PLEASE RETURN THIS PACKET WITH YOUR SUPPORTING DOCUMENTATION.

EMAILED DOCUMENTS, CELL PHONE PHOTOS AND SCREENSHOTS ARE NOT ACCEPTED. The front desk can make copies of original documents if you drop your packet off in person.

FAXES ARE ACCEPTED FROM LANDLORDS, EMPLOYERS, AND UTILITY COMPANIES ONLY.

PLEASE ALLOW UP TO 2 WEEKS FOR YOUR APPLICATION TO BE PROCESSED ONCE WE RECEIVE ALL REQUIRED DOCUMENTATION.

▼ ▼ ▼

See frequently asked questions in your "keep at home" packet for more information.

BRADFORD COUNTY HUMAN SERVICES
HOUSING PROGRAM
CONSENT FOR OBTAINING CONFIDENTIAL INFORMATION

I, _____ hereby authorize
NAME OF CLIENT OR PERSON AUTHORIZED TO CONSENT FOR CLIENT

Bradford County Housing Program to provide and receive information to/from:

X	Main Link HAP Program	_____	Grace Connection
_____	The Bridge	_____	Salvation Army
_____	MH/ID	_____	Northern Tier Counseling
_____	Allied Services	_____	Endless Mountains Mission Center
X	TREHAB	_____	Bradford County Housing Authority

Please list names / companies →

X	Landlord (name & #):	_____
X	Other: Utility Companies:	_____
_____	Other:	_____

This specific reason for this request is: *Verification of information needed to provide housing support.*
The information to be obtained will be limited to: *Verification of income, housing barriers/needs/preferences information, verification of tenancy, verification of eligibility for funding, and other information as needed*
I fully understand the nature of this consent and that this authorization shall remain effective for one year from the date of my signature; however, I may revoke this authorization at any time by written, dated communication to the Administrator or his/her designee.
I hereby release the Bradford County Housing Program and said person or facility from all legal responsibility and liability for acting upon this authorization, and I intend to be legally bound hereby.

*

_____ _____
DATE SIGNATURE OF CLIENT OR PERSON AUTHORIZED TO CONSENT FOR CLIENT

_____ _____
DATE SIGNATURE OF STAFF MEMBER OBTAINING CONSENT

To be completed if client is physically unable to provide a signature but has indicated verbally or behaviorally, that he/she consents to obtaining information.

We affirm that, _____ was physically unable to provide a signature, understands the nature of the consent and freely gave his/her verbal or behavioral consent. This authorization shall remain effective from this date to _____ (60 days hence); however this may be revoked by verbal or behavioral communication to the Administrator or his/her designee.

_____ _____
DATE WITNESS

_____ _____
DATE WITNESS

SELF-DECLARATION OF INCOME

Applicant Name: _____

This is to certify the income status for the above named individual. Income includes but is not limited to:

- The full amount of gross income earned before taxes and deductions.
- The net income earned from the operation of a business, i.e., total revenue minus business operating expenses. This also includes any withdrawals of cash from the business or profession for your personal use.
- Monthly interest and dividend income credited to an applicant's bank account and available for use.
- The monthly payment amount received from Social Security, annuities, retirement funds, pensions, disability and other similar types of periodic payments.
- Any monthly payments in lieu of earnings, such as unemployment, disability compensation, SSI, SSDI, and worker's compensation.
- Monthly income from government agencies excluding amounts designated for shelter, and utilities, WIC, food stamps, and childcare.
- Alimony, child support and foster care payments received from organizations or from persons not residing in the dwelling.
- All basic pay, special day and allowances of a member of the Armed Forces excluding special pay for exposure to hostile fire.

Check only one box and complete only that section

☐ I certify, under penalty of perjury, that I currently receive the following income:

Source: _____ Amount: _____ Frequency: _____
Source: _____ Amount: _____ Frequency: _____
Source: _____ Amount: _____ Frequency: _____

Applicant Signature: _____ Date: _____

☐ I certify, under penalty of perjury, that I do not have any income from any source at this time.

Applicant Signature: _____ Date: _____

I understand that third-party verification is the preferred method of certifying income for assistance. I understand self declaration is only permitted when I have attempted to but cannot obtain third party verification.

