HOUSING SERVICES

Emergency Services Application

WHO CAN APPLY FOR ASSISTANCE?

Carroll County renters who are experiencing an eviction, in need of a security deposit, or any household with a water turn off, with a household income below 200% of the Federal Poverty Level (see table below). HSP can also provide limited assistance with dental needs.

Income Limit, Fiscal Year 2025		
Number of Household Members	Gross Monthly Income	Gross Annual Income
1	$2,510	$30,120
2	$3,407	$40,880
3	$4,303	$51,640
4	$5,200	$62,400
5	$6,097	$73,160
6	$6993	$83,920
7	$7,980	$94,680
8	$8,787	$105,440

WHAT CAN THE PROGRAM HELP WITH?

- Eviction Prevention (with a court ordered eviction)
- Security Deposit Assistance
- Water Turn Offs
- Access Carroll Dental Assistance

WHAT NEEDS TO BE SUBMITTED WITH THE APPLICATION?

- ☐ Proof of all gross (pre-tax) income for all adults in the household for the last 30 days. This includes earned income, disability insurance, and any government subsidy. Any adults who received no income in the 30 days prior to application submission must sign a Declaration of Zero Income form. If you have a Section 8 Housing Choice Voucher or other subsidized housing, please provide a copy of this, which includes your rental portion.
- ☐ Proof of need: Official Court Ordered Eviction Notice, Written Confirmation of Security Deposit from Landlord, Water Turn Off Notice, Access Carroll Invoice or estimate.
- ☐ Rental/Lease agreement – must be current and signed by Landlord and Applicant.
- ☐ Landlord Documents: Landlord Verification, Agreement, and signed W9 Form.

HOW TO TURN IN YOUR APPLICATION

- Drop off a complete application at HSP at 10 Distillery Drive, Suite G-1, Westminster, MD between the hours of 8AM and 4PM Monday – Friday.
- Mail the complete Application Packet to Human Services Programs of Carroll County, Inc. at P.O. Box 489 Westminster, MD 21158
- Email documents to dthomas@hspinc.org – PDF/scanned documents preferred. All documents must be legible.

TWO ADULTS, CHILDREN

- ☐ Please complete the following forms
- ☐ Make sure you sign and date the form
- ☐ Pages 1 – 4 are for the head of household
- ☐ Pages 5 – 8 are for the other adult in the family
- ☐ Pages 9 – 10 are for any children or dependents under 18 years of age
- ☐ If you need additional pages for children or dependents, please ask our receptionist

Thank you for providing this information.
We look forward to working with you!

Carroll County CoC Universal Data Assessment (Head of Household)

Complete this form for singles or the head of household.

FOR STAFF ONLY:
CSP Client ID: _____
Staff: _____
Date: _____

First Name	Middle	Last Name	Preferred Name

Social Security Number	US Military Veteran?	Date of Birth
____ - ____ - ____ ☐ Don't Know ☐ Prefer Not to Answer	☐ Yes ☐ No ☐ Prefer Not to Answer	___ / ___ / ____

Primary Language		Translation Services Needed?	☐ Yes ☐ No

Marital Status *Select one.*
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Prefer Not to Answer

Household Type *Select one.*
☐ Single Adult ☐ Female Single Parent ☐ Male Single Parent ☐ Two Parent Family ☐ Couple with no Children
☐ Grandparent(s) and Child ☐ Multigenerational ☐ Other: please specify: _____

Gender *Select all that apply.*
☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Questioning ☐ Don't Know
☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Different Identity:_____ ☐ Prefer Not to Answer

Race and Ethnicity *Select all that apply.*
☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White
☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know
☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer

Phone Number	Email Address

Street Address	City	State	Zip

Mailing Address	City	State	Zip

Zip Code of Last Permanent Address	_____	Transportation Problem?	☐ Frequently ☐ Sometimes ☐ Never

If you are from outside Carroll County, what brought you here? *Select one.*
☐ Grew up in Carroll County ☐ Returned to Live with Family ☐ Relocated for Relationship ☐ Relocated for a Job
☐ Discharged from CHC ☐ Discharged from CCDC ☐ Recovery House ☐ Affordable Hotel
☐ Better Resources ☐ Other: _____

Do you have Health Insurance coverage? ☐ Yes *(If yes, check type(s) below)* ☐ No
☐ Medicaid ☐ Medicare ☐ State Children's Health Insurance Program ☐ Veteran's Administration Medical Services
☐ Employer-Provided Health Insurance ☐ Health Insurance through COBRA ☐ Private Pay Health Insurance
☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (specify): _____

