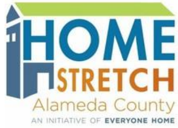


HOME STRETCH
HOUSING ASSISTANCE FUND APPLICATION

Purpose of Fund

The Home Stretch Housing Assistance Fund, managed by Alameda County Health Care Services Agency, provides financial assistance for costs related to accessing housing. To be eligible, applicants must be enrolled in Medi-Cal in Alameda County **and** currently experiencing homelessness, at-risk of homelessness, or have experienced homelessness in the past 24 months; or be identified as a frequent user of multiple systems by Alameda County Care Connect.

The applicant must be working with an agency that serves households experiencing homelessness or at risk of homelessness in Alameda County.

Eligible applicants may apply for financial assistance for the following:

There are three categories of eligible uses. In order for a funding request to be approved, there must be rationale explaining why the funding is necessary and how it will impact the applicant's housing stability.

Rental Assistance	Move In Assistance – Approximately $1,000-$4,000 per household	Safety and Accessibility
Eligible expenses: Security deposit and 1st month's rent only. The Fund does not pay back rent to avoid eviction.	*Eligible expenses:* Utility start-up costs, housing application fees, essential home furnishings, household items such as food preparation items and bed/bath linens, and non-emergency, non-medical transport such as a moving company. See "Approved Home Furnishings and Household Items" checklist. Please note that luxury items will not be purchased and items must be reasonably priced.	*Eligible expenses:* Needed items and services to make the home safe and accessible: medically necessary items such as hospital beds and Hoyer lifts; unit modifications to meet accessibility needs such as ramps and grab bars; pest control; hoarding clean up.
Up to of $8,000 per household per year based on need		Up to of $8,000 per household per year based on need

Instructions for Applicants and Service Providers:

1. Please carefully read the Home Stretch Housing Assistance Fund policy and the Home Stretch Housing Assistance Fund application before beginning this application. Please call the Home Stretch Housing Assistance Fund office at 1 (510) 567-8030 prior to completing the application if you are unsure that an applicant meets eligibility criteria or if an expense can be covered.

2. The application should be completed jointly by the eligible service provider and the applicant or their parent/ guardian.

3. Please complete the entire application form on the following pages. Questions in this application refer to the applicant unless otherwise specified. Do not skip any applicable sections. If the section does say "if applicable," it must be completed for every application.

4. Legible handwritten forms are accepted, but typed forms are preferred.

5. All applications must include applicant information, applicant's documentation for eligibility, service provider information, HMIS forms, the housing lease, and general information.

6. Fax the fully completed application and eligibility documentation to Home Stretch Housing Assistance Fund at 1 (877) 489-4642 or send by *secure* e-mail to HomeStretchFund@acgov.org. Please only use e-mail that is secure according to federal and state privacy standards.

Please use this checklist to ensure all of the necessary application materials are received:

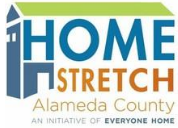
- ☐ Fully Completed Home Stretch Housing Assistance Fund Application.
- ☐ Signed HMIS Release of Information.
- ☐ Completed HMIS Client Profile Form (or a dated print out, marked "updated" and signed by provider)
- ☐ Completed HMIS Intake Form (or a dated print out, marked "updated" and signed by provider)
- ☐ Copy of applicant's lease or rental agreement.
- ☐ Approved Home Furnishings and Household Items checklist for home furnishing and household items.
- ☐ Copy of utility bill with account number information for utility startup costs.
- ☐ Verification of medical necessity from a medical professional for requests for unit modifications or medical equipment. For medical equipment, verification that the applicant has attempted to obtain the items using their health insurance is also necessary.
- ☐ Business Vendor Add/Update Form if the application requests security deposit or rent payment, or a new vendor is being used for unit modifications, moving services or safety and accessibility requests.
- ☐ Verification of housing authority inspection, if applicable.

The HCSA finance department requires *an invoice AND W-9 form* in order to process approved payments to landlords/property managers and other new vendors. ***These two (2) documents cannot be faxed; the originals must be mailed*** *to the HCSA Housing Solutions for Health office:*

HCSA Home Stretch Housing Assistance Fund
1900 Embarcadero, STE 206
Oakland, CA 94606

- ☐ Fully completed invoice
- ☐ W-9 form with signature (may be scanned or DocuSign)

Contact Information: HomeStretchFund@acgov.org or (510) 567-8030.