Documentation of attempt made for third-party verification:

_____
_____
_____

Staff Signature: _____ Date: _____

This form does not replace proof of income for PHARE.

INTAKE PERSON _____ DATE _____CLIENT TRACK ID #_____

BRADFORD COUNTY HUMAN SERVICES - HOUSING ASSISTANCE APPLICATION

NAME: _____

ADDRESS: _____

_____

PLEASE COMPLETE NEXT SECTION FOR YOURSELF AND ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN – ATTACH ADDITIONAL PAGES IF NEEDED

EMAIL: _____PHONE:_____

Name	DOB	Age	Soc. Security #	Relationship	Gender*	Race**	Ethnicity***
				SELF			

*Gender: Male, Female, Non-binary, Other

**Race: American Indian/Alaska Native; Asian; Black/African American; Native Hawaiian/Pacific Islander; White; Other; Unknown/Declined * **Ethnicity: Hispanic; Non-Hispanic; Unknown/Declined

REASON FOR REQUEST:_____

Check all that you are asking for help with		Amount	Landord/Utility Information
	RENT	$	
	SECURITY DEPOSIT	$	
	FUEL	$	
	ELECTRIC	$	
	GAS	$	
	WATER	$	
	EMERGENCY SHELTER	# of days	

DOES THE FAMILY HAVE ALTERNATE HEAT SOURCES? Yes or No If so, list sources (kerosene, wood stove, etc.)_____

Do you receive any subsidy to help pay your rent from another source (Section 8, Housing Choice Voucher, etc.)? YES / NO If so, what is the amount you are responsible for? $_____

****PLEASE PROVIDE A COPY OF BOTH YOUR LANDLORD LEASE AND HUD LEASE****

Have you receive any help with rent and/or utilities from any of the following in the past 2 years?

Program Name	YES / NO	Amount
Main Link or Futures HAP Program		
Grace Connection		
The Bridge		
Endless Mountain Mission Center		

BUDGET WORKSHEET:

MONTHLY INCOME FOR HOUSEHOLD:

$ _____ EMPLOYMENT
$ _____ FOOD STAMPS/CASH ASSISTANCE
$ _____ CHILD SUPPORT
$ _____ SSI/SSD/RSDI/ETC
OTHER
$ _____ (PLEASE DESCRIBE)

AMOUNT OF MONTHLY HOUSEHOLD EXPENSES:

_____ RENT/MORTGAGE
_____ ELECTRIC
_____ GROCERIES
_____ PHONE
_____ CABLE/SATELLITE

(PLEASE LIST EXPENSES)

_____ LOANS
_____ CAR PAYMENT/INSURANCE
_____ GAS (HEATING/COOKING)
_____ WATER/SEWER
_____ DAY CARE

AMOUNT OF ANY UNPAID UTILITY BILLS: $ _____

DOES THE FAMILY HAVE THE MEANS TO PAY THE BILL IN THE FUTURE? (PLEASE EXPAIN):

_____

_____

AMOUNT OF FUNDING AVAILABLE FROM OTHER AGENCY: $ _____

WHAT AGENCY? _____ $ _____

_____ $ _____

By my signature below, I attest that all statements and documents associated and submitted with my application for rental and/or utility assistance are true and accurate. I also understand that any falsification or misrepresentation of the facts constitutes fraud and is punishable by both criminal and civil penalties.

_____ _____

Applicant Date

_____ _____

Applicant Date

_____ _____

Witness Date

ERAP 2 UTILITY ASSISTANCE VERIFICATION FORM

Tenant Name(s): _____

Please choose ONE of the following:

☐ I am requesting assistance with the following utilities for any authorized months (unpaid arrears plus future only). Please provide copies of bills for all utilities you are requesting assistance with. It will be your responsibility to provide us with a copy of the original bill (front and back) for all future bills. We must have the billing detail (photo copy, fax, or pdf version) and cannot accept cell phone photos or emailed summaries.

Utility Type	Name of Company	Account Number	Total amount of arrears (if none, write 0)
ELECTRIC			
Propane/Natural Gas			
Fuel Oil			
Water			
Sewer			
Garbage (no bag stickers)			
Wood/Wood Pellets			
Other:			
Other:			

OR

☐ By checking this box, I am confirming that I do not wish to receive assistance with my utility bills at this time. If I change my mind at a later date, I understand that no arrears will be paid that date prior to my first month of authorized ERAP 2.