Pregnant? ☐ Yes ☐ No If Yes, Due Date: _____ ☐ Prefer Not to Answer

Do you have any of the following HUD defined Disabling Conditions? ☐ Yes *(If yes, check type(s) below)* ☐ No

	Yes	No	If yes, is it expected to be of long-continued and indefinite duration, substantially impeding the ability to live independently, and of such a nature that such ability could be improved by more suitable housing conditions?	Yes	No	Notes on Disability
Alcohol Use Disorder	☐	☐		☐	☐	
Both Alcohol and Drug Use Disorder	☐	☐		☐	☐	
Chronic Health Condition	☐	☐		☐	☐	
Developmental	☐	☐		☐	☐	
Substance Use Disorder	☐	☐		☐	☐	
HIV / AIDS	☐	☐		☐	☐	
Mental Health Disorder	☐	☐		☐	☐	
Physical Disability	☐	☐		☐	☐	

Carroll County CoC Universal Data Assessment (Head of Household)

Complete this form for singles or the head of household.

Highest Level of Education *Select one.*

☐ No Schooling	☐ Grades 7-8	☐ High School Diploma	☐ Associate's Degree	☐ Graduate Degree
☐ Less than Grade 5	☐ Grades 9-11	☐ GED	☐ College Degree	☐ Don't Know
☐ Grades 5-6	☐ Grade 12; No Diploma	☐ Some College	☐ Vocational Cert	☐ Prefer Not to Answer

Employment Status *Select one.*

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disability ☐ Seasonal ☐ Temp/Casual ☐ Self-Employed ☐ Retired ☐ Other: ____

Do you have *MONTHLY* income from any source?

☐ Yes *(If yes, check type(s) below and estimate amount)* ☐ No

	Per MONTH
☐ Earned Income (i.e., employment income)	$_____
☐ Unemployment Insurance	$_____
☐ Supplemental Security Insurance (SSI)	$_____
☐ Social Security Disability (SSDI)	$_____
☐ Alimony or Other Spousal Support	$_____
☐ Child Support	$_____
☐ General Assistance (GA/TDAP)	$_____
☐ Needy Families (TANF/TCA)	$_____
☐ Pension/Retirement Income from a job	$_____
☐ Private disability insurance	$_____
☐ Retirement income from social security	$_____
☐ VA non-svc connected disability pension	$_____
☐ VA svc connected disability compensation	$_____
☐ Worker's Compensation	$_____
☐ Other Source (specify): _____	$_____

Total *MONTHLY* Income: $ _____

Do you receive any non-cash benefits?

☐ Yes *(If yes, check type(s) below)* ☐ No

- ☐ SNAP (Food Stamps) $_____
- ☐ Special Supp. Nutrition Program for WIC
- ☐ TANF Child Care Services
- ☐ TANF Transportation Services
- ☐ Other TANF-Funded Services
- ☐ Other Source (specify): _____

Please add any income that children under 18 receive to the head of household's monthly income information.

What are the primary and secondary reasons you are experiencing housing instability? *Select two.*

1	2		1	2		1	2	
☐	☐	Criminal Activity	☐	☐	Loss of Public Assistance	☐	☐	Release from an Institution
☐	☐	Domestic Violence Survivor	☐	☐	Loss of Transportation	☐	☐	Substance Abuse
☐	☐	Eviction	☐	☐	Medical Condition	☐	☐	Substandard Housing
☐	☐	Eviction by Family	☐	☐	Mental Health	☐	☐	Underemployment / Low Income
☐	☐	Health / Safety	☐	☐	Mortgage Foreclosure	☐	☐	Utility Shutoff
☐	☐	Loss of Child Care	☐	☐	No Affordable Housing	☐	☐	Other: _____
☐	☐	Loss of Job	☐	☐	Previous Home Condemned			

Have you experienced domestic violence?

☐ Yes ☐ No ☐ Don't Know ☐ Prefer Not to Answer

When did the last experience occur? Select one.	☐ Within the past 3 months	☐ 3 to 6 months ago	☐ 6 to 12 months ago	☐ More than a year ago	☐ Don't Know	☐ Prefer Not to Answer
Are you currently fleeing? Select one.	☐ Yes	☐ No	☐ Don't Know	☐ Prefer Not to Answer		
Are you in immediate danger? Are you afraid to return to where you are staying?	☐ Yes	☐ No				

Carroll County CoC Universal Data Assessment (Head of Household)

Complete this form for singles or the head of household.

