITY