For Official Use Only

Application Number: _____ Date/Time Application Received _____

Agency: _____ Service Provided: _____

Pasco County Community H.E.A.R.T.

Helping with Emergency Assistance Relief for Tenants

Application and Income Certification Form – 2021

Applicant Name: _____ Phone Number: _____

Address: _____ Email: _____

1. **HOUSEHOLD COMPOSITION, CHARACTERISTICS AND FAMILIAL STATUS:** As of today, list all members of the household. (Attached a separate sheet is needed.)

Household Member's Name	Relationship to Head of Household	Last 4 #s of SSN	Age	Sex M or F	Race (enter all that apply): White, Asian, Black/African American, Native American, Hispanic/Latino	Disabled Y or N	Veteran Status Active, Retired or N/A

2. **INCOME INFORMATION:** Annual family income is required to determine eligibility for public services funded with federal Consolidated Appropriation Act of 2021 money. Income is defined as the total gross income for of all family and non-family members 18+ years old living within the household. All sources of income must be counted from all persons in the household, to include, but is not limited to gross income from employment, net income from self-employment, rental income, interest and dividends, Social Security, annuities, retirement funds, pensions, unemployment benefits, disability benefits, TANF, public assistance, alimony, child support, cash assistance, etc. **Food Stamps are not considered income.**

A. Please check your Income Range based on your family size (for example, if there are 5 people in your household, go to Household of 5; if there are 8 or more in your household go to Household of 8):

	30 % AMI	50% AMI	80% AMI
Household of 1:	☐ $0 - $15,550	☐ $0 - $25,850	☐ $0 - $41,350
Household of 2:	☐ $0 - $17,750	☐ $0 - $29,550	☐ $0 - $47,250
Household of 3:	☐ $0 - $21,960	☐ $0 - $33,250	☐ $0 - $53,150
Household of 4:	☐ $0 - $26,500	☐ $0 - $36,900	☐ $0 - $59,050
Household of 5:	☐ $0 - $31,040	☐ $0 - $39,900	☐ $0 - $63,800
Household of 6:	☐ $0 - $35,580	☐ $0 - $42,850	☐ $0 - $68,500
Household of 7:	☐ $0 - $40,120	☐ $0 - $45,800	☐ $0 - $73,250
Household of 8:	☐ $0 - $44,660	☐ $0 - $48,750	☐ $0 - $77,950

B. INCOME INFORMATION: List all household members and their income. Proof of Income is required. (Attached a separate sheet is needed.)

Household Member's Name	Student Y or N	Source of Income (include employer name if employed)	Payment Basis: Weekly, Bi-Weekly, Monthly, Yearly	Amount

C. UNEMPLOYMENT STATUS: Complete for all household members that are unemployed.

Household Member's Name	Date Became Unemployed	Reason for Unemployment	Eligible for Unemployment Benefits Yes or No	Name & Telephone # of Former Employer

3. ASSISTANCE NEEDED: One or more household members are experiencing housing instability or risk of homelessness due to (check all that apply)

☐ Rent notice, or eviction notice for past due rent
☐ Unsafe or unhealthy living conditions
☐ Past due utilities
☐ Other risk _____

Describe how you have experienced financial hardship due to COVID-19.

Describe how you have experienced financial hardship due to COVID-19 continuation.

4. PROPERTY INFORMATION:

Landlord's Name: _____ Landlord's Telephone Number: _____

Landlord's E-mail: _____ Month(s) Due _____

Total Amount Due _____ Section 8 recipient - circle one: Yes or No ☐ ☐

5. APPLICANT'S CERTIFICATION: Initial each box

☐ I hereby certify that I am a resident of Pasco County, and I am either a US Citizen, permanent resident, or have been granted legal status.

☐ I hereby certify that I have not previously received assistance for the same services that I am seeking assistance for nor have I used CARES money for financial assistance on any of the bills that I am currently seeking assistance on.

