



WHAT'S NEXT?

Here are some things you can do to help us in making timely decisions on the large volume of applications we receive.

- Please do not contact us about your application. If we need more information from you, we will contact you in writing.
- If we have already asked you for more information, please send it right away or bring all requested information with you to your appointment, if one has been scheduled. We cannot complete your application until we receive the requested documents.
- Please do not send cell phone photos or screen shots of documents or requested information. We cannot accept them.
- You and your landlord will receive a notice in the mail once your application has been processed.
- We encourage you to utilize the other supports on the list included with your application packet in order to prevent an eviction or utility disconnection from occurring.

HAVE YOU INCLUDED THE FOLLOWING WITH YOUR APPLICATION?

- PHOTO ID FOR ANYONE AGES 18 AND OLDER (MUST BE FOR CURRENT RESIDENCE)
- SOCIAL SECURITY CARDS FOR ANYONE AGES 18 AND OLDER
- SOCIAL SECURITY CARDS OR ACCEPTABLE ALTERNATIVE FOR CHILDREN UNDER AGE 18
- PROOF OF INCOME FOR THE PAST 30 DAYS
- PROOF OF A DECREASE IN INCOME OR INCREASE IN EXPENSES OCCURING IN THE PAST 6 MONTHS
- ALL UTILITY BILLS FOR ANY BALANCE OR UTILITY YOU ARE REQUESTING HELP WITH (OR A DETAILED STATEMENT OF ARREARS FROM YOUR UTILITY COMPANY. STATEMENTS MUST INCLUDE AMOUNT OWED FOR EACH MONTH THAT YOU OWE ARREARS FOR.
- LANDLORD CERTIFICATION COMPLETED AND SIGNED BY THE LANDLORD
- DETAILED STATEMENT OF ARREARS FORM FROM THE LANDLORD, IF ARREARS ARE OWED
- W-9 FROM THE LANDLORD (THEY MAY FAX THIS FORM TO OUR OFFICE DIRECTLY IF PREFERRED)
- LEASE OR RENTAL AGREEMENT

If you are re-applying after having previously received ERAP assistance, please ALSO provide the following:

- Certificate of completion for the "Become a Great Tenant in Bradford County Course" found at: www.bradfordcountypa.org/housing, and
- Proof of progress made towards stabilizing your housing situation since you last applied

IMPORTANT! IF YOU DO NOT HAVE AN INCOME, OR IF YOUR RENT IS HIGHER THAN YOUR INCOME CAN AFFORD TO PAY, THEN AN APPOINTMENT WILL BE REQUIRED. PLEASE CALL 570-265-1760, EXT. 2947 AND REQUEST AN APPOINTMENT TO COMPLETE A HOUSING STABILITY PLAN.

PLEASE COMPLETE ALL SECTIONS. INCOMPLETE APPLICATIONS WILL BE RETURNED.

BRADFORD COUNTY HUMAN SERVICES - HOUSING ASSISTANCE APPLICATION

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____

Mailing Address:
 (If different than above) City: _____ State: _____ Zip: _____

For Homeless Only - Zip Code where you slept last night: _____

EMAIL: _____ Phone: _____

IMPORTANT: Please select one of the following: HOMEOWNER TENANT STREET HOMELESS

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

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

Check all that you are asking for help with	Amount	Landlord/Utility Co	Phone Number	Account Number
Rent				
Security Deposit				

Fuel Oil				
Natural Gas / Propane				
Electric				
Water				
Sewer				
Emergency Shelter				
Other(Explain Below)				

DOES THE FAMILY HAVE ALTERNATE HEAT SOURCES?