Where did you sleep last night? *Select one.*

Homeless Situation

- ☐ Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent)
- ☐ Emergency shelter
- ☐ Hotel/motel paid for by a shelter

How long have you been staying there?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Don't Know
- ☐ Prefer not to answer

Approximate Date This Episode of Homelessness Began: _____

Institutional Situation

- ☐ Hospital / Residential medical facility
- ☐ Substance abuse treatment/Detox center
- ☐ Psychiatric hospital / facility
- ☐ Jail / Prison / Juvenile detention
- ☐ Long-term care facility / Nursing home
- ☐ Foster care home

Please list Name of Institution: _____

How long have you been staying there?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Don't Know
- ☐ Prefer not to answer

If less than 90 days, on the night BEFORE, were you staying on the streets or in a shelter? ☐ Yes ☐ No

If so, what was the approximate date you started staying on the street or in a shelter? _____

Temporary or Permanent Housing Situation

- ☐ Staying/living at friend's house
- ☐ Staying/living at family's house
- ☐ Hotel/motel paid for by you / family / friend
- ☐ Owned, no subsidy
- ☐ Owned, with a subsidy (Please specify: _____)
- ☐ Rental, no subsidy
- ☐ Rental, with a subsidy (Please specify: RRH, VASH, HCV, Other)
- ☐ Perm. Supp. Housing (not RRH)
- ☐ Host Home
- ☐ Trans. housing for homeless youth
- ☐ Residential/halfway house

How long have you been staying there?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Don't Know
- ☐ Prefer not to answer

If less than 7 days, on the night BEFORE, were you staying on the streets or in a shelter? ☐ Yes ☐ No

Approximate Date of This Episode of Homelessness: _____

How many TIMES have you stayed in a place not meant for habitation or an emergency shelter in the past three years (including this time if you are currently experiencing homelessness)?

☐ Zero Times ☐ One Time ☐ Two Times ☐ Three Times ☐ Four or more times

How many MONTHS have you stayed in a place not meant for habitation or an emergency shelter in the past three years (including this time if you are currently experiencing homelessness)?

Carroll County CoC Universal Data Assessment (Head of Household)

Complete this form for singles or the head of household.

Client Acknowledgement of Data Entry into Community Services

Community Services (CS) is a Homeless Management Information System (HMIS) used by Carroll County's Continuum of Care (CoC). A HMIS is required for use by all homeless service providers funded by the Department of Housing and Urban Development (HUD). All providers entering data into CS practice high standards of confidentiality and are required to seek explicit permission from the client before releasing any identifiable client information. Client information is used by CS provider agencies to enhance service delivery and data quality among partner agencies. This information helps the agencies provide services to clients and evaluate service delivery for equity and system improvement.

By signing this document, you are acknowledging the following:

- Protected client information is handled securely and responsibly in accordance with client wishes. Information about you and your household will be entered into Community Services (CS). This information includes, but is not limited to your name, SSN, contact information, demographic information, disability, veteran, and medical insurance status, and all other HUD required client information.
- Client consent (verbal or written) must be obtained before any protected personal information can be shared, and you as the client have the right to view or keep a printed copy of your own records contained in CS.
- See the Carroll County HMIS Privacy Notice for more information on how client information is handled in Carroll County's HMIS.
- HMIS data is uploaded to the Maryland State Homeless Services Data Warehouse (MSHDW) on a quarterly basis, and de-identified data is required to be submitted to HUD and other funders throughout the year. See the MSHDW Privacy Notice for more information on how client information is handled in the MSHDW.
- CS provider agencies include Carroll County Health Department (CCHD), Carroll County Department of Citizen Services (CCDCS), and Human Services Programs of Carroll County, Inc. (HSP). These agencies can view your information in CS for the purposes stated above. You have the right not to share your information with one or more partner agencies **without affecting your eligibility status.** If you do not wish to share information with a particular agency or agencies, please advise who: _____.
- You will receive the same services whether or not you share your personal information.

_____ _____

Head of Household's Signature | Other Party

_____ _____

Date Signed | Relationship to Head of Household

Carroll County CoC Universal Data Assessment (Other Adults >18 yrs)

Complete this form for all other adults in the household.