Tenant Signature: _____ Date: _____

BRADFORD COUNTY HUMAN SERVICES

HOUSING ASSISTANCE LETTER OF CIRCUMSTANCE

PLEASE WRITE A BRIEF SUMMARY EXPLAINING HOW YOU AND YOUR HOUSEHOLD HAVE BEEN FINANCIALLY AFFECTED BY **OR DURING** COVID-19 ... PLEASE USE AS MUCH DETAIL AS POSSIBLE.

Please select "YES" or "NO" from the following options:

	YES	NO
Are you currently experiencing or have you recently experienced a decrease in income or increase in expenses?		
If yes, was the hardship due to COVID?		
Are you at risk of housing instability or homelessness?		

If any of the above answers are "YES," please provide proof (examples may include but are not limited to: unpaid medical bills not covered by insurance, eviction notice, past due utility bills, proof of missed work, etc.)

All adults in household must sign below:

CLIENT_____ DATE_____

CLIENT_____ DATE_____

PLEASE SEND VERIFICATION TO SUPPORT YOUR STATEMENT ABOVE.

BRADFORD COUNTY HUMAN SERVICES
HOUSING PROGRAM
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is being provided to acknowledge your receipt of our **Notice of Privacy Practices**.

What is the Notice of Privacy Practices?

The **Notice of Privacy Practices** explains how your patient health information may be used or disclosed by us. In addition, it explains your rights with regard to your patient health information, as well as our legal responsibilities.

Acknowledgement of Receipt

By signing below, you are acknowledging that the Notice of Privacy Practices has been provided to you,

I, _____ (client's name)

residing at _____

(client's address) have received the Notice of Privacy Practices from Bradford County Human Services, Housing Department.

_____ _____

Signature Date

Attestation/Certification
I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf. I certify that all information that has been entered is true under penalty of perjury. I understand that the information entered in this application will be kept confidential and used only to administer benefits. I understand that I may be required to work with other agencies as a condition of my approval for assistance. I agree to provide upon request any additional documentation required (i.e. pay stub, lease, recent bills, proof of unemployment etc) to aid in determining eligibility.
Signature - Tenant
Name Printed - Tenant
Signature - Landlord *(only if form was completed by landlord)*
Name Printed - Landlord *(only if form was completed by landlord)*

Notice of Your Right to Appeal

You have the right to request a hearing to appeal a decision if you believe it is unfair or incorrect.

Step 1.

Contact the Bradford County Human Services, Housing Specialist, 220 Main St. Unit 1, Towanda, PA 18848. Telephone # 570-265-1760.

If you still disagree or feel you have been discriminated against, you may request a hearing with the Fair Housing Officer: Megan Johnson, 301 Main St. Towanda, PA 18848

Rights and Responsibilities

RIGHT TO NONDISCRIMINATION

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Additionally, program information may be made available in languages other than English.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS):

(1) mail: U.S. Department of Health and Human Services (HHS)
HHS Director, Office for Civil Rights, Room 515-F
200 Independence Avenue, S.W.
Washington, D.C. 20201; or

(2) call: (202) 619-0403 (Voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to decide which programs you may be eligible for. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine, not exceeding one hundred ($100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 483).

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct and complete information. You must help in proving the information, you give. Benefits may be denied if you fail to provide certain proof. If you are contacted by Department of Human Services (DHS) or the Office of State Inspector General, you must fully cooperate with those persons or investigators.

PRIVACY ACT STATEMENT

The collection of this information, including the Social Security number (SSN) of each household member, is authorized under 42 U.S.C. § 405(c)(2)(C)(I-iv) and 62 P.S. § 432.2(b)(3).

The information will be used to determine whether your household is eligible or continues to be eligible to participate in the Emergency Rental Assistance Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. Failure to provide an SSN may result in the denial of Emergency Rental Assistance to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members. If someone wants help getting an SSN:

(1) call: 1-800-772-1213 or 1-800-325-0778 (TTY); or

(2) visit: www.ssa.gov.