Have you received any help with rent and/or utilities from any of the following in the past 2 years?		Do you receive any subsidy to help pay your rent from another source YES / NO If so, what is the amount you are responsible for? \$
Program Name	Check all that apply	
Main Link or Futures HAP Program		
Grace Connection		
The Bridge		
Endless Mountain Mission Center		
TREHAB		
ERAP 1		
ERAP 2		
Other		
Explain (If Yes)		

PLEASE COMPLETE ALL SECTIONS. INCOMPLETE APPLICATIONS WILL BE RETURNED

UTILITY CERTIFICATION-ERAP 2 APPLICANTS ONLY

I am requesting assistance with the following utilities (please provide bills):

Utilities:

I am DECLINING assistance with my utilities, OR my utilities are included in my rent. I understand that If I change my mind later, assistance will not be provided for any utilities that pre-date my authorized funding period.

NOTE: YOU MUST HAVE APPLIED FOR AND USED ANY CASH/CRISIS LIHEAP BENEFIT FOR HEATING BILLS, AS WELL AS LIWAP FOR WATER/SEWER BILLS BEFORE WE WILL ASSIST WITH THEM. YOU CAN APPLY FOR LIHEAP AND LIWAP THROUGH THE PA COMPASS WEBSITE.

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 receiving assistance. I agree to provide upon request any additional documentation required (pay stubs, lease, recent bills, etc.) to aid in determining eligibility. I understand that future funding is not guaranteed, and that I may be asked to be responsible for a portion of my rent/utilities should assistance be approved.

PLEASE REFER TO YOUR "KEEP AT HOME" PACKET FOR A LIST OF REQUIRED DOCUMENTATION TO SUBMIT WITH YOUR APPLICATION.

Applicant

Date

WHAT'S NEXT?

- ALL APPLICATIONS ARE PROCESSED IN THE ORDER IN WHICH THE APPLICATION AND SUPPORTING DOCUMENTATION IS RECEIVED. IT CAN TAKE UP TO 30 DAYS FOR AN APPLICATION TO BE PROCESSED, EVEN IN CASES WHERE THERE IS AN EVICTION OR SHUT OFF NOTICE.
- WE ENCOURAGE YOU TO CONTINUE TO REACH OUT TO OTHER LOCAL AGENCIES FOR ASSISTANCE WHILE YOUR APPLICATION IS UNDER REVIEW.

**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,

First Name M Last Name

I, _____

residing at _____

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

Signature

Date

BRADFORD COUNTY HUMAN SERVICES - HOUSING ASSISTANCE APPLICATION

**RIGHTS AND RESPONSIBILITIES
GENERAL CONSENT TO OBTAIN INFORMATION**

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 benefit. Additionally, program information may be available in languages other than English.

To file a complaint of discrimination write to:
U.S. Department of the Treasury,
Director, Office of Civil Rights and Diversity
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220;
Call (202) 622-1160;
Or send an email to:
crccomplaints@treasury.gov

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 4863)

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 contact 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)(J-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 participation 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 explanation and to laws enforcement officials for the purpose of apprehending person 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 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 through the county agency by following the information provided on the eligibility notice from the ERAP agency for your county. If you appeal, you may also request a conference with the ERAP agency before the hearing.

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

By signing below I am confirming that I have read & understood the above information:

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: _____

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 approval for assistance. I agree to provide upon request any additional documentation required (pay stubs, lease, recent bills, etc.) to aid in determining eligibility. I understand that future funding is not guaranteed, and that I may be asked to be responsible for a portion of my rent/utilities should assistance be approved.

Applicant _____

Date _____

**** CONTINUED NEXT PAGE ****

EMERGENCY RENTAL ASSISTANCE 2 - PROGRAM OVERVIEW

The Emergency Rental Assistance Program (ERAP 2) is designed to be a hand up to assist tenants during a temporary period of hardship. Below is a chart summarizing what the ERAP program can, and can't, do to help guide you as you work with your tenant during their period of temporary hardship:

ERAP CAN:	ERAP CANNOT
Assist with rent or utility arrears, not to exceed a lifetime maximum of 18 months.	<ul style="list-style-type: none"> • Provide more than 18 months of assistance, regardless of whether the help provided was for rent, utilities, or both. • Pay excessive late fees or accommodate large jumps in rent after the tenant is applying for or receiving assistance (aka rent gouging)
Assist with SHORT TERM, future (forward) rent assistance on a limited, case by case basis for a period of up to three to six months. (Generally 3 months full followed by 3 months partial assistance)	<ul style="list-style-type: none"> • Exceed three months of future (forward) rental assistance at a time. • Replace programs such as HUD subsidized or Section 8 (housing choice) vouchers
Assist with heating bills through the winter, as long as the tenant has used BOTH their cash and crisis LIHEAP benefit for the current heating season.	Pay future (forward) utilities for more than 3 months with the exception of heating bills during the heating season only.
Assist with the following utilities on a short term (generally 3 month maximum) basis: Water/Sewer (after LIWAP has been used), Garbage (excluding bag stickers), propane/natural gas for heating/cooking, fuel oil/wood pellets/fire wood (see heating section), electric, and other utilities deemed essential under the rules of the grant.	Assist with car insurance, car payments, home or heating repairs, telephone, cell phone or internet bills, bag stickers for garbage and other utilities or bills not covered under the rules of the grant program.
Assist with a security deposit to move into a new rental unit under certain circumstances.	Pay a security deposit if one has previously been paid by the county for a given tenant, unless the security deposit was returned in full.
Supplement payments made by other programs, such as Rapid Rehousing, HUD subsidy, or emergency vouchers provided through other agencies	<ul style="list-style-type: none"> • Duplicate funding support provided by other agencies. • Duplicate a payment already made by a tenant so that the tenant can receive a refund.

ERAP PROGRAM HOURS: Monday – Friday from 8 a.m. – Noon
Please allow 1-2 business days for an ERAP coordinator to return your call.

CONFIRMATION OF TENANCY – TO BE COMPLETED BY LANDLORD ONLY

Complete for ALL tenants	Date:
	Tenant Full Name(s):
	Full Street Address of Rental Unit:
	Date Rent is Due Each Month:
	Amount of One Month's Rent: \$
	Please list which utilities are included in the rent:
	Please list 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? \$_____
	HAS TENANT RECEIVED ANY ASSISTANCE WITH THEIR RENT FROM ANY OTHER SOURCE SINCE MARCH 13, 2020? Yes / No
	If yes, please explain:

NEW tenants only	Security Deposit Amount (if still owed by tenant): \$ _____ Date Tenant can move into apartment with our guarantee of payment: _____ Amount of First Month's rent: \$ _____
-------------------------	---

CERTIFICATION OF RENTAL ARREARS

- PLEASE LIST EACH MONTH SEPARATELY AS OUTLINED IN THE CHART BELOW.
- THE TOTAL MONTHS OF ERAP CANNOT EXCEED 18 MONTHS, INCLUSIVE OF ERAP RECEIVED THROUGH ANY OTHER AGENCIES IN ANY JURISDICTION.
- TENANTS MUST RE-APPLY EVERY THREE MONTHS TO DETERMINE IF THEY REMAIN ELIGIBLE FOR THE PROGRAM.

In addition to helping with arrears, ERAP 2 may be able to assist with up to 3 months full or partial future (forward) rent. As condition of accepting future/forward rent payments, I agree not to raise the rent while the tenant is enrolled in the ERAP 2 program.

___ I am willing to accept future rental assistance as noted below:

- ___ 1 month future/forward rent
- ___ 2 months future/forward rent
- ___ 3 months future/forward rent

___ I am NOT willing to accept future rental assistance for this tenant.

I understand that any future rent authorized will be included in the same check with any arrears, late fees or other rental charges that are authorized under the ERAP 2 program, and that the tenant.