☐ I hereby certify that the contact information provided on this application is the same as the contact information listed on the bill(s) for which I am requesting assistance.

☐ I hereby certify, under penalty of perjury, that all information submitted on this form is true and complete. I understand that providing false statements or information for the purpose of obtaining assistance is grounds for termination of housing assistance and is punishable under Chapter 817 of the Florida Statues as a first-degree misdemeanor.

☐ I hereby certify that I have experienced significant financial hardship directly related to, or caused by, COVID-19 on or after March 1st, 2020

6. APPLICANT'S AUTHORIZATION:

I authorize the above-named Subrecipient, Sponsor, State or Vendor to obtain information about me and my household that is pertinent to determining my eligibility for participation in the Program. I acknowledge that:

(1) A photocopy of this form is as valid as the original; AND
(2) I have the right to review information received using this form; AND
(3) I have the right to a copy of information provided to the Subrecipient and to request correction of any information I believe to be inaccurate; AND
(4) All adult household members will sign this form and cooperate with the Subrecipient in the eligibility verification process, AND
(5) If the applicant falsifies information to obtain assistance, all funds paid on behalf of the applicant must be repaid to the program.

We, the applicant and all other adult household member(s), understand that this Application and Income Certification may be subject to further verification by the agency and/or municipality providing services, and/or Pasco County. We therefore, authorize such verification, and we will provide supporting documents, if necessary. All adult household members will sign this form and cooperate with the Subrecipient in the eligibility verification process. The undersigned further understand(s) that providing false representations herein constitutes an act of fraud.

_____ _____
Signature of applicant Date

_____ _____
Signature of other adult household member Date

_____ _____
Signature of other adult household member Date

_____ _____
Signature of other adult household member Date

Items Needed to be Include with Application:

1. **Identification needed:**

- Driver's license for all household members 18 or older
- Birth Certificates, SS card, shot record, **or** school ID for all household members under 18,

2. **Proof of income needed (include all that apply):**

- 2020 Income Tax Return
- Wage Information (Form W-2 and/or 2 months of paystubs)
- Social Security or Disability (Form 1099-SSA)
- Pension/Retirement/Annuity Income (Form 1099R)
- Interest Income (Form 1099INT)
- Dividend Income (Form 1099DIV)
- Rental Income (Schedule E)
- Self-Employed Income (Schedule C)
- All other Miscellaneous Income

3. **Proof of Employment/Unemployment needed (include all that apply):**

- Notice from Unemployment
- Termination Letter
- Pay Stubs

4. **Rental Information needed:**

- Full copy of signed lease
- 3-Day Notice and/or Eviction Notice
- Rent Invoice (if applicable)

Pasco County Continuum of Care and Coalition for the Homeless of Pasco County, Inc.

RELEASE OF INFORMATION

Authorization to Use or Disclose Personal Information including Protected Health Information (PHI)

Head of Household Name:	HoH Social Security Number:	HoH Date of Birth:
Name of Provider Agency: OCN Connections		

I authorize the use or disclosure of personal information, including protected health information, about the individual named above.

I am: ☐ the individual named above
☐ a personal representative because the person is a minor, incapacitated, or deceased

OCN Connections participates in the Pasco County Continuum of Care (FL-519) Coordinated Entry System (CES) and/or the Pasco County Homeless Management Information System (HMIS). These systems include organizations that provide homeless and housing assistance and supportive services. As part of HMIS and the CES system, agencies agree to share information about individuals and families with other agencies in order to coordinate services and help a household find and/or keep housing as quickly as possible.

The information to be disclosed may include personal information contained within the Pasco County Homeless Management Information System (HMIS), records from providers detailing my medical conditions and including information on disabilities, mental health, drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection, AIDS, and other communicable disease test results and diagnoses. Information contained within the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT), the Service Prioritization Decision Assistance Tool (SPDAT), other assessment forms, and other information collected as part of case management, case planning and case conferencing will be shared in HMIS and as it relates to the coordination of services for housing placement and stability.