RIGHT TO APPEAL

You have the right to ask for a DHS hearing to appeal a decision if you believe it is unfair or incorrect, or if the provider fails to act on your application for benefits. You may file the appeal at:

DHS Office of Hearings and Appeals
PO Box 2675
Harrisburg, PA 17105.

If you appeal, you may also request a conference before the hearing by contacting the Emergency Rental Assistance Program (ERAP) program manager via email at: RA-PWERAPOIM@pa.gov.

At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

Authorization for Release of Information *(Tenant only)*

I hereby authorize and request the disclosure to the county office any information concerning the age, residence, citizenship, employment, income, and any additional information involving eligibility for the rental and utility assistance programs for myself. It is understood that the information obtained will only be used for determination of rental/utility assistance or other housing assistance programs.

Signature of Tenant	Date

Name Printed - Tenant

Landlord Completes

Bradford County Human Services
Housing Assistance Landlord Certification form

Landlord Completes

CONFIRMATION OF TENANCY

Complete for ALL tenants	
	Date:
	Tenant Name(s):
	Address of Rental Unit:
	Date Rent is Due Each Month:
	Amount of One Month's Rent: $
	Please indicate which utilities are included in the rent:
	Please indicate which utilities are NOT included in the rent:
	Does the tenant receive Section 8 or a housing choice voucher subsidy? YES / NO If yes, what is the amount that the TENANT is responsible for paying? $_____

NEW TENANTS (Please skip to next section for existing tenants)

NEW tenants	
	Security Deposit Amount: $_____ Move in Date: _____ (This is the date the tenant will have access to the rental unit with our guarantee of payment) Amount of First Month's rent: $_____

CONFIRMATION OF PAST DUE RENT (Please complete for existing tenants)

EXISTING tenants	
	Total amount of arrears NOT including late fees (if none, write 0): $
	Total amount of late fees owed (NOTE: You agree to accept this amount as late fees): $
	****IMPORTANT***** ***Please attach a detailed statement that shows what amount of arrears is owed by month.*** **Rent arrears must be listed separately from late fees.**

LANDLORD CERTIFICATION

Landlord's name (please print):
Landlord's mailing address:
Landlord's phone number:
Landlord's email (optional):
I agree to accept ERAP, PHARE, or other program funds toward the payment of this rent. Payment will be received directly from the Bradford County Human Services Office. Payment will guarantee residency for an additional 30 days after the final month's payment. In the event of a lump sum payment, landlord agrees not to evict for at least 30 days after the latest month paid in the lump sum. I further acknowledge that I do not expect to receive any additional funding for this tenant's rent from any source. Should I evict sooner for reasons other than non-payment of rent, I will return the unused portion of the rent to: Bradford County Human Services, Housing, 220 Main Street Unit 1, Towanda, PA 18848. Failure to return unused funds or any overpayments may result in civil or criminal penalties as allowed by law. **LANDLORD SIGNATURE:** _____ **Date:** _____

PLEASE **ATTACH COMPLETED AND SIGNED W-9**

Send with ... landlord

Landlord's Info:

Form **W-9**
(Rev. January 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

☐ Exempt payee

☐ Other (see instructions) ▶

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

City, state, and ZIP code

Requester's name and address (optional)
Bradford Co. Human Services
220 Main St., Unit 1
Towanda, PA 18848

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 the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

☐☐☐ - ☐☐ - ☐☐☐☐

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).

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 on page 4.

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

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

PLEASE KEEP THESE AT HOME

CLIENT COPY
Please keep for future reference

Bradford County Human Services – Housing

FREQUENTLY ASKED QUESTIONS

Q: I've filed my housing assistance application, now what can I expect?

A: The next step is for the housing specialist to review your application to ensure all required documentation is present. This process can take 1 – 5 business days. If there is documentation missing, you will be notified by mail.

Q: How long does it take for an application to be approved?

A: Once all required documentation has been received, it can take up to 2 weeks for your application to receive final approval.

Q: How will I know if my application was approved?

A: You will receive written notice within 7 – 10 days of final processing by our accounting office. Updates are not provided via phone. If there is an eviction or shut off notice, we will contact your landlord or utility company directly to advise them of the outcome of your application once it is processed.

Q: I have an eviction or shut off notice. Will my application be processed in time to prevent this from happening?