PLEASE COMPLETE BOTH SIDES OF THIS FORM

BLANK, UNSIGNED OR INCOMPLETE FORMS WILL BE RETURNED

Tenant Full Name(s):

PLEASE LEAST ARREARS DETAIL HERE MONTH AND YEAR	AMOUNT OWED (PLEASE SUBTRACT ANY PAYMENTS MADE BY TENANT OR ANOTHER SOURCE)	LATE FEES DUE FOR THIS MONTH (SHOULD NOT EXCEED 20% OF THE MONTHLY RENT AMOUNT)	COMMENTS
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
TOTAL EACH COLUMN: TOTAL AMOUNT DUE:	\$	\$	
	\$		

Landlord's name (please print): _____

Landlord's FULL mailing address: _____

Landlord's phone number: _____

Landlord's email (for notifications about tenant eligibility): _____

I certify that the above information is true and correct under penalty of perjury, and agree to accept ERAP, PHARE, or other program funds toward the payment of this rent/security deposit. I acknowledge that as long as I have provided a completed and signed W9, payment will be mailed directly to me from the Bradford County Treasurer. Payment will guarantee residency for the entire time period for which funding was authorized, unless the tenant otherwise does not comply with the terms of their lease. I further acknowledge that I do not expect to receive any additional funding for this tenant's rent from any source. Payments received through the above funding sources are intended for the identified tenant only and are not transferrable to other tenants. Should I evict sooner for reasons other than non-payment of rent or should the tenant vacate the residence, I will return the unused portion of the rent and/or security deposit to: Bradford County Human Services, Housing, 220 Main Street Unit 1, Towanda, PA 18848. **PLEASE INCLUDE THE TENANT'S NAME IN THE MEMO LINE WHEN RETURNING FUNDS.** Any returned security deposit at any point in the future should also be sent to the above address. Failure to return unused funds or any overpayments may result in civil or criminal penalties as allowed by law.

LANDLORD SIGNATURE: _____ **Date:** _____

****ELECTRONIC SIGNATURES NOT ALLOWED ON THIS FORM****

ATTENTION LANDLORD: THIS FORM MAY BE FAXED TO 570-265-8541 OR EMAILED TO:
 BCHSERAP@BRADFORDCO.ORG. WHEN SENDING, PLEASE SPECIFY WHICH TENANT THIS IS FOR, SO WE
 CAN LINK IT UP TO THE CORRECT CHART. THANK YOU.

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.

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) _____

Other (see instructions) ▶

Exempt payee

Address (number, street, and apt. or suite no.) **Requester's name and address (optional)**

City, state, and ZIP code _____

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										
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black; height: 20px;"></td> <td style="width: 5%; border: 1px solid black; text-align: center;">-</td> <td style="width: 25%; border: 1px solid black; height: 20px;"></td> <td style="width: 5%; border: 1px solid black; text-align: center;">-</td> <td style="width: 40%; border: 1px solid black; height: 20px;"></td> </tr> </table>		-		-						
	-		-							
Employer identification number										
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> <td style="width: 10%; border: 1px solid black; height: 20px;"></td> </tr> </table>										

Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- 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:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued).
- Certify that you are not subject to backup withholding, or
- 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.

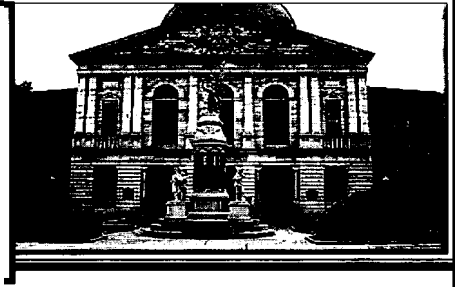
PLEASE REFER TO THIS PACKET AS YOU
COMPLETE YOUR APPLICATION.

IT CONTAINS IMPORTANT INFORMATION YOU
MAY NEED:

- Frequently Asked Questions
- Documentation checklist {submit these with your application)
- Acceptable Proof of Income list
- ERAP 2 Income Guidelines
- Privacy Practice Notice
- Right to Appeal Notice
- Housing Assistance Sheet with other resources



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.

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	<ol style="list-style-type: none"> 1. Paystubs to cover last 30 day period 2. Newly employed (less than 30 days) <ul style="list-style-type: none"> *must have at least 1 pay stub *must recertify within 3 months
Self Employed	Current Tax Return Documentation <ul style="list-style-type: none"> • 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

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.