Important Rights and Other Required Statements You Should Know

You can revoke this authorization at any time by writing to the Coalition for the Homeless of Pasco County, Inc., 8039 Youth Lane, Port Richey, FL 34668 or by email request to info@pascohomelesscoalition.org. If you revoke this authorization, it will not apply to information that has already been used or disclosed.

You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to Coalition for the Homeless of Pasco County, Inc., 8039 Youth Lane, Port Richey, FL 34668 or by email request to info@pascohomelesscoalition.org.

If you have any questions about anything on this form, or how to fill it out, we can help. Please call the Coalition for the Homeless of Pasco County, Inc. at 727-842-8605.

This authorization will expire seven (7) years from the date this document was signed by the individual or personal representative below.

By signing this authorization, I am attesting that I understand: ***(Initial each line)***

_____The reason I am being asked to release information.

_____My protected health information, including, but not limited to, mental health, drug & alcohol, HIV/AIDS information can be shared with partner providers and HMIS participating organizations. I understand that agencies participating may change from time to time and that a copy of the current list of agencies is available upon request from the Coalition for the Homeless of Pasco County, Inc. at 727-842-8605.

_____The HMIS operates over the internet and uses many security protections to ensure the complete confidentiality of my records.

_____Signing this authorization is voluntary, and I do not have to agree to authorize any use or disclosure. I understand that the ability to receive services or support is not conditioned upon authorizing this disclosure. However, by not giving authorization to share information, I may not be able to access housing help as quickly as possible and that some services that result from a coordination of activities between providers may be limited in availability. Some agencies require certain questions to be answered in order to determine eligibility for their projects.*

_____The providers that have access to my protected health information are prohibited from re-disclosing information outside of the terms of his release of information form, without my written authorization except as permitted by federal or state law.

Signature_____Date (required) _____

All Dependent(s) that the Legal Guardian Authorizes to Participate in the HMIS:

Name_____DOB___/___/___Name_____DOB___/___/____

Name_____DOB___/___/___Name_____DOB___/___/____

Name_____DOB___/___/___Name_____DOB___/___/____

For All Additional Adult Members of the Household, please see Pages 3-5, if necessary.

Signature of Personal Representative (if applicable)

Signature_____Date (required) _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare and services. You may be asked to provide us with the relevant legal document giving you this authority.

Relationship to the individual (required): _____

Signature of Witness

Signature_____Date (required) _____

*Agencies may have additional requirements that must be agreed upon by the participant.

Additional Adult Member: Release of Information Consent

By signing this authorization, I am attesting that I understand: *(Initial each line)*

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Signature_____Date (required) _____

Date of Birth: _____Social Security Number: _____

Additional Adult Member: Release of Information Consent

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Signature_____Date (required) _____

Date of Birth: _____Social Security Number: _____

PASCO H.E.A.R.T. – Helping with Emergency Assistance Relief for Tenants
AFFIDAVIT OF DUPLICATION OF BENEFITS WITH RECIPIENT

This Agreement is entered into by and between OCN Connections [subrecipient] ("Partner") and _____ (list all adult household members) ("Recipient(s)").

Whereas, Recipient(s) is/are receiving US Department of the Treasury Emergency Rental Assistance funds through Pasco County's Helping with Emergency Assistance Relief for Tenants Program (H.E.A.R.T.) in the amount of $_____ ("Award") to provide funding to pay Rent and/or utilities for the property located at

_____

If Recipient(s) meet(s) all other qualifications associated with this application, the Partner will directly pay Recipient's landlord/utility provider funds on his/her/their behalf to serve as his/her/their rent and/or utility payment(s) for the period beginning _____ and ending _____("Rent/Utilities").