Head of Household Name: _____

FOR STAFF ONLY:
CSP Client ID: _____
Staff: _____
Date: _____

First Name	Middle	Last Name	Preferred Name

Social Security Number	US Military Veteran?	Date of Birth
_____ - ____ - _____ ☐ Don't Know ☐ Prefer Not to Answer	☐ Yes ☐ No ☐ Prefer Not to Answer	___ / ___ / ____

Primary Language		Translation Services Needed?	☐ Yes ☐ No

Marital Status *Select one.*
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Prefer Not to Answer

Relationship to Head of Household
☐ Head of Household's Spouse or Partner ☐ Head of Household's Child ☐ Other Relation to Head of Household : _____
☐ Other: Non-Relation Member: _____

Gender *Select all that apply.*
☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Questioning ☐ Don't Know
☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Different Identity:_____ ☐ Prefer Not to Answer

Race and Ethnicity *Select all that apply.*
☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White
☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know
☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer

Phone Number	Email Address

Street Address	City	State	Zip

Mailing Address	City	State	Zip

Zip Code of Last Permanent Address	_____	Transportation Problem?	☐ Frequently ☐ Sometimes ☐ Never

If you are from outside Carroll County, what brought you here? *Select one.*
☐ Grew up in Carroll County ☐ Returned to Live with Family ☐ Relocated for Relationship ☐ Relocated for a Job
☐ Discharged from CHC ☐ Discharged from CCDC ☐ Recovery House ☐ Affordable Hotel
☐ Better Resources ☐ Other: _____

Do you have Health Insurance coverage? ☐ Yes *(If yes, check type(s) below)* ☐ No

☐ Medicaid ☐ Medicare ☐ State Children's Health Insurance Program ☐ Veteran's Administration Medical Services
☐ Employer-Provided Health Insurance ☐ Health Insurance through COBRA ☐ Private Pay Health Insurance
☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (specify): _____

Pregnant? ☐ Yes ☐ No If Yes, Due Date: _____ ☐ Prefer Not to Answer

Do you have any of the following HUD defined Disabling Conditions? ☐ Yes (If yes, check type(s) below) ☐ No

	Yes	No	<u>If yes</u>, is it expected to be of long-continued and indefinite duration, substantially impeding the ability to live independently, and of such a nature that such ability could be improved by more suitable housing conditions?	Yes	No	Notes on Disability
Alcohol Use Disorder	☐	☐		☐	☐	
Both Alcohol and Drug Use Disorder	☐	☐		☐	☐	
Chronic Health Condition	☐	☐		☐	☐	
Developmental	☐	☐		☐	☐	
Substance Use Disorder	☐	☐		☐	☐	
HIV / AIDS	☐	☐		☐	☐	
Mental Health Disorder	☐	☐		☐	☐	
Physical Disability	☐	☐		☐	☐	

Carroll County CoC Universal Data Assessment (Other Adults >18 yrs)

Complete this form for all other adults in the household.

Highest Level of Education *Select one.*

☐ No Schooling	☐ Grades 7-8	☐ High School Diploma	☐ Associate's Degree	☐ Graduate Degree
☐ Less than Grade 5	☐ Grades 9-11	☐ GED	☐ College Degree	☐ Don't Know
☐ Grades 5-6	☐ Grade 12; No Diploma	☐ Some College	☐ Vocational Cert	☐ Prefer Not to Answer

Employment Status *Select one.*

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disability ☐ Seasonal ☐ Temp/Casual ☐ Self-Employed ☐ Retired ☐ Other:_____

Do you have *MONTHLY* income from any source?

☐ Yes *(If yes, check type(s) below and estimate amount)* ☐ No

	Per MONTH
☐ Earned Income (i.e., employment income)	$_____
☐ Unemployment Insurance	$_____
☐ Supplemental Security Insurance (SSI)	$_____
☐ Social Security Disability (SSDI)	$_____
☐ Alimony or Other Spousal Support	$_____
☐ Child Support	$_____
☐ General Assistance (GA/TDAP)	$_____
☐ Needy Families (TANF/TCA)	$_____
☐ Pension/Retirement Income from a job	$_____
☐ Private disability insurance	$_____
☐ Retirement income from social security	$_____
☐ VA non-svc connected disability pension	$_____
☐ VA svc connected disability compensation	$_____
☐ Worker's Compensation	$_____
☐ Other Source (specify): _____	$_____
Total *MONTHLY* Income:	$ _____

Do you receive any non-cash benefits?

