Model District Application for Shelter Allowance Supplement

Local District: Orange

Contact Person: Mary Fish

Telephone: 845-291-4358

Implementation Date: 1/1/04

Amount of Supplement (for example:Household Size, Shelter Maximum, Supplement Amount):

$100.00 per month above rent schedule for a certified homeless household with 4+ children in the TA grant. Everyone in the household must be a TA recipient to be eligible for the supplement.

Type of Cases Covered by Supplement/Targeted Population:
(List eligibility criteria and how determined and documented including the following:)

1. How much will non-legally responsible Non-Temporary Assistance (NTA) individuals residing in the same dwelling be required to contribute towards the excess shelter costs? (e.g., a prorata share of shelter costs, 30 percent of income, the lesser of these two variables, etc.) NTA households will not eligible.
Will SSI recipients or ineligible aliens residing in the household be expected to contribute towards rent cost? Households with SSI or aliens will not be eligible for the supplement.
If so, how will this amount be determined? ______

2. How will contributions towards rent cost from individuals outside the household be verified and what standards will be applied in determining whether such contributions can be sustained in the future? Statements from the individual as verified in initial eligibility.
How will the agency assure that third party contributors are not legally responsible relatives? by ongoing documentation/statements.

3. Will it be required that there be a court proceeding concerning the nonpayment of shelter cost prior to the family being determined eligible for supplemental shelter payments? no *
If not, how will the district assure that the shelter arrears are legitimate and the responsibility of the TA recipient? will require 30 day notice from landlord.

4. How will co-tenant of record lease arrangements be handled? These households will not be eligible.
Will leases be required of all tenants of record? no

5. Will shelter arrears for shelter supplementation cases be limited in monetary amount (e.g., $3,000) or to six months of arrears? yes $100.00 above rent schedule for 6 months.

* threat of eviction and certified homelessness

6. How will the district handle modifications (e.g., moves, rent increases, etc)? evaluate case by case basis. What standards will be followed in determining whether supplementation will continue following a move? evaluate on case by case basis.
Will the district require the recipient of the supplemental shelter allowance to report changes related to the supplemental allowance timely as a condition of eligibility for the allowance? yes

7. Will any local forms be used to facilitate the supplementation process? yes
If so, copies must be provided with the plan.

8. Will there be any health and safety standards adhered to prior to paying supplemental allowances or arrears? As is current - CO is required within county's cities - contracted agency worker will evaluate for rest of county.

9. Will the supplemental allowance be time limited in any way? yes - 6 months

10. Will the supplementation process include a onetime incentive payment to the landlord? no

11. Districts that already have existing rent supplement programs that are not court ordered (such as the Human Resource Administration's Employment Incentive Housing Program and the Department of Homeless Service's Long Term Stayer's Rent Supplement Program) should consolidate all existing rent supplementation programs into one uniform submission. Explain how this is being done: N/A

12. How will the district ensure that the existence of the supplement does not adversely affect the ability of non-TA recipient families (i.e. low income working families) to find and retain affordable housing? The $100.00 supplement added to allowable is still below market value in Orange County.

Length of Time Supplement Offered to Individual Cases:
(e.g. 3 months, indefinitely)

Maximum 6 months

Estimate of Annual Cost (Show all calculations):

Gross	Federal	State	Local
$18,000	$9,000	$4,500	$4,500

15 cases per month @ $100 = $1,500 per month x 12 = $18,000

Purpose/Justification:
(Provide relevant statistics)

Based on current statistics, we estimate 15 families per month reside in temporary housing that would meet the supplemental criteria.

Additional Information:

CERTIFICATION OF HOMELESSNESS FORM

NAME OF REFERRING AGENCY: ______________________________________

Based on information available to this agency, the individual (s) named below is a homeless person or family who is undomiciled or living in a temporary shelter in accordance with Public Assistance Source Book for Regulations, New York State Department of Social Services (83 AM/DM-47) Section X111-D-3.1, dated 4/1/84.

______________________________	______________________________
Name of person making referral	**Signature**
______________________________	______________________________
Title	**Date**
______________________________	______________________________
Name of Head of Household	**Name of Spouse/co-head**

Current Address: ____

The address above is: ☐ Friends/relatives ☐ Shelter ☐ Vehicle ☐ Hotel/Motel ☐ Other ______________________________

Mailing Address: ____

Telephone # where you can be contacted ______________________________

Number of Household member (s) ______ **Number of minors in household** ______

Date homelessness began _______

Explain circumstances leading to homelessness:

____

____

Appropriate supporting documentation proving the above must be attached to this form.
<u>Form cannot be accepted without documentation</u>

Previous addresses: ____

____

Income $ __________ ☐ **monthly** ☐ **weekly** **Source of income** __________________

Are you disabled (Y / N) **Elderly (Y / N)** **Victim of Domestic Violence (Y / N)**

______________________	________	______________________	________
Signature-Head of Household	**Date**	**Signature-spouse/co-head**	**Date**

I/we certify that the information given on this form is accurate and complete to the best of my knowledge and belief. I/we understand that false statements or information are punishable under Federal law. I/we also understand that false statements are grounds for termination of my housing assistance.

SHELTER ALLOWANCE SUPPLEMENT

CASE NAME: ______________________________

CASE NUMBER: ______________________________

ADDRESS: ______________________________

HOUSEHOLD COMPOSITION:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

REASON FOR SUPPLEMENT:

____
____
____
____
____
____
____
____
____

CURRENT INSPECTION/EVALUATION ☐ **YES** ☐ **NO**

ACTUAL SHELTER: ______________________

SHELTER ALLOWANCE: ***Without Supplement*** __________ ***With Supplement*** __________

TOTAL GRANT: ***Without Supplement*** __________ ***With Supplement*** __________

EFFECTIVE DATES: ______________________________

______________________________ ______________

Examiner's Signature ***Date***

Office Manager Approval ______________________________ ***Date*** __________

Shelter Supplement (10/03)