HOME STRETCH
HOUSING ASSISTANCE FUND APPLICATION

SERVICE PROVIDER INFORMATION

Name of Referring Service Provider: ______________________________
(First, Middle, Last, Suffix)

Name of Referring Service Agency: ______________________________

Name of Referring Service Program: ______________________________

Service Provider Phone Number: ______________________________

Service Provider E-mail Address: ______________________________

Service Provider Address: ______________________________
(Number, Street, City, Zip Code)

____

APPLICANT INFORMATION

Name of Applicant: ______________________________
(First, Middle, Last, Suffix)

If the applicant is a child, name of parent/guardian: ______________________________
(First, Middle, Last, Suffix)

Social Security #: ____________________ Applicant's Date of Birth: ____________________

Applicant's Current Address, (if applicable): ______________________________

____
(Number, Street, City, Zip Code)

Applicant's Phone Number: ____________________ Applicant's E-mail Address: ____________________

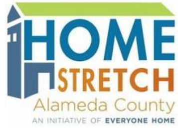
Is the applicant currently homeless or have they been homelessness in the last 24 months? Yes ☐ No ☐

Is the applicant at risk of homelessness? Yes ☐ No ☐

Is this applicant the head of household? Yes ☐ No ☐

Is the applicant currently enrolled in Medi-Cal in Alameda County? Yes ☐ No ☐

An Alameda County HMIS Release of Information, HMIS Client Profile form, and HMIS Intake Form must be attached to this application in order for the application to be complete. If this information is already in HMIS and is up-to-date, you may print these pages and write "updated" with the date the information was verified and the provider's signature.



Home Stretch

Housing Assistance Fund Application

Housing History

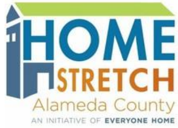
Current and planned future living situation after receiving assistance. Please check **ONE** box for **CURRENT** and **ONE** box for **PLANNED**:

Current	Planned	Living Situation*	Current	Planned	Living Situation
		Place not meant for habitation			Permanent housing (other than RRH) for formerly homeless persons
		Emergency shelter including hotel/motel paid for with voucher			Rental by client, no ongoing housing subsidy
		Safe Haven			Rental by client, with VASH subsidy
		Interim Housing			Rental by client, with GDP TIP subsidy
		Foster care home or foster care group home			Rental by client with other housing subsidy (including RRH)
		Hospital or other residential non-psychiatric medical facility			Residential project or halfway house with no homeless criteria
		Jail, prison or juvenile detention center			Staying or living in a family member's room, apartment or house
		Long-term care facility or nursing home			Staying or living in a friend's room, apartment or house
		Psychiatric hospital or other psychiatric facility			Transitional housing for homeless persons
		Substance Use Treatment Facility or Detox			Client doesn't know
		Hotel or motel paid for without emergency shelter voucher			Client Refused
		Owned by client, no ongoing housing subsidy			Other:

** A list of definitions for these living situations is available. If you are not sure of the correct response, please contact the Home Stretch Office.*

Housing History and Housing Plan Information

1) Please briefly describe the applicant's homelessness history. 2)The Home Stretch Housing Assistance Fund is meant to be one time and have a lasting impact. Please describe the applicant's plan to maintain this housing moving forward. Are there any additional resources or supports that are needed? Please add pages if needed.



Home Stretch
Housing Assistance Fund Application

Rental/Housing Information

Please include a copy of the lease with the application.

What size is the applicant's current/proposed unit? ________ How many people will live there? ________

What is the total rent the client will pay? ________

What is the total rent for the unit: ________

Is there a housing subsidy like Section 8, VASH, Shelter + Care, if so which one? ________

Has the unit passed a housing authority inspection? Yes ☐ No ☐
If yes, please include a copy of the inspection report with the application.

Does the applicant have a bank account? Yes ☐ No ☐

Does the applicant or their parent/guardian have a payee that manages their money? Yes ☐ No ☐

If yes, who is their payee: ________

Housing Utility Costs – if applicable

Please include a copy of the utility bill with the applicant's account number.

What is the amount owed? ________

Is the applicant required to pay a deposit in order to establish service? If so, how much? ________

What is the total amount requested? ________

In order to increase affordability of utility costs associated with PG&E, please learn more about the CARE or FERA programs. You can visit this link www.pge.com/care or call 1-866-743-2273 for more information.

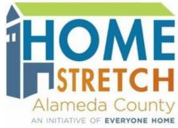
Home Furnishings and Household Items – if applicable

Please enclose a completed Approved Home Furnishings and Household Items checklist.