☐ Yes *(If yes, check type(s) below)* ☐ No

- ☐ SNAP (Food Stamps) $_____
- ☐ Special Supp. Nutrition Program for WIC
- ☐ TANF Child Care Services
- ☐ TANF Transportation Services
- ☐ Other TANF-Funded Services
- ☐ Other Source (specify): _____

What are the primary and secondary reasons you are experiencing housing instability? *Select two.*

1	2		1	2		1	2	
☐	☐	Criminal Activity	☐	☐	Loss of Public Assistance	☐	☐	Release from an Institution
☐	☐	Domestic Violence Survivor	☐	☐	Loss of Transportation	☐	☐	Substance Abuse
☐	☐	Eviction	☐	☐	Medical Condition	☐	☐	Substandard Housing
☐	☐	Eviction by Family	☐	☐	Mental Health	☐	☐	Underemployment / Low Income
☐	☐	Health / Safety	☐	☐	Mortgage Foreclosure	☐	☐	Utility Shutoff
☐	☐	Loss of Child Care	☐	☐	No Affordable Housing	☐	☐	Other: _____
☐	☐	Loss of Job	☐	☐	Previous Home Condemned			

Have you experienced domestic violence?

☐ Yes ☐ No ☐ Don't Know ☐ Prefer Not to Answer

When did the last experience occur? Select one.	☐ Within the past 3 months	☐ 3 to 6 months ago	☐ 6 to 12 months ago	☐ More than a year ago	☐ Don't Know	☐ Prefer Not to Answer
Are you currently fleeing? Select one.	☐ Yes	☐ No	☐ Don't Know	☐ Prefer Not to Answer		
Are you in immediate danger? Are you afraid to return to where you are staying?	☐ Yes	☐ No				

Carroll County CoC Universal Data Assessment (Other Adults >18 yrs)

Complete this form for all other adults in the household.

Where did you sleep last night? *Select one.*

Homeless Situation

- ☐ Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent)
- ☐ Emergency shelter
- ☐ Hotel/motel paid for by a shelter

How long have you been staying there?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Don't Know
- ☐ Prefer not to answer

Approximate Date This Episode of Homelessness Began: _____

Institutional Situation

- ☐ Hospital / Residential medical facility
- ☐ Substance abuse treatment/Detox center
- ☐ Psychiatric hospital / facility
- ☐ Jail / Prison / Juvenile detention
- ☐ Long-term care facility / Nursing home
- ☐ Foster care home

Please list Name of Institution: _____

How long have you been staying there?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Don't Know
- ☐ Prefer not to answer

If less than 90 days, on the night BEFORE, were you staying on the streets or in a shelter? ☐ Yes ☐ No

If so, what was the approximate date you started staying on the street or in a shelter? _____

Temporary or Permanent Housing Situation

- ☐ Staying/living at friend's house
- ☐ Staying/living at family's house
- ☐ Hotel/motel paid for by you / family / friend
- ☐ Owned, no subsidy
- ☐ Owned, with a subsidy (Please specify: _____)
- ☐ Rental, no subsidy
- ☐ Rental, with a subsidy (Please specify: RRH, VASH, HCV, Other)
- ☐ Perm. Supp. Housing (not RRH)
- ☐ Host Home
- ☐ Trans. housing for homeless youth
- ☐ Residential/halfway house

How long have you been staying there?

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Don't Know
- ☐ Prefer not to answer

If less than 7 days, on the night BEFORE, were you staying on the streets or in a shelter? ☐ Yes ☐ No

Approximate Date of This Episode of Homelessness: _____

How many TIMES have you stayed in a place not meant for habitation or an emergency shelter in the past three years (including this time if you are currently experiencing homelessness)?

☐ Zero Times ☐ One Time ☐ Two Times ☐ Three Times ☐ Four or more times

How many MONTHS have you stayed in a place not meant for habitation or an emergency shelter in the past three years (including this time if you are currently experiencing homelessness)?

Carroll County CoC Universal Data Assessment (Other Adults >18 yrs)

Complete this form for all other adults in the household.

Client Acknowledgement of Data Entry into Community Services

Community Services (CS) is a Homeless Management Information System (HMIS) used by Carroll County's Continuum of Care (CoC). A HMIS is required for use by all homeless service providers funded by the Department of Housing and Urban Development (HUD). All providers entering data into CS practice high standards of confidentiality and are required to seek explicit permission from the client before releasing any identifiable client information. Client information is used by CS provider agencies to enhance service delivery and data quality among partner agencies. This information helps the agencies provide services to clients and evaluate service delivery for equity and system improvement.