Now, therefore, the Partner has the right to recoup the Award in the event of a Duplication of Benefits upon the terms, conditions and contingencies herein set forth:

Federal Benefits and Charitable Donations
Recipient(s) agrees that if he/she/they receive(s) further federal benefits or charitable donations to pay the Rent/Utilities, the Recipient(s) will report receiving benefits by emailing OCNcares@gmail.com (Partner's e-mail address) or calling (727) 849 - 4724 (Partner's telephone number) within fourteen (14) days of receipt of additional proceeds and/or benefits. If Recipient(s) fails to report additional federal benefits or charitable donations, then the Partner may require the Recipient(s) to immediately repay the Award.

Duplication of Benefits
Recipient(s) agrees that if benefits received subsequent to the receipt of the Award are a duplication of benefits proceeds ("Subsequent DOB Proceeds") received from other sources such as federal benefits or charitable donations, that the following shall apply:

1. If the Recipient(s) has/have received the full amount of the Award, any Subsequent DOB Proceeds shall be repaid by Recipient(s) to the Partner up to the amount of the Award.
2. If no portion of the Award has been paid by the Partner to the Recipient(s), any Subsequent DOB Proceeds shall be paid by Recipient(s) to the Partner and used to reduce the Award. If the application of the Subsequent DOB Proceeds would reduce the Award to zero, all Subsequent DOB Proceeds and any funds previously paid by the Recipient(s) to the Partner shall be returned to the Recipient(s), and this Agreement shall terminate.
3. If some portion of the Award has been expended by the Partner to the Recipient, any Subsequent DOB Proceeds shall be used, retained and/or disbursed in the following order: (1) Subsequent DOB Proceeds shall first be paid by Recipient to the Partner to reduce the unexpended portion of the Award; (2) if the application of the Subsequent DOB Proceeds would reduce the unexpended Award to zero, any remaining Subsequent DOB Proceeds shall be applied to expended portion of the Award and retained by the Partner; (3) if the application of the Subsequent DOB Proceeds reduces both the unexpended and the expended portions of the Award to zero, any remaining Subsequent DOB Proceeds shall be returned to the Recipient(s), and this Agreement shall terminate.
4. If the Partner makes the determination that the Recipient(s) does not qualify to participate in the Program or the Recipient(s) decide(s) not to participate in the Program, the Subsequent DOB Proceeds and any funds previously paid by the Recipient(s) to the Partner that have not been used or obligated by the Program shall be returned to the Recipient(s), and this Agreement shall terminate.
5. Once the Partner has recovered an amount equal to the Award, the Partner will reassign to Recipient(s) any rights assigned to the Partner pursuant to this Agreement.

Income Eligibility
Recipient(s) certifies that he/she/they has/have provided complete, accurate, and current information regarding household income to demonstrate Recipient's eligibility to receive H.E.A.R.T. funds.

Chapter 817 of the Florida Statutes provides that willful false statements or misrepresentation concerning income and assets or liabilities relating to financial condition is a misdemeanor of the first degree and is punishable by fines and imprisonment provided under §775.082 or 775.083.

Recipient is hereby notified that intentionally or knowingly making a materially false or misleading written statement relating to the Award could result in ineligibility for benefits, action to recover any Award paid to or on behalf of Recipient, and/or a referral to criminal law enforcement.

Recipient represents that all statements and representations made by Recipient regarding household income has been and shall be true and correct.

Enforcement
The Recipient(s) and the Partner acknowledge that the Partner has the right and responsibility to enforce this Agreement. The Partner may assign its rights under this Agreement to Pasco County, such assignment shall give Pasco County the same rights as those provided to the Partner in this Agreement.

IN WITNESS WHEREOF, the undersigned recipient(s) has/have affixed his/her signature(s) and seal(s) this _____ day of_____, 2021.

