



# Community Action Organization of Western New York, Inc.

## Housing Development Office

564 Dodge St. Bldg. 400 | Buffalo, New York 14208 | (716) 881-6543 | Fax (716) 881-6010

### CLIENT INTAKE FORM 100

**Funding Sources:**  
U.S. Dept. of H.H.S.  
N.Y. State Dept. of State  
County of Erie  
City of Buffalo

### PLEASE PRINT CLEARLY AND COMPLETE BOTH SIDES OF THIS FORM

Please be advised that this application is strictly confidential. Any information regarding sex, ethnicity; education or disability is gathered for reporting to funding sources only. This agency does not discriminate in any way in provision of services.

**Application Date:** \_\_\_\_\_ **Department/Site:** Housing Development

#### Head of Household:

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Last MM/DD/YY

**Address:** \_\_\_\_\_ NY  
City State Zip

**Phone Number:** \_\_\_\_\_ **Sex:** Male Female Other

**Military Status:** Veteran \_\_\_\_\_ Active \_\_\_\_\_ **Email Address:** \_\_\_\_\_

#### Contact Type:

Previous Client  
Walk-In  
Outreach  
Referral

#### Head Start Client?

\_\_\_ Yes \_\_\_ No

**Age:**  
\_\_\_ 0-5 \_\_\_ 45-54  
\_\_\_ 6-13 \_\_\_ 55-59  
\_\_\_ 14-17 \_\_\_ 60-64  
\_\_\_ 18-24 \_\_\_ 65-74  
\_\_\_ 25-44 \_\_\_ 75+

**Education Level**  
\_\_\_ Grades 0-8  
\_\_\_ Grades 9-12/Non-Graduate  
\_\_\_ HS Graduate/Equivalency Diploma  
\_\_\_ 12 Grade + Some Post-Secondary  
\_\_\_ 2 or 4 years College Graduate  
\_\_\_ Graduate of other Post-Secondary School

**Health Information:**  
Disabling Condition \_\_\_ Yes \_\_\_ No  
Health Insurance \_\_\_ Yes \_\_\_ No  
\_\_\_ Medicaid  
\_\_\_ Medicare  
\_\_\_ State Health Insurance for Adults  
\_\_\_ State Children's Health Insurance Program  
\_\_\_ Military Health Care  
\_\_\_ Direct-Purchase  
\_\_\_ Employment Based

**Housing:**  
Number of people in Household \_\_\_\_\_  
(List all on reverse)  
\_\_\_ Own  
\_\_\_ Rent  
\_\_\_ Other permanent housing  
\_\_\_ Homeless  
\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Number of youths ages 14-24  
neither working or in school

**Work Status:**  
\_\_\_ Employed Full-Time  
\_\_\_ Employed Part-Time  
\_\_\_ Migrant Seasonal Worker  
\_\_\_ Unemployed (Short-term,  
6 months or less)  
\_\_\_ Unemployed (Long-term,  
more than 6  
months)  
\_\_\_ Unemployed (Not in labor  
force)  
\_\_\_ Retired

**Ethnicity:** Latin(x), Spanish, or Hispanic Origins  
\_\_\_ Yes \_\_\_ No \_\_\_ Unknown/not reported

**Race**  
\_\_\_ American Indian or Alaska Native  
\_\_\_ Asian  
\_\_\_ Black/African-American  
\_\_\_ Native Hawaiian & Other Pacific Islander  
\_\_\_ White  
\_\_\_ Other  
\_\_\_ Multi-Race (any 2 or more above)

**Household Source of Income & Benefits:** (Check all that apply & list the amount received. Indicate Yearly, Monthly or Weekly) W M Y

