Rent Assessments must include the following prior to emailing CAO

- ✓ Household Assessment Application
- ✓ IDs for everyone 18 and older
- ✓ Verification of Income for all adults 18 and older of the household: for the full past 30 days or for the past full 12 months prior to the application date is needed.
    - Income Self Attestation may be used *(ONLY if verification of income is not available)*
- ✓ Household Eligibility Self-Certification Form
- ✓ Grievance Procedure ROI
- ✓ Landlord ROI
- ✓ Written nonpayment of rent notice from landlord
- ✓ Copy of a signed rental lease/contract

No nonpayment Notice:

- An amount *must* be due: Verify amount owed using ledger or tenant portal snapshot.
- All adults in the household *must* be on the rental contract/lease.
- Address *must* be Inside Urban Growth Boundary https://gis.oregonmetro.gov/metromap/

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Assessment Date: _____

Eviction Prevention Assessment

Assessor Contact Information

Name: _____

Partner Agency Name: _____

Phone: _____ Email: _____

Client Information		
1	Do you live in Washington County?	☐ Yes ☐ No
2	Is your name on the rental lease?	☐ Yes ☐ No
3	Are all the adult members in the household named on the rental lease?	☐ Yes ☐ No
4	Do you have an Eviction Notice for Nonpayment of rent?	☐ Yes ☐ No
5	When does your lease end?	
6	Do you live in subsidized housing?	☐ Yes ☐ No
7	How long have you lived at current address? Choose an option	
8	History of Literal Homelessness (street/shelter/transitional housing) Choose an option	
9	In the past three years how many times have you and your family been housed and then homeless again?	
10	Are you doubled up, living with someone temporarily?	☐ Yes ☐ No
11	Domestic violence victim/survivor?	☐ Yes ☐ No
12	If *yes f*or Domestic violence victim/survivor, when did experience occurred Choose an option	
13	If *yes* for Domestic Violence victim/survivor, are you currently fleeing?	☐ Yes ☐ No
14	Have you ever been evicted?	☐ Yes ☐ No
15	Number of evictions in the last 5 years	

Client Address

Client Full Name _____

Address _____Apt. #_____

City _____ Zip _____

Phone Number _____ Email Address _____

Landlord Information

Landlord Name _____

Address _____Apt. #_____

City _____ Zip _____

Phone Number _____ Email Address _____

Prevention Assistance Information					
16	Total monthly rent		17	Total amount owed	
18	Which months are currently owed?				
19	Reason for assistance *(Check all that apply)*:	☐ Lost Job ☐ Lost Job due to COVID-19 ☐ Lost roommate ☐ Lost roommate due to COVID-19 ☐ Medical ☐ Medical due to COVID-19		☐ New to area ☐ No income ☐ No income due to COVID-19 ☐ Unaffordable housing ☐ Wages/hours cut ☐ Wages/hours cut due to COVID-19	
	☐ Benefits cut/lost ☐ Benefits cut/lost due to COVID-19 ☐ Crime victim ☐ Divorce/family break up ☐ Family Emergency ☐ Family Emergency due to COVID-19				
20	Household size:				
21	Gross monthly household income	$			
22	Is family income under 50% Median Family Income?	☐ Yes ☐ No			
23	Is anyone in the household a US Military Veteran?	☐ Yes ☐ No			

Family Members Last Name, First Name, M.I.	Relationship to Head of Household (HOH)	Gender^	DOB	SSN	Race* & Ethnicity**	Primary Language	Disability Documented		Disability Type^^	Active Military?	
							Yes	No		Yes	No
	SELF						☐	☐		☐	☐
							☐	☐		☐	☐
							☐	☐		☐	☐
							☐	☐		☐	☐
							☐	☐		☐	☐
							☐	☐		☐	☐

***Race Key:** **N =** American Indian/Alaska Native, **P =** Native Hawaiian/Pacific Islander, **W =** White, **A** = Asian, **B** = Black/African American, **O** = Other

**** Ethnicity Key:** **H =** Hispanic/Latino

^Gender Key: F = Female**, M =** Male**, NB =** Non-binary, **TRANS =** Transgender**, Q =** Questioning, **DK =** Client doesn't know. **CR =** Client refused