A: While we make every attempt to process applications as quickly as possible, we cannot guarantee that every application will be processed in time to prevent an eviction filing or utility shut off from occurring. You can help expedite your application by providing all required documents as soon as possible after you complete an application for assistance.

Q: What documentation do you need to process my application?

A: At the time of your application, you should be prepared to provide the following: photo ID for all adults, social security cards or equivalent for all household members, including children, proof of income for the past 30 days (pay stubs, etc.), a copy of your lease or rental agreement if you have one, and copies of all utility bills. Additional documentation will be required, depending on the grant you are applying for.

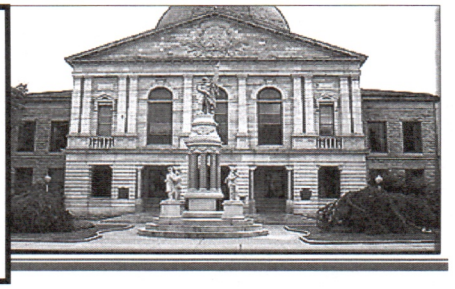
Q: Who do I contact if I have any questions later?

A: You can call housing at 570-265-1760, or email bchousing@bradfordco.org. Please be patient. Someone will respond by the end of the next business day. Please do not leave more than one voice mail, as this will only delay our ability to respond.

Q: What are your hours of operation?

A: Bradford County Human Services is open Monday through Friday 8 a.m. to 4:30 p.m. We are closed for all major holidays.

Bradford & Sullivan County
Mental Health/Intellectual Disabilities/Autism
Early Intervention
220 Main St. Unit #1
Towanda, PA 18848
570-265-1760 Fax: 570-265-8541
bchousing@bradfordco.org



DOCUMENTATION CHECKLIST FOR HOUSING ASSISTANCE APPLICATIONS

PLEASE PROVIDE COPIES OF THE FOLLOWING DOCUMENTS AT THE TIME YOU DROP OFF YOUR APPLICATION. DO NOT FAX OR EMAIL THE REQUESTED DOCUMENTS.

- ☐ Photo ID for all adults
- ☐ Social Security Card or acceptable alternative for all household members including children
- ☐ Proof of SNAP eligibility
- ☐ Proof of Income (see separate sheet for acceptable proof of income)
- ☐ Lease/Renters Agreement (preferred but can waive under some circumstances)
- ☐ Completed and signed letter of circumstance (attached)
- ☐ Documents to support letter of circumstance
- ☐ Completed and signed release of information (attached)
- ☐ Complete the missing information and/or signatures on application (attached)
- ☐ Eviction or Shut off Notice
- ☐ Proof of Bradford County residency
- ☐ Copies of all utility bills
- ☐ Tenant Utility Certification Form
- ☐ W-9 from landlord
- ☐ Completed and signed Landlord Certification

Documents must be clear and legible.
WE CANNOT ACCEPT CELL PHONE PHOTOS OR SCREENSHOTS.

Requested documents may be dropped off along with your completed application at our office located at 220 Main Street, Unit 1 (upstairs), Towanda or mailed to:

BRADFORD COUNTY HUMAN SERVICES
ATTN: HOUSING
220 MAIN STREET, UNIT 1
TOWANDA, PA 18848

PLEASE ALLOW UP TO 14 DAYS FOR YOUR APPLICATION TO BE PROCESSED ONCE WE RECEIVE ALL NECESSARY DOCUMENTATION FROM ALL PARTIES.

If you have any questions, please call (570) 265-1760 during normal business hours.