By signing this document, you are acknowledging the following:

- Protected client information is handled securely and responsibly in accordance with client wishes. Information about you and your household will be entered into Community Services (CS). This information includes, but is not limited to your name, SSN, contact information, demographic information, disability, veteran, and medical insurance status, and all other HUD required client information.
- Client consent (verbal or written) must be obtained before any protected personal information can be shared, and you as the client have the right to view or keep a printed copy of your own records contained in CS.
- See the Carroll County HMIS Privacy Notice for more information on how client information is handled in Carroll County's HMIS.
- HMIS data is uploaded to the Maryland State Homeless Services Data Warehouse (MSHDW) on a quarterly basis, and de-identified data is required to be submitted to HUD and other funders throughout the year. See the MSHDW Privacy Notice for more information on how client information is handled in the MSHDW.
- CS provider agencies include Carroll County Health Department (CCHD), Carroll County Department of Citizen Services (CCDCS), and Human Services Programs of Carroll County, Inc. (HSP). These agencies can view your information in CS for the purposes stated above. You have the right not to share your information with one or more partner agencies **without affecting your eligibility status.** If you do not wish to share information with a particular agency or agencies, please advise who: _____.
- You will receive the same services whether or not you share your personal information.

_____ _____

Client's Signature Other Party

_____ _____

Date Signed Relationship to Head of Household

Carroll County CoC Universal Data Assessment (Dependents Under 18 yrs)

Complete this form for the children/dependents in household.

Head of Household's Name: _____

List of Children / Dependents (Under 18 years of age)

First Name	Middle	Last Name	Relationship to Head of Household	Social Security Number	Date of Birth (Month / Day / Year)
1.				_____ - _____ - _____	_____ /_____ /_____

Gender (select all that apply)	☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Questioning ☐ Different Identity:_____ ☐ Don't Know ☐ Prefer Not to Answer
Race (select all that apply)	☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White ☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know ☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer
Covered by Health Insurance? ☐ Yes ☐ No	☐ Medicaid ☐ Veteran's Administration Medical Services ☐ Private Pay Health Insurance ☐ Medicare ☐ Employer-Provided Health Insurance ☐ Indian Health Services Program ☐ State Children's Health Insurance Program ☐ Health Insurance through COBRA ☐ Other (specify): _____
Has Disabling Condition? ☐ Yes ☐ No	☐ Developmental ☐ Physical ☐ Chronic Health Condition ☐ Mental Health Disorder ☐ Drug Use Disorder ☐ Alcohol Use Disorder ☐ HIV/AIDS ☐ Don't Know ☐ Prefer Not to Answer
Highest Level of Education	☐ No Schooling ☐ < Grade 5 ☐ Grades 5-6 ☐ Grades 7-8 ☐ Grades 9-11 ☐ Grade 12, No diploma ☐ High School Diploma ☐ GED ☐ Prefer Not to Answer

First Name	Middle	Last Name	Relationship to Head of Household	Social Security Number	Date of Birth (Month / Day / Year)
2.				_____ - _____ - _____	_____ /_____ /_____

Gender (select all that apply)	☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Questioning ☐ Different Identity:_____ ☐ Don't Know ☐ Prefer Not to Answer
Race (select all that apply)	☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White ☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know ☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer
Covered by Health Insurance? ☐ Yes ☐ No	☐ Medicaid ☐ Veteran's Administration Medical Services ☐ Private Pay Health Insurance ☐ Medicare ☐ Employer-Provided Health Insurance ☐ Indian Health Services Program ☐ State Children's Health Insurance Program ☐ Health Insurance through COBRA ☐ Other (specify): _____
Has Disabling Condition? ☐ Yes ☐ No	☐ Developmental ☐ Physical ☐ Chronic Health Condition ☐ Mental Health Disorder ☐ Drug Use Disorder ☐ Alcohol Use Disorder ☐ HIV/AIDS ☐ Don't Know ☐ Prefer Not to Answer
Highest Level of Education	☐ No Schooling ☐ < Grade 5 ☐ Grades 5-6 ☐ Grades 7-8 ☐ Grades 9-11 ☐ Grade 12, No diploma ☐ High School Diploma ☐ GED ☐ Prefer Not to Answer

Carroll County CoC Universal Data Assessment (Dependents Under 18 yrs)

Complete this form for the children/dependents in household.