What is the estimated total cost of all items requested? $________

List address where the items should be delivered: ________

____
(Number, Street, City, Zip Code)



HOME STRETCH
HOUSING ASSISTANCE FUND APPLICATION

UNIT MODIFICATIONS AND MEDICAL EQUIPMENT – IF APPLICABLE

Please enclose verification of medical necessity from a medical professional, as well as verification that the applicant attempted to obtain any requested medical equipment through their health insurance.

Are you requesting any unit modifications? If so, what modifications are needed? ______________________________

____

____

____

Verification of need must be provided for anything listed in this section.

What is the estimated cost of the unit modifications? ______________________________

Has the landlord agreed to the unit modifications? Yes ☐ No ☐

Are you requesting medical equipment? If so, what is needed? ______________________________

____

Verification of need as well as verification of an attempt to obtain the requested equipment utilizing health insurance must be included.

What is the estimated cost of the equipment?______________________________

Address where the items should be delivered:______________________________

____

(Number, Street, City, Zip Code)

OTHER ALLOWABLE EXPENSES – MOVING SERVICE – IF APPLICABLE

For Other Allowable Expenses (i.e. Moving Service; Pest Control, etc.):

Please keep in mind that the amount of funding needed must be determined in advance. This means that a moving service with rates based on mileage is not an allowable expense.

Please write an explanation of what is needed: ______________________________

____

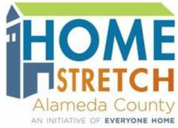
____

____

____

____

What is estimated cost? ______________________________



HOME STRETCH
HOUSING ASSISTANCE FUND APPLICATION

HOME STRETCH HOUSING ASSISTANCE FUND REQUEST SUMMARY

For the funds requested, check all that apply and place the estimated dollar amount(s) next to each expense. If no funding is requested for a specific line, please write "$0." The individual amounts should add up to the total amount of funds requested.

Rental Assistance:

Move-in Expense – first month's rent, tenant's portion Amount = $____________________

Move-in Expense – security deposit Amount = $____________________

Total Requested: Total Amount = $____________________

Move In Assistance:

Utility Start-Up Costs Amount = $____________________

Estimated Home Furnishings & Household Items Amount = $____________________

Estimated Moving Services Amount = $____________________

Estimated Total Requested: Total Amount = $____________________

Safety and Accessibility:

Medically Necessary Items (such as a hospital bed) Amount = $____________________

Unit Modifications Amount = $____________________

Pest Control Amount = $____________________

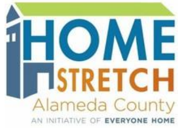
Estimated Total Requested: Total Amount = $____________________

All payments are made to eligible third parties. The HCSA finance department requires *a signed, original invoice AND original W-9 form* in order to process approved payments to landlords/property managers and other new vendors.

These two (2) documents cannot be faxed; the originals must be mailed *to the HCSA Housing Solutions for Health office:*

HCSA Home Stretch Housing Assistance Fund
1900 Embarcadero, STE 206
Oakland, CA 94606

If you have questions, please contact us at: HomeStretchFund@acgov.org or (510) 567-8030.



HOME STRETCH
HOUSING ASSISTANCE FUND APPLICATION

HOME STRETCH HOUSING ASSISTANCE FUND AGREEMENT

I have requested assistance from the Home Stretch Housing Assistance Fund to help me access housing or stay housed. I understand that I have certain obligations that come with receiving this assistance.

- ✓ I agree to complete the application with my service provider and to provide accurate and truthful information.
- ✓ I agree to work with my service provider and others in my support system on my housing plan.
- ✓ I understand that staff of the Fund may follow up with my service provider or me within 13 months from the date I receive assistance to get updates on my housing situation.

I have read, understood and accepted the above agreement and verify my application contains truthful and accurate information.

Applicant Signature: ______________________________ Date: ______________________

Print Name of Applicant: ____

As the service provider working with this applicant, I agree to support the applicant in working on his/her housing plan. I understand that the Home Stretch Office will contact me at six and twelve months from the date of support regarding the applicant's living situation.

Service Provider Signature: __________________________ Date: ______________________

Print Name of Service Provider: ____

FOR HOME STRETCH PROGRAM USE ONLY – DO NOT WRITE BELOW

Client ID (HMIS) #: ____________ Provider Agency/Program: ______________________________

Application incomplete Application approved Application rejected (reason):

Reviewer's Signature: __________________________ Date: ____________________________

Notes:

____

____

____

____