___ No Income (Complete No Income Form for file)	W M Y	___ Workers Comp/Disability Ins.	\$ _____
___ Employment	\$ _____	___ Retirement Income from SS	\$ _____
___ TANF	\$ _____	___ Pension	\$ _____
___ SSI (Supplemental Security Income)	\$ _____	___ Child Support	\$ _____
___ SSD Soc. Security Disability Compensation	\$ _____	___ Alimony/Spousal Support	\$ _____
___ VA Non-Service Connected Disability Pension	\$ _____	___ Unemployment Insurance	\$ _____
___ VA Service- Connected Disability Compensation	\$ _____	___ EITC	\$ _____
___ Private Disability Insurance	\$ _____	___ Other	\$ _____

\* Please use the totals above to calculate the **Household Annual Income.**

**Total Annual Income \$** \_\_\_\_\_ **CAO Employee Calculate % of Income** \_\_\_\_\_ %  
(Refer to Federal Poverty Guidelines Chart)

**Non-Cash Benefits (Please check for all that apply)**

SNAP  Housing Choice Voucher  HUD-VASH  WIC  Public Housing  LIHEAP  Other  
 Childcare Voucher  Permanent Supportive Housing  Affordable Care Act Subsidy

**Additional Household Members (use additional sheet if needed)**

- 1) Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_ MI \_\_\_\_\_ M / F DOB: \_\_\_\_\_  
 Disabled  Yes  No Active Military  Yes  No Veteran  Yes  No How is person related to the HoH: \_\_\_\_\_
- 2) Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_ MI \_\_\_\_\_ M / F DOB: \_\_\_\_\_  
 Disabled  Yes  No Active Military  Yes  No Veteran  Yes  No How is person related to the HoH: \_\_\_\_\_
- 3) Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_ MI \_\_\_\_\_ M / F DOB: \_\_\_\_\_  
 Disabled  Yes  No Active Military  Yes  No Veteran  Yes  No How is person related to the HoH: \_\_\_\_\_
- 4) Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_ MI \_\_\_\_\_ M / F DOB: \_\_\_\_\_  
 Disabled  Yes  No Active Military  Yes  No Veteran  Yes  No How is person related to the HoH: \_\_\_\_\_
- 5) Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_ MI \_\_\_\_\_ M / F DOB: \_\_\_\_\_  
 Disabled  Yes  No Active Military  Yes  No Veteran  Yes  No How is person related to the HoH: \_\_\_\_\_
- 6) Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_ MI \_\_\_\_\_ M / F DOB: \_\_\_\_\_  
 Disabled  Yes  No Active Military  Yes  No Veteran  Yes  No How is person related to the HoH: \_\_\_\_\_

**Client is requesting Assistance With:**

- |  |  |
|--|--|
| <input type="checkbox"/> Housing               | <input type="checkbox"/> Utilities             |
| <input type="checkbox"/> Health/Med. Services  | <input type="checkbox"/> Finance Development   |
| <input type="checkbox"/> Employment            | <input type="checkbox"/> Day Care              |
| <input type="checkbox"/> Emergency Services    | <input type="checkbox"/> Education             |
| <input type="checkbox"/> Social Services       | <input type="checkbox"/> Senior Services       |
| <input type="checkbox"/> Food                  | <input type="checkbox"/> Community Development |
| <input type="checkbox"/> Clothing              | <input type="checkbox"/> Legal Aid             |
| <input type="checkbox"/> Other (Specify) _____ |  |

**Household Size:**

- Single Person  
 Two  
 Three  
 Four  
 Five  
 Six or more

**Household Type:**

- Single Person  
 Two Adults NO Children  
 Single Parent Female  
 Single Parent Male  
 Two Parent Household  
 Non-related Adults w/Children  
 Multigenerational Household  
 Other

**Case Notes, Comments, Follow-up:** \_\_\_\_\_

“I acknowledge and understand that all staff of the CAO Program, under New York State Social Services law section 413, are required to report any suspected case of abuse and maltreatment to the appropriate authorities when they have reasonable cause to suspect that a child coming before them in their professional capacity, is an abused or maltreated child”.