Rev. 4/19/2022/mes

PROOF OF INCOME

** Other Income form provided by counselor

TYPES OF INCOME	ACCEPTABLE PROOF
Cash Gifts and Contributions	Use other income form provided by counselor
Child/Spousal Support	Court Award letter, domestic relations printout
Department of Public Welfare (TANF)	Benefits letter, Notice to Applicant Letter
Foster Care	Statement from Social Services
Insurance Proceeds	NOT considered income
Military Pay	Only if household has access to person's wages
Pension	Copy of check & stub or letter from pension board
Recent loss of ANY type of income	Follow No Income Guidelines
Rent paid by HUD	NOT considered income
Rental Income	Lease or notarized statement
Reverse Mortgage Income	NOT considered income
Room and Board income	Use Other Income form provided by counselor
Salary/Wages	1. Paystubs to cover last 30 day period 2. Newly employed (less than 30 days) *must have at least 1 pay stub *must recertify within 3 months
Self Employed	Current Tax Return Documentation • i.e. Form 1040 and Schedule C
SSI, SS, SSD or Veteran's Benefits	Letter for Social Security Administration Copy of check or direct deposit statement
Student Loans	NOT considered income
"Under the Table"	Use Other Income form provided by counselor
Unemployment	Letter of Determination
Utility Allowances	NOT considered income
Work Study	NOT considered income
Workers Compensation	Statement from Workers Compensation
	If none of the above is available, acceptable proof is Self-Declaration of Income

Please do not fax this page back (Client keeps)

FY 2022 Income Limits Summary

Selecting any of the buttons labeled "Click for More Detail" will display detailed calculation steps for each of the various parameters.

FY 2022 Income Limit Area	Median Family Income	FY 2022 Income Limit Category	Persons in Family							
	Click for More Detail		1	2	3	4	5	6	7	8
Bradford County, PA	$71,500	Very Low (50%) Income Limits ($) Click for More Detail	25,550	29,200	32,850	**36,450**	39,400	42,300	45,200	48,150
		Extremely Low Income Limits ($)* Click for More Detail	15,300	18,310	23,030	**27,750**	32,470	37,190	41,910	46,630
		Low (80%) Income Limits ($) Click for More Detail	40,850	46,650	52,500	**58,300**	63,000	67,650	72,300	77,000

For ERAP applications only, proof of income is not required if the household has a verified open SNAP case.

Please do not return this with application.

CLIENT COPY

Attachment A

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully

.BRADFORD COUNTY HUMAN SERVICES – INTELLECTUAL DISABILITIES PROGRAM HAS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

All employees, volunteers, staff, doctors, health professionals and other personnel are legally required to and must abide by the policies set forth in this notice to protect the privacy of your health information.

This protected health information, or PHI for short, includes information that can be used to identify you. We collect or receive this information about your past, present, or future health condition to provide health care to you, or to receive payment for this health care.

We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose (release) your PHI. With some health exceptions, we may not use or release any more of our PHI than is necessary to accomplish the need for information. We must abide by the terms of the notice of privacy practices currently in effect.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the PHI already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy of this notice from the contact person listed at the end of this notice any time.

WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION for many different reasons. The Commonwealth of Pennsylvania provides a broad range of services through a wide variety of health and human services programs. If you receive services from a Commonwealth program, the Commonwealth program may use your protected health information and disclose it to other Commonwealth health and human services programs and outside the Commonwealth. For some of these reasons we will need your permission for a specific signed authorization. Below, we describe the different categories of when we use and release your PHI, give you some examples of each category and tell you when we need your permission.

WE MAY USE, OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. YOUR CONSENT IS NOT REQUIRED FOR THESE PURPOSES.

For Treatment. We may release your PHI to physicians, nurses, medical students, and other health care personnel and agencies and business associates who provide or are involved in your health care. For example, if you are being treated by one program, which sees a need for other services, we may release your PHI to other county departments/programs in order to coordinate your care.

To obtain payment for treatment. We may use and release your PHI in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date PHI. For example, we may release portions of you PHI with our billing department and you health plan to get paid for the health care services we provided to you. We may also release your PHI to our business associates, such as billing companies, claims processing companies and others.

To run our health care business. We may release your PHI in order to operate our facility in compliance with healthcare regulations. For example, we may use your PHI to review the quality of our services and to evaluate the performance of our staff in caring for you.

WE ALSO DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PHI.

When federal, state or local law, judicial or administrative proceedings, or law enforcement agencies request your Protected Health Information.

We release your protected health.information only when a law requires that we report information to government agencies or law enforcement personnel. For example, we would notify the appropriate authorities about victims of child abuse, or neglect. We would also notify Law Enforcement officials about the following: for notification and identification purposes when a crime has occurred; in missing person cases, or when ordered in a judicial or administrative proceeding.

