



MID-COLUMBIA STARR PROGRAM

The Mid-Columbia STARR Program provides rental assistance for households that are at or below 80% Area Median Income and have experienced a loss of income related to COVID-19, been directly impacted by business closure related to COVID-19, have a compromised health condition, diagnosed or exposed to COVID-19, and/or displaced or unstably housed as the result of public health measures taken to reduce the spread of COVID-19. MCHA is administering this program on behalf of Mid-Columbia Community Action Agency (MCCAC).

Funds are available for any or all the following eligible expenses incurred 04/01/20-06/30/21:

- Rent payments, including current, future, and past due rent and late fees
- Manufactured home rental space ("lot rent") or RV space for primary housing

In order to access this assistance please:

1. **Complete the entire application packet.** Please do not leave any black spaces or leave out information.
2. **To expedite this process, provide documentation verifying information certified in the application.** Specifically, provide proof of income and source for last 30 days, copy of current lease, or other documents connected to your housing status.
3. **Return the completed application packet to Mid-Columbia Housing Authority by mail, fax, email, or drop box outside our office.** Applicants will be considered in order of date and time the application is received.
4. After MCHA receives your application, MCHA will review it and complete any required verifications. MCHA will call you with follow up questions.
5. Payment will be made directly to your landlord on your behalf.

Checklist required for your completed application (if applicable):

- Application
- Income from past 30 days
- Lease that shows rent amount
- Statement from landlord that shows past due rent and fees
- Copies of Social Security cards *NOTE: If you do not have a Social Security card due to residency status, you are still eligible for this program*
- MCHA Release of Information
- ROCC HMIS Release of Information

Please contact Angela Phillips at 541-296-5462 or angelap@mid-columbiahousingauthority.org if you have any questions or need help filling out this application.





Name: _____

Address: _____

Phone: _____ Alternate Phone: _____

Email: _____

1. **Household Composition:** List the head of household and all other members who live in your household. Give the relationship of each member to the head of household.

SSN	Last name	First name	Sex	Relation to Head	Birthdate

2. **Income:** List all current income for all adult household members over the age of 18. Do not list income earned by household members who are minors or full-time students. **Attach income verification for past 30 days (paystubs, SSI award letter, etc.). Failure to provide income documentation will result in a delay in funds.**

Household Member Name	Income Source	Amount Per Month

3. **COVID-19 Impact:** Please mark the box that best describes the impact COVID-19 has had on your household.

- Loss of income due to COVID-19 related factors
- Directly impacted by business closure related to COVID-19
- Diagnosed or exposed to COVID-19
- Compromised health status or elevated risk of infection or vulnerability to health as related to COVID-19





Incurred significant cost or experienced a financial hardship due to COVID-19

4. **Housing Status:** Please mark the box and initial below to verify your current living situation.

- Unstably Housed Due to COVID-19 related factors
- o This means you are at risk of losing your housing and you been notified to vacate current residence or otherwise demonstrate high risk of losing current housing; AND
 - o Lack the resources or support networks to obtain other permanent housing

_____ I verify that the statement above matches my current living situation. I do not have any other resources to prevent me from losing my housing and I have not and will not receive any other assistance for the expenditures listed below.

5. **Request for Funds:** Please fill out the information about your landlord and then fill out the type of assistance you are requesting. We need a copy of your lease that shows your rent amount. If you have past due rent, we need a statement from the landlord that shows the amount owed (including past due rent and late fees).

Landlord Name		Contact Information (phone or email)	
Type of Assistance	Months Requested	Amount Per Month	Total
Rent (current or future)			
Past due rent			
Late Fees (rent)			

Applicant Certification: I understand that the above information is collected to determine if I am eligible to receive funding from the Mid-Columbia STARR Program. My signature provides self-certification of COVID-19 impact on my household and my current housing status. I authorize the Program Coordinator to verify all information provided on this application. I authorize the Program Coordinator, Mid-Columbia Housing Authority, Mid-Columbia Community Action Council, or other local service agency to discuss my household as it pertains to this program.

Applicant Signature: _____

Date: _____





**AUTHORIZATION TO
RELEASE INFORMATION
For the
Mid-Columbia STARR Program**

I, _____, applicant for the Mid-Columbia STARR Program hereby authorize Mid-Columbia Housing Authority, Mid-Columbia Community Action Council, or other local Public Service Agency (PSA) _____, and their authorized representatives and employees to share the identity, location, social services status, and any other pertinent information about my household.

I further authorize the Mid-Columbia Housing Authority, Mid-Columbia Community Action Council, and specified PSA to release the same information to the Oregon Housing and Community Services (OHCS) and Rural Oregon Continuum of Care (ROCC). I understand that the Mid-Columbia Housing Authority, Mid-Columbia Community Action Council, and PSA may release this information to OHCS or ROCC for the purpose of coordination, evaluation, and other activities associated with the administering of these funds.

