



**APPLICATION for
FAMILY HOMELESSNESS PREVENTION PROGRAM (FHP)**

Section 1: Technical Eligibility

Head of Household Information

Name (Last, First, MI)		Social Security #	Birth Date	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (circle one) White African American African American & White Asian Asian & White			
Vet Status <input type="checkbox"/> Yes <input type="checkbox"/> No	Native Hawaiian/Pacific Islander American Indian/Alaskan Native American Indian/Alaskan Native & White American Indian/Alaskan Native & African American Other Multi-Racial			
Current Address: Number, Street, Apt. or Lot Number		City	State	Zip code
Mailing Address (if different)		City	State	Zip code
Home Phone	Cell Phone		Email address	
Family or Friend Contact: Name/Phone #				

Household Members Information List the additional household members of the FHP-assisted housing unit.

#	Legal Name (Last, First, MI)	Relationship	Social Security #	Birth Date	Birthplace: Country	Vet? Y/N	Gender
2							<input type="checkbox"/> M <input type="checkbox"/> F
3							<input type="checkbox"/> M <input type="checkbox"/> F
4							<input type="checkbox"/> M <input type="checkbox"/> F
5							<input type="checkbox"/> M <input type="checkbox"/> F
6							<input type="checkbox"/> M <input type="checkbox"/> F
7							<input type="checkbox"/> M <input type="checkbox"/> F

Section 2: Income Eligibility

Does anyone in the household expect to receive any income from the following sources within the next 12 months? If yes, list name of household member(s) receiving the income.

Yes	No	Income Source	Yes	No	Income Source
<input type="checkbox"/>	<input type="checkbox"/>	Wages or Salary from a Job, including Day Labor or Sick leave or vacation pay Name(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	Social Security / SSI, Retirement funds, Insurance policies, Pension, Veterans Benefits Name(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	Self Employment, Contracted Employment, or Work for friends or relatives, including selling cans or newspapers, etc. Name(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation, Worker's Compensation Name(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	Armed Forces Income Name(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	Dividend Income Name(s): _____

<input type="checkbox"/>	<input type="checkbox"/>	Regular contributions or gifts (monetary or not) from friends or relatives not living with you. Name(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	Welfare Assistance, including TANF or HHS Financial Assistance, etc. Name(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	Income from Rental of Room, Real Estate or Business Property Name(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	Other (Please specify):
<input type="checkbox"/>	<input type="checkbox"/>	Alimony or Child Support (Any payment within the last 90 days?) Name(s): _____ For which children: _____ _____			

Does anyone in the household have a bank account, safety deposit box, trust fund, equity in rental property or other capital investments, stocks, bonds, retirement, inheritance, or whole life insurance? Yes No

Does anyone in the household own property? Yes No

Has anyone in the household transferred any assets in the last 90 days? Yes No

If Yes, asset type: _____ and date of transfer: _____

FHP RECEIPT OF APPLICATION & APPLICANT CERTIFICATION

This is to verify that I am applying for assistance through the FHP program. I understand that applying does not guarantee I will receive assistance, and that the eligibility determination is a process that could take up to 4-6 weeks. I understand that my Case Manager will notify me once a decision has been made on my application. **I will notify my Case Manager if there are any changes in my contact information.**

Giving True and Complete Information

I certify that all the information provided on the FHP application, including household composition, income, and assets, is accurate and complete to the best of my knowledge. I have reviewed the application form and declaration forms and certify that the information shown is true and correct.

Cooperation

I know I am required to cooperate in supplying all information needed to determine my eligibility, level of benefits, or verify my true circumstances. Cooperation includes attending pre-scheduled meetings and completing and signing needed forms. I realize that I could be asked to provide further documentation in order to help determine my eligibility, and I will provide any requested information in a timely fashion. I understand failure or refusal to do so will result in delays or denial of assistance.

Follow Up

I understand that approval of FHP services involves participation in follow up surveys at 3 months and 6 months after exit from the program. I agree to participate, and **I prefer to be contacted by (circle one):** mail email phone

Signature of Head of Household

Social Security Number

Date