^^Disability Types: Alcohol abuse, drug abuse, both alcohol and drug abuse, developmental, HIV/AIDS, mental health problem, physical, chronic health condition, hearing impaired, vision impaired, other

Educational Information		
Highest grade completed by everyone in household:		
Name	**Grade Level**	**Enrolled in school**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Income Sources		**$ Amount**	**Who?**
Supplemental Security Income (SSI)	☐ Yes ☐ No	$	
Social Security Disability Income (SSDI)	☐ Yes ☐ No	$	
Social Security	☐ Yes ☐ No	$	
General Public Assistance	☐ Yes ☐ No	$	
Temporary Aid to Needy Families (TANF)	☐ Yes ☐ No	$	
Veterans Benefits	☐ Yes ☐ No	$	
Employment Income	☐ Yes ☐ No	$	
Child Support	☐ Yes ☐ No	$	
Farm work (Nursery, etc.)	☐ Yes ☐ No	$	
Unemployment Benefits	☐ Yes ☐ No	$	
No Financial Resources- 0 income	☐ Yes ☐ No	$	
Other:	☐ Yes ☐ No	$	
Non-Cash Benefits			
TANF Transportation Services	☐ Yes ☐ No		
TANF Child Care Services (**ERDC**)	☐ Yes ☐ No		
Food Stamps (**SNAP**)	☐ Yes ☐ No	$	
Special Supplemental Nutrition Program (**WIC**)	☐ Yes ☐ No		
Other TANF - Funded services	☐ Yes ☐ No		
Other source	☐ Yes ☐ No		

Employment and Financial Information (fill for adults ONLY)	
HH Member Name	Work Status*

*** Acceptable work statuses:** Employed part-time, employed full-time, migrant seasonal farm worker, unemployed (short term, 6 months or less), unemployed (long term, more than 6 months), unemployed (not in labor force), retired.

Health Summary		
Name	Covered by health insurance?	Health Insurance Type*
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
***Health insurance types =** MEDICAID, MEDICARE, State Children's Health Insurance Program, Employer – Provided Health Care Insurance, State Health Insurance for adults, Veteran's Administration (VA) Medical Services, Health Insurance obtained through COBRA, Private Pay Health Insurance		
24	Is head of household pregnant?	☐ Yes ☐ No
25	Due date if pregnant:	

Date: _____ Client Signature: _____

Date: _____ Assessor Signature: _____

COMMUNITY ACTION DISCLAIMER

I understand that the information on this application will be used to determine and verify my eligibility for services. Under penalty of perjury, I affirm that to the best of my knowledge, all of the information that I have provided is complete and correct. I understand that I am under criminal penalty prosecution if false information results in assistance for which I am not eligible, and my family may not be eligible for further services. I hereby authorize the release of all personal information and records, financial or otherwise collected from this application to Community Action and its agents. My signature also gives consent for Community Action Organization to share information related to my application with my utility company(s), landlord, school district, and Oregon Health and Human Services as appropriate. I declare that any funds received by me will be used solely for the purpose intended.

Client Signature: _____ **Date** _____

COMMUNITY ACTION RELEASE OF INFORMATION FOR SERVICE POINT

Notice of Use:

Community Action provides services through a variety of funding sources, which may include government grants, public funds, or grants from private foundations. Community Action is required to collect and report on certain information to account for how these funds are used. In addition, this information may aid the effort to increase assistance by demonstrating how many individuals and families in the area need services.

The information you have provided will be entered into a database and used to provide statistical information about services provided to persons at risk of homelessness in Washington County and the metropolitan area.

Your identifying information will be kept confidential: it will only be seen by persons employed by or volunteering with Community Action, organizations providing funding for this service and persons administering or auditing the data system.

_____ _____

Client signature **Date**

_____ _____

Client signature **Date**

_____ _____

Staff Signature **Date**

Household Eligibility/Self-Certification Form

Washington County

(this form MUST be attached to every emergency rent assessment)

To be eligible for SHS, or ORE-DAP household must be eligible under the following criteria, please check all that apply:

One or more household members can demonstrate risk of homelessness or housing instability and must be below 50% Area median Income. Following examples provided by County:

- ☐ i. Has received a written eviction notice from their landlord for non-payment
- ☐ ii. Has a first appearance scheduled in eviction court
- ☐ iii. Is currently in a stipulated agreement with their landlord and is unable to comply
- ☐ iv. Has a history of housing instability and/or homelessness documented in HMIS
- ☐ v. Has been referred by a culturally specific organization, is an immigrant or refugee household, or speaks English as a second language
- ☐ vi. Has received a no-cause eviction notice and meets criteria iv or v above
- ☐ vii. Is living in unsafe/unhealthy housing and meets criteria iv or v above
- ☐ viii. Fleeing Domestic violence
- ☐ ix. Other—please describe:

CERTIFICATION

By my penned or electronic signature, I certify under penalty of perjury that the foregoing is true and correct. (If applicant is unable to pen or electronically sign, all applicable below must be identified)

Applicant Signature and Printed name: _____ / Date: _____

Interviewer Signature: _____ / Date: _____

If the applicant is unable to immediately sign this certification all applicable below *must* be checked.

□ ***I do not have the technology needed***

□ ***I have a disability that will not allow me to sign***

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Release and Exchange of Confidential Information

I (We _____, hereby authorize Community Action staff to contact and discuss any and all information pertinent to my family's plan with the following individual or agency:

Property Owner / Landlord:

_____

Address:

_____

_____

Phone: _____ Email: _____

To Provide Information to: Housing Assistance

Of: Community Action
1001 SW Baseline St
Hillsboro, OR 97123

Fax: (503) 648-4175
Phone: (503) 648-6646

Include Records of:

Family History	☐ Yes	☐ No	☒ Not Requested
Employment/Unemployment	☐ Yes	☐ No	☒ Not Requested
Housing	☒ Yes	☐ No	☐ Not Requested
Alcohol/Drug Treatment	☐ Yes	☐ No	☒ Not Requested
Criminal History	☐ Yes	☐ No	☒ Not Requested
Mental Health Services	☐ Yes	☐ No	☒ Not Requested
Medical/Dental Records Other	☐ Yes	☐ No	☒ Not Requested
(Specify) _____	☐ Yes	☐ No	☒ Not Requested

I understand that all information concerning my family will be treated as confidential and that information will only be shared if it is pertinent to the case and/or is deemed necessary for the benefit of my family or the program. This release expires 1 year after date signed.
I recognize that the information disclosed may contain information that is protected by Federal and State law, and I specifically consent to disclosure of such information.

_____ _____
Client/Guardian Signature Date

_____ _____
Client/Guardian Signature Date

_____ _____
Community Action Staff Date

_____ _____
Community Action Staff Date

Non-Discrimination and Client Appeals

Policy and Procedure

Family & Community Resources

1. Non-Discrimination Policy:

Community Action is committed to fair, respectful and unbiased treatment of participants in our services and programs. Community Action does not discriminate on the basis of age, race, color, national origin, religion, gender, familial status, disability, marital status, source of income, sexual orientation, gender identity, veteran/military status, or toward survivors of domestic violence.

2. Client Appeals Process:

If I have an issue regarding a staff person, eligibility determination, program plan, program services, or termination from a Community Action program, I understand that I have a right to appeal any decision made and agree to follow these steps:

1. If a program participant is unable to resolve an issue directly with the appropriate staff person involving how they have been treated, eligibility determination, a program plan, program services, or termination from a program, she or he may contact the Program Manager, Wendy Polanco, at wpolanco@caowash.org or (503) 648 – 6646, orally or in writing, within 30 days.
2. If the program participant is not satisfied that their issue has been resolved, she or he may file their concern in oral or written form with the Director of Family & Community Resources at the Community Action address provided below within 10 days.
3. The Department Director will respond to the participant in writing within 10 business days, providing details on action(s) to be taken, if necessary, to resolve the issue.
4. If the program participant is still not satisfied that their issue has been resolved, she or he may appeal to the Community Action Executive Director in writing within 10 days, describing their remaining concern and the action requested. The Executive Director will issue a final written decision.

Participant	Date
Participant	Date
Family Advocate	Date

Zoila Coppiano
(503)693-3284
zcoppiano@caowash.org
Community Action 1001
SW Baseline Street
Hillsboro OR 97123

09/29/2022

EQUAL HOUSING OPPORTUNITY

If you have a fair housing question, or to report a fair housing complaint, please call (503) 223-8197 Ext. 2 or (800) 424-3247 Ext. 2 (translation available), or HUD at (800) 877-0246.