I understand that neither Mid-Columbia Housing Authority, Mid-Columbia Community Action Council, the PSA, OHCS, nor ROCC will identify me or any other members of my household by name, address, or telephone number 1) to other social service agencies except to further the purpose of coordinating activities associated with administering these funds, or 2) to any other members of the public or press for any purpose whatsoever without my specific further approval. I do, however, authorize the Mid-Columbia Housing Authority, Mid-Columbia Community Action Council, the PSA, OHCS and ROCC to release descriptive profile information about me and my household relating to these funds.

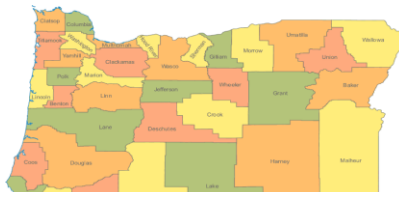
SIGNATURE:

Head of Household

Date

This Release of Information is valid for one year from the date of signature, or until otherwise rescinded.





Member Counties: Baker, Benton, Clatsop, Columbia, Coos, Curry, Douglas, Gilliam, Grant, Harney, Hood River, Josephine, Klamath, Lake, Lincoln, Linn, Malheur, Marion, Morrow, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler, Yamhill

Rural Oregon Continuum of Care (ROCC) HMIS Client Consent to Release of Information for Data Sharing in Rural Oregon Balance of State

Rural Oregon Continuum of Care Homeless Management Information System (HMIS) is a computer system that is used to collect and share information on homelessness and social services throughout Rural Oregon Balance of State. The information gathered by Mid-Columbia Housing Authority and HMIS allows agencies to plan and deliver services that help people in need. By sharing information with each other, agencies are able to simplify service delivery by coordinating services and referrals across agencies.

Maintaining the privacy and safety of those using our services is very important to us. The HMIS runs in compliance with all Federal and State laws and codes, including Health Insurance Portability and Accountability Act (HIPAA). Every person and agency that is authorized to read or enter information into the database has been trained on client confidentiality policies and has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights ended and may be subject to further penalties.

Services will not be denied should you choose not to share information. Information will still be collected and entered because of our federal and state requirements. **Certain minimum client information is shared throughout our HMIS in order to avoid creating duplicate client records.** Authorized HMIS persons at participating community agencies will be able to see the following data elements of all client records:

- First Name
- Last Name
- Date of Birth
- Veteran Status
- Gender
- Social Security Number (required for specific services)

Please read the following statements and consult with your agency staff if you have any questions:

I UNDERSTAND THAT:

- I will not be denied services if I decline to share my data beyond the minimum requirements.
- The release of my information does not guarantee that I will receive assistance.
- The partner agencies will share my basic identifying information (Name, DOB, Veteran Status, Gender, SSN) in order to improve service delivery and reduce duplicate data collection.
- Any details about the programs I participate in or information I share with agency staff will not be disclosed to any third party unless I give written authorization or it is otherwise required by law. We must still report some information because of our federal, state or funder requirements.
- This authorization will remain in effect for 7 years unless I revoke it in writing by signing a written statement or Revocation form.
- I understand that I may cancel my consent to data sharing at any time. However, doing so will not change information that has already been given out or actions already taken. Revocation will be effective as of that date.
- I have the right to see my HMIS record, ask for changes, and to have a copy of my record from this agency upon written request.

- I have the right to file a complaint if I feel I have been harmed in some way by the use of HMIS.
- I have the right to receive a copy of the HMIS Notice to Clients of Uses and Disclosures.
- Agencies with access to shared information can be found on the Rural Oregon Continuum of Care website: <https://caporegon.org/what-we-do/the-rocc/>

Maintaining the privacy and safety of those using our services is very important to us. Your record will only be shared if you give us permission to do so. There may be risks and/or benefits for you to consider before you decide whether or not to consent to the release of information.

By writing your initials below, you agree to share the following level of information for yourself and all household members listed below with other Rural Oregon Balance of State HMIS partner agencies.

____ 1) In addition to the minimum required data elements (Name, DOB, Gender, Veteran Status, SSN), **I agree to share** additional demographic information (including Race and Ethnicity), program enrollment and exit information, information about the nature of my situation, services and referrals I receive, and contact information via the Rural Oregon Balance of State HMIS with other Rural Oregon Balance of State HMIS partner agencies.

____ 2). Beyond the minimum required data elements (Name, DOB, Gender, Veteran Status, SSN), **I DO NOT agree to share** any additional information through the Rural Oregon Balance of State HMIS with other Rural Oregon Balance of State HMIS partner agencies.

Please list the names and dates of birth of all household members participating in services:

Client/Parent or Guardian Name (please print)

Client/Parent or Guardian Signature Date

If applicable:

Additional Adult's Name (please print)

Additional Adult's Signature

Date

Agency Personnel Name (please print)

Agency Personnel Signature

Date
