



SCOTTS VALLEY BAND OF POMO INDIANS

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EMERGENCY RENTAL ASSISTANCE PROGRAM (ERAP)

Program Description: Up to 12 months of Emergency Rental and Utility Assistance (current and past due) to eligible households. Funds are received by SVBPI through the U.S. Department of Treasury and are administered through SVBPI Housing Department.

WHO IS ELIGIBLE

- Must be a Renter; AND
- The Rental Household must be income-qualified (below 80% of the Area Median Income) to receive services (income must be verifiable); AND
- Someone in the household must either qualify for unemployment OR experienced a loss of employment, reduction of hours, increase of expenses or financial hardship due to COVID-19.

PLEASE NOTE: Homeowners do not qualify for this program and need to apply to the Homeowner's Assistance Fund Program when available.

WHAT IS THE ASSISTANCE

Current and past due rental and utility payments paid directly to landlord or utility company. (Mortgage payments are ineligible for this program; please apply to the Homeowner's Assistance Fund Program when available.)

Eligible Utility Payments include Water, Sewer, Electricity, Internet, Trash and Home Heating (i.e. gas, wood/pellets and oil).

WHEN CAN PAYMENTS BE RECEIVED

Eligible households may receive assistance up to 12 months of past rent and up to three months of current/future rent, not to exceed a total assistance of 12 months (15 months in certain circumstances) and subject to availability of funding. However, past due payments cannot cover expenses incurred prior to March 13, 2020.

THIS FUNDING CANNOT DUPLICATE ANY OTHER FEDERAL ASSISTANCE!!!

FOR MORE INFORMATION, PLEASE CONTACT:

Shannon Ford, Housing Director
shannon.ford@sv-nsn.gov
707-533-2882 (o); 707-349-5477 (cell)

Kate Ray, Family Advocate
katie.ray@sv-nsn.gov
707-263-4253 (o); 707-349-8996 (cell)

PLEASE ALLOW AT LEAST 10 BUSINESS DAYS FOR PROCESSING

EMERGENCY RENTAL ASSISTANCE (ERAP) APPLICATION

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

Please list the names, relationship, gender, birthdate and enrollment status of all people who reside in your household, including yourself.

NAME	RELATIONSHIP [To Head of Household]	GENDER [M/F/O]	BIRTHDATE [mm/dd/yy]	ENROLLED W/ SVBPI [Yes/No]

Have you or someone in your household qualified for unemployment? Yes _____ No _____
If yes, who? _____ What was the date _____

If the answer to the above question was "no", have you or someone in your household lost employment due to COVID-19? Yes _____ No _____

If yes, who? _____

Please identify the employer and the date of termination: _____

If the answer to the above question was "no", have you or someone in your household experienced a reduction in hours due to COVID-19? Yes _____ No _____

If yes, who? _____

Please identify the employer and explain the reduction: _____

If the answer to the above question was "no", have you or someone in your household incurred significant costs due to COVID-19? Yes _____ No _____

If yes, who? _____

Please identify the cost(s) and explain the situation: _____

If the answer to the above question was "no", have you or someone in your household experienced financial hardship due to COVID-19? Yes _____ No _____

If yes, who? _____

Please explain: _____

Do you need assistance with past due RENT or UTILITIES due to unemployment, loss of income, or increase of due to COVID-19? Yes _____ No _____

If yes, please provide supporting documentation and answer the following:

How much rent do you owe? _____

How many months is that for? _____

What is the date of the first missed rental payment? _____

How much do you owe in past due utilities? _____

How many months are you behind? _____

What is the date of the first missed utility payment? _____

Do you need assistance with current/future RENT or UTILITIES due to unemployment, loss of income, or increase of due to COVID-19? Yes _____ No _____

If yes, please provide supporting documentation and answer the following:

How much is your monthly rent? _____

How many months are you requesting assistance for? _____

How much are your current utility expenses? _____

How many months are you requesting assistance for? _____

Have you received any Federal Funding assistance for Rent or Utilities prior to submission of this application? Yes _____ No _____ [Please note: It is your responsibility to let us know if you receive any federal assistance for Rent or Utilities whether prior to or after submission of this application.]

If requesting Rental Assistance, please provide the following:

Landlord: _____ Phone: _____

Mailing Address: _____ Email: _____

If requesting Utility Assistance, please provide the following for each Utility you are requesting assistance with:

Utility Company: _____ Phone: _____

Mailing Address: _____

Type of Utility: _____ Amount Owed: _____

Utility Company: _____ Phone: _____

Mailing Address: _____

Type of Utility: _____ Amount Owed: _____

Utility Company: _____ Phone: _____

Mailing Address: _____

Type of Utility: _____ Amount Owed: _____

Utility Company: _____ Phone: _____

Mailing Address: _____

Type of Utility: _____ Amount Owed: _____

(If more than four utility companies, please provide on an additional piece of paper.)

For every individual working in the household, please provide the following and submit supporting documentation:

Family Member: _____
Employer: _____
Address: _____
Phone: _____ Email: _____
Hours worked per week: _____ Amount paid (per hour or per year): _____

Family Member: _____
Employer: _____
Address: _____
Phone: _____ Email: _____
Hours worked per week: _____ Amount paid (per hour or per year): _____

Family Member: _____
Employer: _____
Address: _____
Phone: _____ Email: _____
Hours worked per week: _____ Amount paid (per hour or per year): _____

Family Member: _____
Employer: _____
Address: _____
Phone: _____ Email: _____
Hours worked per week: _____ Amount paid (per hour or per year): _____

(If more than four people in the household are working, please provide on a separate piece of paper.)

For every individual receiving income from sources other than employment (i.e. TANF, SSI, SSB, SSD, Veterans, Unemployment, etc.), please provide the following and submit supporting documentation:

Family Member: _____
Agency: _____
Address: _____
Phone: _____ Amount paid (per month): _____

Family Member: _____
Agency: _____
Address: _____
Phone: _____ Amount paid (per month): _____

Family Member: _____
Agency: _____
Address: _____
Phone: _____ Amount paid (per month): _____

(If more than three people in the household are receiving income other than from working, please provide on a separate piece of paper.)

APPLICANT CERTIFICATION

All Adult Members of the Household Are Required to Review and Sign Below

1. **Giving True and Complete Information:** I certify that all the information provided on the application for the Emergency Rental Assistance Program, including any "Statement of Need", is accurate and complete to the best of my knowledge. I have reviewed the entire application and certify that the information shown is correct.
2. **Reporting Changes in Income or Household Composition:** I know that I am required to report changes in income and any changes in the who lives in the household whether by birth, death or moves in/moves out.
3. **No Duplicate Residence or Assistance:** I certify that the residence listed on this application is my primary residence and I will not obtain duplicate program assistance either from another agency or for another address while I am receiving assistance through this program.
4. **Cooperation:** I know I am required to cooperate in supplying all information needed to determine my eligibility, level of benefits or verify my true circumstances. Cooperation includes completing and signing all required forms and providing supporting documentation and verification as required.
5. **Criminal and Administrative Actions for False Information:** I understand the knowingly supplying false, incomplete or inaccurate information is punishable under federal criminal law and is grounds for termination from and repayment to the Emergency Rental Assistance Program.

I certify that I have read, understood, and agree to the above.

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