Head of Household's Name: _____

First Name	Middle	Last Name	Relationship to Head of Household	Social Security Number	Date of Birth (Month / Day / Year)
3.				_____ - _____ - _____	_____ /_____ /_____
Gender (select all that apply)	☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Questioning ☐ Different Identity:_____ ☐ Don't Know ☐ Prefer Not to Answer				
Race (select all that apply)	☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White ☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know ☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer				
Covered by Health Insurance? ☐ Yes ☐ No	☐ Medicaid ☐ Veteran's Administration Medical Services ☐ Private Pay Health Insurance ☐ Medicare ☐ Employer-Provided Health Insurance ☐ Indian Health Services Program ☐ State Children's Health Insurance Program ☐ Health Insurance through COBRA ☐ Other (specify): _____				
Has Disabling Condition? ☐ Yes ☐ No	☐ Developmental ☐ Physical ☐ Chronic Health Condition ☐ Mental Health Disorder ☐ Drug Use Disorder ☐ Alcohol Use Disorder ☐ HIV/AIDS ☐ Don't Know ☐ Prefer Not to Answer				
Highest Level of Education	☐ No Schooling ☐ < Grade 5 ☐ Grades 5-6 ☐ Grades 7-8 ☐ Grades 9-11 ☐ Grade 12, No diploma ☐ High School Diploma ☐ GED ☐ Prefer Not to Answer				

First Name	Middle	Last Name	Relationship to Head of Household	Social Security Number	Date of Birth (Month / Day / Year)
4.				_____ - _____ - _____	_____ /_____ /_____
Gender (select all that apply)	☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Questioning ☐ Different Identity:_____ ☐ Don't Know ☐ Prefer Not to Answer				
Race (select all that apply)	☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White ☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know ☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer				
Covered by Health Insurance? ☐ Yes ☐ No	☐ Medicaid ☐ Veteran's Administration Medical Services ☐ Private Pay Health Insurance ☐ Medicare ☐ Employer-Provided Health Insurance ☐ Indian Health Services Program ☐ State Children's Health Insurance Program ☐ Health Insurance through COBRA ☐ Other (specify): _____				
Has Disabling Condition? ☐ Yes ☐ No	☐ Developmental ☐ Physical ☐ Chronic Health Condition ☐ Mental Health Disorder ☐ Drug Use Disorder ☐ Alcohol Use Disorder ☐ HIV/AIDS ☐ Don't Know ☐ Prefer Not to Answer				
Highest Level of Education	☐ No Schooling ☐ < Grade 5 ☐ Grades 5-6 ☐ Grades 7-8 ☐ Grades 9-11 ☐ Grade 12, No diploma ☐ High School Diploma ☐ GED ☐ Prefer Not to Answer				

EMERGENCY NEED – WHAT ARE YOU SEEKING ASSISTANCE FOR?

☐ **For all services: please attach signed participant agreement**

Eviction Prevention

☐ Attach Court Ordered Eviction
☐ Attach lease signed by you and landlord
☐ Amount Requested: $_____

Please explain how you will contribute to this.

_____

_____

Please explain how you will pay your rent moving forward.

_____

_____

Security Deposit Assistance

☐ Attach lease (can be unsigned)
☐ Amount Requested: $_____

Please explain how you will contribute to this.

_____

_____

Please explain how you will pay your rent moving forward.

_____

_____

Water Turn Offs

☐ Attach Turn Off Notice
☐ Amount Requested: $_____

Please explain how you will contribute to this.

_____

_____

Access Carroll Dental Assistance

☐ Attach Invoice
☐ Amount Requested: $_____

Please explain how you will contribute to this.

_____

_____

INCOME

Please list all forms and amounts of income received by your household in the last 30 days:

_____

_____

☐ Attach verification of all income received and/or Zero Declaration of Income

LANDLORD INFORMATION

Please list name and contact information for Landlord:

_____

_____

☐ Attach/have landlord send W9 Statement, Landlord Agreement, and Landlord Verification forms

HOUSING SERVICES
Emergency Services
Participant Agreement

To be completed by Tenant

Check each type of assistance requested:

- ☐ Eviction Prevention
- ☐ Security Deposit Assistance

Please initial next to each of the following statements:

_____ I certify that all the information provided in the application is correct and complete to the best of my knowledge. This includes information regarding my household, income, rental obligation, housing instability, and financial hardship. I understand that providing false statements or information is grounds for termination of the assistance and is punishable under federal and state law.

_____ I certify that my household has not received assistance from another program for the same costs that I am requesting assistance for.

_____ I understand that I need to provide all requested documentation within 30 days of submission or my application for assistance will be denied.

_____ I understand that assistance is not guaranteed and is based on the eligibility requirements described on the application cover page.

_____ I acknowledge that the assistance I receive may not cover the entire amount owed and I am responsible for paying what is not covered by the assistance.

_____ If I receive any assistance, I will have the opportunity to openly discuss my budget and new strategies to manage my income while making appropriate spending choices, and I will have the opportunity to engage with HSP's employment and financial education Services.