Client Print Name \_\_\_\_\_ Client Signature \_\_\_\_\_ Date \_\_\_\_\_

**As a CAO Employee, I am signing this document as a declaration that I have reviewed all of the information listed above from this client. I made sure they filled in each section correctly and that all required proofs of identification, residence and income have been added to their client file.**

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**CAO Staff Member Print Name**                      **CAO Staff Member Signature**                      **Date**



**Community  
Action  
Organization**  
of WNY

**Housing Development Office**

564 Dodge Street, Building #400

Buffalo, NY 14208

Phone: 716.881.6543

Fax: 716.881.6010

**Needs Assessment Questionnaire**

<b>Information on the following:</b>	<b>YES</b>	<b>NO</b>
Employment & Job Services		
Continued Education (GED/Trade School/College)		
Food Assistance (pantry/delivery services/SNAP benefits)		
Senior Services		
Childcare Assistance		
Child(ren) Needing Tutoring		
Child(ren) aged 3 – 4 Needing Head Start Services		
Youth Summer Camp		
Youth Sports Programming		
Counseling Services		
Assistance Filing You Income Taxes		
Addiction Recovery Services		
Small Business Development?		
Health Insurance Coverage		
Utility Assistance or HEAP Application		
Home Weatherization & Energy Efficiency Services		
Home Safety or Mobility Repair Services		
Credit Counseling		
Other Services Not Listed (please explain below)		

# COVID-19 RENT/MORTGAGE RELIEF PROGRAM (CARES ACT)

## Program Details:

The COVID-19 Rent/Mortgage Relief Program requires applicants to be 1) residents of Erie County, 2) have experienced a loss of income due to COVID-19, and be at of below 200% of the federal poverty level (see table).

Clients will need to demonstrate the ability to remain current on their rent/mortgage going forward and complete 4 months of budget coaching after receiving relief funds.

The program can only go toward late/past due rent and mortgage payments; no deposits, late fees, escrow fees, etc. are eligible. Funding for back mortgage payments will only cover mortgage principal and interest.

### INCOME ELIGIBILITY (200% FED POV)

FAMILY SIZE	Annual	Monthly
1	\$25,520	\$2,127
2	\$34,480	\$2,873
3	\$43,440	\$3,620
4	\$52,400	\$4,367
5	\$61,360	\$5,113
6	\$70,320	\$5,860
7	\$79,280	\$6,607
8	\$88,240	\$7,353
<b>ADDITIONAL</b>	<b>+\$8,960</b>	<b>+\$747</b>

**IMPORTANT!** Payment must guarantee residency for an additional 30 days.

## Applicant Information

*(to be completed by applicant)*

Applicant Name

Date

Address

Phone Number

City, State, Zip Code

Email Address

### Required Documentation:

Proof of COVID-19 Related Loss of Income  
- Employee Termination/Furlough/Layoff Notice  
- Proof of Business Closure/Hours Reduction

Notice of Past Due Rent/Mortgage

Copy of Rental/lease Agreement or Landlord Statement

Current Picture ID

Denial notice from Erie County Department of Social Services or Tenants Not Eligible for the Assistance (for renters)

Proof of 1 Months Current Income

- Pay Stubs/Benefit Letters/etc.

Copy of 2019 Income Tax Returns (for homeowners)

Documented proof of Social Security number

W9 - Completed by Landlord / Mortgage Holder

Type of Assistance:

Past Due Rent

Past Due Mortgage

Type Current Rent/Mortgage (Principal and Interest Only):

Amount Requested:



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(716) 881-6543 | Fax (716) 881-6010

## Landlord/Mortgage Holder Verification

**\*\*Complete Attached W9\*\***

*(to be completed by landlord/mortgage holder)*

This is to confirm that rent/mortgage for \_\_\_\_\_

for the property at (full address) \_\_\_\_\_

with a monthly rent amount of \$ \_\_\_\_\_ (rent only; no deposits, late fees, or other charges) or with a

mortgage with a monthly payment of \$ \_\_\_\_\_ (principal and interest only; no escrow payments or

other fees) is/was due on (month/day/year) \_\_\_\_\_.