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							
			1	2	3	4	5	6	7	8
Bradford County, PA	\$71,500	Very Low (50%) Income Limits (\$)	25,550	29,200	32,850	36,450	39,400	42,300	45,200	48,150
		Extremely Low Income Limits(\$)*	15,300	18,310	23,030	27,750	32,470	37,190	41,910	46,630
		Low (80%) Income Limits (\$)	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.

Client Copy

Bradford County Human Services
HOUSING ASSISTANCE
(Security Deposit, Rent, Utilities, Food, Transportation)

RENTAL ASSISTANCE:

If you are homeless or within 14 days of eviction, the following resources may be available:

- **Call 211 (Dial 211 or 1-855-567-5341 or text your zip code to 898211)-this is a free service to help you reach local resources. Some programs may REQUIRE a 211 referral for you to qualify for funding.**
- **Endless Mountain Mission Center:** 570-297-4489
Homeless Shelter and Rapid Rehousing/Homelessness Prevention funds
- **The Main Link:** 570-637-8789
Homeless Assistance Program and Emergency Shelter funds
- **Bradford/Tioga Housing Authority:** 570-265-3678
Public Low-Income Housing and Section 8 Housing Choice Vouchers
570-638-2151
- **The Bridge (Valley area only):** 570-888-8826
Emergency rent/utility assistance; used furniture
- **Grace Connections:** 570-268-0431
Rental & Utility Assistance and food bank, furniture vouchers
(serves Towanda, Wyalusing, and Northeast School Districts)
- **Salvation Army, Towanda** 570-265-5932
- **Salvation Army, Sayre** 570-888-2153

Both Salvation Army's provide rent and utility assistance for their Respective coverage areas, as well as seasonal needs such as School supplies (back pack program), Christmas for low income Families, etc.

UTILITY ASSISTANCE:

If you are facing a shut-off notice, the following resources may be available to you:

- **Bradford County Trehab: (Claverak/UGI/Valley Energy Customers) 570-255-2072**
Utility Assistance Program, Celeste Kranick
- **Low Income Energy Bill Assistance Program (LIHEAP)** 866-857-7095
- **Dollar Energy (Penelec Customers):** 800-375-1388
NOTE: On-Hold Wait times are high.

Updated: 9/14/2020

Client Copy

Other agencies that may help with assistance:

Abuse & Rape Crisis Center (ARCC)	570-265-5333
Area Agency on Aging, Towanda	570-265-6121
Bradford County Human Services	570-265-1760
Canton Food Pantry, Canton	570-673-7732
Child Hunger Outreach Partners	570-485-5050
Children & Youth Services: -Bradford County -Sullivan County -Chemung County, NY	570-265-1760 570-928-0307 607-737-5302
Department of Public Welfare (Bradford), Towanda	570-265-9186
Department of Public Welfare (Sullivan), Laporte	570-928-8596
Elmira Homeless Shelter, Elmira, NY	607-732-5954
Helping Hands, Wyalusing	570-726-1384
Housing Authority - Sullivan County, Laporte	570-946-7677
Housing Authority – Bradford/Tioga County	570-638-2151
Open Door Mission Men's Shelter , Tioga County, NY	607-687-1121
Sullivan County Food Pantry, Dushore	570-928-8253
TACO Food Pantry, Wysox	570-265-4422
TREHAB -Affordable Housing Units	570-265-2072
Troy Food Bank, Troy	570-297-1095
Valley Food Pantry, Wave y. NY	607-565-8718
Veterans Affairs, Towanda	570-265-1704
Transportation:	
BEST Transit Authority	570-888-7330
Valley Taxi	570-888-2365

Updated: 9/14/2020

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 professional 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 Commonwealth program, the Commonwealth program may use your protected health information and disclose it to other Commonwealth health and human series programs and outside the Commonwealth. For some of these reason 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 your PHI with our billing department and your 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 your 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 your 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 disclose 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 healthcare 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 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 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 information 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 future 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 situation. 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 request. 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 request 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 PHIO 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 request 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 reason and explain your right to file a written state 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 future 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 request 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 11th, 2003