By signing this agreement, I acknowledge I understand how HSP can supply housing assistance, and I understand my role in the process.

Participant Name(s): _____

Participant Signature(s): _____

Date: _____

HOUSING SERVICES

Zero Declaration

Instructions: All household members age 18 and older who have had no income in the last 30 days must sign this form. Income includes but is not limited to: wages, self-employment, child support, Social Security, SSI/SSDI, Disability, TCA/TDAP, Unemployment benefits, monetary gifts and loans. Each person declaring they have had no income in the last 30 days is referred to as the "Declarer" and must print, sign and date on the lines below.

Applicant's Name: _____

I certify that I have had no income of my own during the past thirty (30) days, from _____ to _____

I swear (or affirm) that all information on this declaration is true, correct and complete to the best of my ability, knowledge and belief.

When this form is completed by other than the applicant, the signer(s) agree to report to HSP, Inc. any changes of which he/she is aware in financial circumstances of the applicant or in his/her relationship to the applicant.

Declarer's Name	Declarer's Signature	Date Signed
Declarer's Name	Declarer's Signature	Date Signed
Declarer's Name	Declarer's Signature	Date Signed
Declarer's Name	Declarer's Signature	Date Signed
Declarer's Name	Declarer's Signature	Date Signed
Declarer's Name	Declarer's Signature	Date Signed

Human Services Programs of Carroll County, Inc.

HOUSING SERVICES

EMERGENCY SERVICES

VERIFICATION OF RENTAL ARREARS OR SECURITY DEPOSIT ASSISTANCE

To be completed by Landlord

☐ Security Deposit Assistance ☐ Court Ordered Eviction Prevention

Date: _____ Tenant Name(s): _____

Rental property address: _____

Is this subsidized housing? ☐ Yes ☐ No

If yes, what kind? ☐ Housing Choice Voucher (Sec. 8) ☐ Project-Based Rental Assistance ☐ Other: _____

Security Deposit Assistance

Do you agree to rent to the above tenant? ☐ Yes ☐ No

Amount of Security Deposit: $_____

If different then the amount of 1 month's rent, please explain why: _____

Court Ordered Eviction Prevention

Have you filed for eviction? If yes, please attach a copy of the filing. ☐ Yes ☐ No

Amount of Monthly Rent: $ _____

Month	Rent Amount Owed	Late/Court Fees Owed	Amount Paid by Tenant
TOTAL			

Landlord Name/Point of Contact: _____

Landlord's Company Name: _____

Mailing Address: _____ Email: _____

Phone Number: _____ Fax: _____

Landlord's Signature: _____ Date: _____

Please attach completed IRS W-9 Form (this is required to receive payment)
If the information above is different from your W-9,
please explain and confirm how you would like to receive payment.

_____

_____

_____

HOUSING SERVICES

Emergency Services

Program Landlord Agreement

To be completed by Landlord

As the landlord for this rental unit and household, I:

- ☐ Agree to participate in the program
- ☐ Decline to participate in the program

Landlords who agree to participate in the program and receive payment directly from HSP Emergency Services program are required to meet the following terms and conditions. Please initial next to each statement:

_____ I certify all the information provided in the application regarding my ownership of the rental property, the tenant's rental obligation, and total amount of rent owed provided in the application are correct and complete to the best of my knowledge. I understand that providing false statements or information is grounds for termination of assistance and is punishable under federal law.

_____ I agree to cancel/rescind all eviction filings currently pending against this tenant once payment is received.

_____ I agree to extend the tenant's lease or renew the lease if it has or is scheduled to expire prior to the end of rental assistance being provided for a period no less than the duration of prospective rental assistance.

_____ I certify that any payment of Eviction Prevention and/ or Security Deposit Assistance Program funds made directly to me for the purpose of paying rent on the household's behalf will only be used for the intended purpose.

_____ I acknowledge that the assistance I receive for the tenant may not cover the entire amount owed.

_____ I understand assistance for my tenant is not guaranteed and is based on the Eviction Prevention and/or Security Deposit Assistance Program eligibility requirements. If the applicant is determined to be eligible for assistance, I will receive a letter pending approval of funds letter from the Case Worker.

By signing this agreement, I acknowledge that I understand the above statements and understand that violation of this agreement may make me ineligible to receive future payments directly from HSP Emergency Services.

Landlord Name: _____

Tenant Name(s): _____

Landlord Signature: _____

Date: _____

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

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

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See *Specific Instructions* on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they