_____
Recipient's Signature

_____
Recipient's Signature

_____
Recipient's Signature

_____
Recipient's Signature

_____
Recipient's Signature

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

PASCO H.E.A.R.T. – Helping with Emergency Assistance Relief for Tenants
AFFIDAVIT OF DUPLICATION OF BENEFITS WITH RECIPIENT

This Agreement is entered into by and between OCN Connections [insert name of sub-recipient] ("Partner") and _____ (landlord) ("Recipient").

Whereas, Recipient is receiving US Department of the Treasury Emergency Rental Assistance funds through Pasco County Helping with Emergency Assistance Relief for Tenants Program (H.E.A.R.T.) in the amount of $_____ ("Award") to provide funding to pay Rent for the property located at: _____

_____

If _____("Tenant(s)") meet(s) all other qualifications associated with this application, the Partner will directly pay Recipient funds on Tenant's behalf to serve as his/her/their rent for the period beginning _____ and ending _____ ("Rent").

Now, therefore, the Partner has an option to recoup the Award in the event of a Duplication of Benefits upon the terms, conditions and contingencies herein set forth:

Federal Benefits and Charitable Donations
Recipient agrees that if he/she/they receive(s) further federal benefits or charitable donations to pay the Rent, the Recipient will report receiving benefits by emailing OCNCares@gmail.com (Partner's email address) or calling (727) 849 - 4724 (Partner's telephone number) within fourteen (14) days of receipt of additional proceeds and/or benefits. If Recipient fails to report additional federal benefits or charitable donations, then Partner may require the Recipient to immediately repay the Award.

Duplication of Benefits
Recipient agrees that if benefits received subsequent to the receipt of the Award are a duplication of benefits proceeds ("Subsequent DOB Proceeds") received from other sources such as federal benefits or charitable donations, that the following shall apply:

1. If the Recipient has received the full amount of the Award, any Subsequent DOB Proceeds shall be repaid by Recipient to the Partner up to the amount of the Subsequent DOB Proceeds.
2. If some portion of the Award has been expended by the Partner to the Recipient, any Subsequent DOB Proceeds shall be used, retained and/or disbursed in the following order: (1) Subsequent DOB Proceeds shall first be paid by Recipient to the Partner to reduce the unexpended portion of the Award; (2) if the application of the Subsequent DOB Proceeds would reduce the unexpended Award to zero, any remaining Subsequent DOB Proceeds shall be applied to expended portion of the Award and retained by the Partner; (3) if the application of the Subsequent DOB Proceeds reduces both the unexpended and the expended portions of the Award to zero, any remaining Subsequent DOB Proceeds shall be returned to the Recipient(s), and this Agreement shall terminate.

Enforcement
The Recipient and the Partner acknowledge that the Partner has the right and responsibility to enforce this Agreement. The Partner may assign its rights under this Agreement to Pasco County, such assignment shall give Pasco County the same rights as those provided to the Partner in this Agreement.

IN WITNESS WHEREOF, the undersigned Recipient has affixed his/her signature and seal this ___ day of _____ _____, 2021.

_____
Landlord Recipient

Pasco County Community H.E.A.R.T

Helping with Emergency Assistance Relief for Tenants

Agency Name: OCN Connections

RENTAL ASSISTANCE AUTHORIZATION INVOICE

Landlord Information	**Client Information**
*Check payable to: _____	Tenant Name: _____
Address: _____	Address: _____
_____	_____
Telephone: _____	Telephone: _____

Payee Signature: _____ Date: _____

Printed Name: _____

Landlord Federal ID# OR SS #: _____

Please note this information must match information on the W-9.

Please write in amount due for each month!

Month: _____	Month: _____	Month: _____
Monthly Amount: $_____	Monthly Amount: $_____	Monthly Amount: $_____
Month: _____	Month: _____	Month: _____
Monthly Amount: $_____	Monthly Amount: $_____	Monthly Amount: $_____

Add additional months as needed

DO NOT FILL IN: FOR ADMIN PURPOSES ONLY

Total Amount Approved $_____