For public health activities. We report information about births, deaths, and various diseases to government officials in charge of collecting that information and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

For purposes of organ donation. For patients that have previously agreed to organ donation, we may notify organ procurement to assist them in organ, eye or tissue donation and transplants.

To avoid harm. In order to avoid a serious threat to health or safety of a person or the public, we may provide your demographic PHI to law enforcement personnel or persons able to prevent or lessen such harm.

For worker's compensation purposes. We may release you PHI in order to comply with worker's compensation laws. If you do not want worker's compensation notified, alternate insurance or payment information must be supplied.

For appointment reminders and health-related benefits and services. We may use you demographic PHI to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

For fundraising activities. We may use your demographic PHI to communicate with you to raise funds for our healthcare system. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

For health oversight activities. We may use PHI and may disclosed PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for oversight of the health

CLIENT COPY

Attachment A

care system, government benefit programs, or entities subject to government regulation or civil rights laws.

YOU HAVE THE OPPORTUNITY TO AGREE TO OR OBJECT TO THE FOLLOWING:

1. Patient Directories. We may include your name, location in our facility, and your general condition in our patient directory, to direct visitors who ask for you by name. We may also include your religious affiliation for use by clergy, unless you object in whole or in part. Your choice to object may be made at any time.

2. Information shared with family, friends, or others. We may release your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. Your choice to object may be made at any time. You will be notified if one of the persons asks to access your PHI.

YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORAMTION NOT INCLUDED ABOVE. We will ask for your written authorization before using or releasing any of your PHI except as previously stated, or in an emergency situation. If you choose to sign an authorization to release your PHI, you may later cancel that authorization in writing. This will stop any futures release of your PHI for the purposes your previously authorized.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the right to request limits on how we use and release your PHI. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit PHI that we are legally required or allowed to release.

You have the right to choose how we communicate PHI to you. All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for, example, email instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed onto you for payment.

You have the right to see and get copies of your PHI.

You must make the request in writing. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you in writing why we denied your request. You have the right to have the denial reviewed. We will choose a licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your first request. You can request a summary or a copy of the entire medical record as long as you agree to the cost in advance. If your request to see the medical information is approved, we will arrange this in accordance with established hospital policy. Please submit all requests for this information to the supports coordinator.

You have the right to get a list of instances of when and to whom we have disclosed your PHI. This list will not include uses you have already authorized, or those for treatment payment or operations. This list will not include uses made for national security purposes, to corrections or law enforcement personnel, if you were in custody, or disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list we will provide will include the last six years of activity unless you request a shorter time. The list will include dates when your PHI was released and why, with whom your PHI was released (including their address if known), and a description of the information released. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame. Please submit all requests for this information to the Director of the INTELLECTUAL DISABILITIES Program.

You have the right to correct or update your PHI. If you believe there was a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If we deny your request, our written denial will state our reasons and explain your right to file a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all futures uses or releases of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change or amendment to your PHI. Please submit all requests for amendments to the supports coordinator.

You have the right to get this privacy notice by email.

Even if you agreed to receive notice by email, you also have the right to request a paper copy of this notice.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below or with the Secretary of the DHHS:

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:

Director, INTELLECTUAL DISABILITIES Program
(570) 265-1760 You will not be penalized for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on June 11, 2003.

Tenant Keeps

NOTICE OF YOUR RIGHT TO APPEAL

You have the right to request a hearing to appeal a decision if you believe it is unfair or incorrect.

Step 1 - Request an information review by contacting:

Bradford County Human Services
Attn: Housing
220 Main Street, Unit 1
Towanda, PA 18848
(570) 265-1760

If you still disagree or feel you have been discriminated against, you may request a hearing with the fair housing officer. This request must be in writing, and may be sent to:

Bradford County Fair Housing Officer
Megan Johnson
301 Main Street
Towanda, PA 18848

If you still disagree, you have the right to ask for a DHS hearing to appeal a decision if you believe it was unfair or incorrect. You may file an appeal at:

DHS Office of Hearings and Appeals
PO Box 2675
Harrisburg, PA 17105

If you appeal, you may also request a conference before the hearing by contacting the ERAP program manager via email at: ra-pwerapoim@pa.gov.

At the hearing you may represent yourself, or someone else, such as a lawyer, friend, or relative may represent you.