The total amount currently owed is \$ \_\_\_\_\_.

The individual/family now has rent/mortgage due/past due for the month(s) of \_\_\_\_\_

**If this assistance will not cure the past due amount, the balance will be paid by the following:**

Once approved, the check will be mailed (5+ business days) to the following address:

Mailig Address:

**\*\*\*Checks must be cashed within 30 days of approval.\*\*\***

## Landlord/Mortgage Holder Certification of Accuracy:

By signing this verification, I certify that I am the owner of the property listed above as verified by County records, or the Mortgage Holder for the property listed above. I also certify that I agree to the above stated plan for the tenant/homeowner to pay rent/mortgage balance.

Program funds MUST be used to prevent eviction for a minimum of 30 days. By signing, I certify that I agree to accept the amount listed above as past due rent/mortgage. If at anytime prior to payment or within 30 days of payment eviction proceedings occur, I will contact CAO Housing Development.

Print Landlord/Mortgage Holder Name:

Phone Number:

\_\_\_\_\_

\_\_\_\_\_

Landlord/Mortgage Holder Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_



## COVID-19 RENT/MORTGAGE RELIEF PROGRAM (CARES ACT)

### Applicant Certification

By signing this form you are not guaranteed assistance, but you are certifying that all the information contained in this application is correct.

Should you receive an eviction notice within 30 days of the COVID-19 Rent/Mortgage Relief Program payment, you are required to inform the CAO Housing Development Office.

Additionally, you can only receive rental/mortgage assistance from one CARES Act provider. By signing below, you understand that your name will be shared with the other CARES Act providers and 2-1-1 WNY to check for duplicate applications.

You also certify that your understanding that four months of financial counseling post rent/mortgage relief is required. By signing this form, you certify that CAO may share your contact information with our financial counseling providers to fulfill this mandatory requirement.

Applicant Printed Name

Phone Number

Applicant Signature:

Date:

**No Applications will be Accepted In-Person**

**Submit COMPLETED Applications Via:**

**Email:**

swatson@caowny.org

**Fax:**

716.881.6010

**Mail:**

564 Dodge St., Bldg. 400  
Buffalo, NY 14208

**Drop Box:**

564 Dodge St., Bldg. 400  
Buffalo, NY 14208

# COVID-19 RENT/MORTGAGE RELIEF PROGRAM (CARES ACT)

## Check Request Coversheet & Applicant Eligibility Certification

\*\*\*\*\*FOR CAO HOUSING DEVELOPMENT OFFICE USE ONLY\*\*\*\*\*

### Check Request Information

Family Requesting Assistance: \_\_\_\_\_ Case Number: \_\_\_\_\_

Type of Assistance:      Past Due Rent              Past Due Mortgage

Current Rent/Mortgage (Principal and Interest Only): \_\_\_\_\_ Amount Requested: \_\_\_\_\_

Vendor Name (Check Payable To): \_\_\_\_\_

Vendor Address: \_\_\_\_\_

Check Delivery Instructions:    Send to Vendor within 10 days >>>>>> post mark by \_\_\_\_\_

### Applicant Eligibility Certification

By signing this document, the Staff Person is certifying that the applicant is eligible and that the following documents are on file for the above named client.

- |  |   |
|--|---|
| Proof of COVID-19 Related Loss of Income     | Landlord Certification  |
| Current Picture ID                           | Completed W9  |
| Proof of 1 Months Current Income             |   |
| Documented proof of Social Security number   | Denial notice from Erie County Department of Social Services or Tenants Not Eligible for the Assistance (for renters) |
| Notice of Past Due Rent/Mortgage             |   |
| Rental/Lease Agreement or Landlord Statement | Copy of 2019 Income Tax Returns (for homeowners)  |

Staff Person Approved by:

Staff Person Signature:

Date:

