COCONINO COUNTY COMMUNITY SERVICES
OWNER OCCUPIED HOUSING REHABILITATION PROGRAM
2625 N. King Street – 2nd Floor
(928) 679-7430 or ngallegos@coconino.az.gov

Dear Applicant:

Thank you for your interest in the Coconino County Owner-Occupied Housing Rehabilitation Program. Attached to this letter is an application for the program. Please be advised that we are unable to do any housing rehabilitation on the Navajo reservation.

In addition to your application, clear copies of the documentation listed below must be submitted. If you have any questions, need assistance, or if you have problems obtaining the required documentation listed below, please contact:

Norma Gallegos, Assistant Director
(928) 679-7430
ngallegos@coconino.az.gov

Please submit:

1. **Original application, completed and signed by all owners of the home**
2. **Copies of all gross income for all household members who had income within the Last 12 months:**
   - **Three most recent paycheck stubs, showing year-to-date totals**
   - **Three most recent bank checking and savings statements**
   - **Most recent Social Security, retirement, or disability award letter**
3. **Social Security cards for all members of the household**
4. **Current property tax statement**
5. **Most recent monthly mortgage statement (showing outstanding balance)**
6. **Proof of homeowner insurance**

Note: Additional documents may be requested to substantiate income for this program, including Federal and State income tax filings, investment and retirement accounts, or income derived from other sources such as rentals or cash sales and services.

Missing required information could result in delay or denial of processing your application for home repair services.

We look forward to receiving your application. Please contact us if you have any questions or need assistance in completing this application.

COCONINO COUNTY ARIZONA
COMMUNITY SERVICES

Helping People. Changing Lives. Community Action PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

Coconino County Community Services
Application for Service

PROGRAM(s) APPLYING FOR:	PROGRAM:	SERVICES INCLUDE:	
☐	SOCIAL SERVICES	Rental/Mortgage/Utility (including deposits) Assistance	*Form A*
☐	SENIOR SERVICES	Case Management, Senior Nutrition, Homecare Services	*Form B*
☐	EMPOWERMENT	Basic Business Empowerment, Individual Development Accounts	*Form C, Form C1 (BBE), C2 (IDA)*
☐	HOUSING REHAB	Owner Occupied Housing Rehabilitation	*Form D*

NUMBER OF ADULTS LIVING IN HOUSEHOLD:	
NUMBER OF CHILDREN LIVING IN HOUSEHOLD:	
TOTAL FAMILY SIZE:	

Date moved to Coconino County (mm/dd/yy) _____

Date moved to Arizona (mm/dd/yy): _____

Do you work for Coconino County?	☐	YES	☐	NO	If yes, what department? _____
Does any family member work for Coconino County?	☐	YES	☐	NO	If yes, what department? _____
Do any family or friends work for Community Services?	☐	YES	☐	NO	If yes, what is their name? _____
Do you live on a reservation?	☐	YES	☐	NO	If yes, which one? _____
Is anyone in your household 60 or over?	☐	YES	☐	NO	If yes, which one? _____

Please complete the following sections with the <u>Applicant</u> information <u>ONLY:</u>

APPLICANT NAME: _____ **APPLICATION DATE:** _____

First *M.I.* *Last*

PHYSICAL ADDRESS: _____

CITY/STATE/ZIP: _____ _____

MAILING ADDRESS (if different): _____

CITY/STATE/ZIP: _____ _____

Coconino County Community Services
Application for Service

HOME PHONE NUMBER: _____ **EMAIL ADDRESS:** _____

CELL PHONE NUMBER: _____ **CELL PHONE PROVIDER:** _____

Would you accept texts as a way to contact you? ☐ YES ☐ NO

SSN#: _____ **BIRTH DATE** (MM/DD/YEAR): _____

PRIMARY LANGUAGE SPOKEN: _____

HOUSING STATUS:

- ☐ Own
- ☐ Rent
- ☐ Homeless
- ☐ Subsidized
- ☐ No-Pay
- ☐ Other - Please describe: _____

MARITAL STATUS:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Other

FAMILY TYPE:

- ☐ Single Adult
- ☐ Single Parent
- ☐ Two-Parent Household
- ☐ Two Adults, No Children
- ☐ Multiple Adults, No Children
- ☐ Multiple Adults, with Children
- ☐ Grandparent raising Grandchild
- ☐ Extended Family (Aunts, Uncles, Cousins, In-laws)
- ☐ Multi-Generational (Grandparents, Parents, Children)

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PLEASE COMPLETE THE FOLLOWING FOR ALL FAMILY/HOUSEHOLD MEMBERS:

	Relationship to Applicant	First Name	MI	Last Name	SSN#	Veteran	Active Military	Gender	DOB	Disabled	Last Grade Completed	Race	Ethnicity	Health Ins.	
						Y/N	Y/N	M/F	MM/DD/YY	Y/N	*Use Guide Below*			*Y/N*	*Type (See Guide)*
1															
2															
3															
4															
5															
6															
7															
8															
9															

GUIDE:

RACE: WH - White
BL - Black/African-American
AI - American Indian/Alaska Native
AS - Asian
NH - Native Hawaiian/Other Pacific Islander
OT - Other
MR - Multi/Mixed Race

ETHNICITY: HL - Hispanic or Latino
NH - Not Hispanic or Latino

LAST GRADE COMPLETED: EL - 0-8th Grade
HS - 9-12th Grade
HSG - High School Graduate/GED
PS - Some Post Secondary
AD - College Graduate - Associates' (2 year)
BD - College Graduate - Bachelors' (4 year)
MD - College Graduate - Masters' (6 year)

HEALTH INSURANCE TYPE: Indian Health Services (IHS)
Medicaid
Medicare
AHCCCS
State Child Health Insurance
Military Health Care (VA, Tricare)
Direct Purchase
ACA Subsidy
Employment
None

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PLEASE LIST ALL FAMILY/HOUSEHOLD INCOME:

	Name of Family Member	Employer/ Source of Income	Address/Phone	Frequency of Pay (Weekly, Biweekly, Monthly, etc.)	Employment Status (Full-time, Part-time, On-Call, Seasonal, Internship, Work Study)	If unemployed, when was your last date of work?
1						
2						
3						
4						
5						

INDICATE ALL INCOME AND BENEFITS RECEIVED IN THE LAST 30 DAYS (CHECK ALL THAT APPLY)

	TYPE OF INCOME	MONTHLY AMOUNT		TYPE OF INCOME	MONTHLY AMOUNT
	Employment			TANF	
	Unemployment			General Assistance	
	SSI			Retirement	
	SSDI			Veteran's Pension	
	Veteran's Disability			Pension from Job	
	Private Disability			Child Support	
	Worker's Compensation			Alimony or other spousal support	
	Self-Employment			School Grants/Scholarships/Loans/EITC	
	SNAP (Food stamps)			Adoption/Guardianship Stipend	
	VA Non-Service Connected Disability Pension			VA Service Connected Disability Pension	

Notes:

Coconino County Community Services
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INDICATE ALL NON CASH BENEFITS/SERVICES RECEIVED IN THE LAST 30 DAYS (CHECK ALL THAT APPLY)

	SNAP - Food Assistance		Child Support Enforcement Referral
	Clothing Voucher Referral		NACOG (Weatherization/Senior Services) Referral
	WIC		Catholic Charities
	Head Start		St. Vincent de Paul
	Your Local Church		Housing Choice Voucher
	LIHEAP		Childcare Voucher
	HUD-VASH		Permanent Supportive Housing
	Public Housing		Other: _____

Notes:

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Form D: Owner Occupied Housing Rehab Intake Application

BOARD OF SUPERVISORS DISTRICT NUMBER _____

HOW DID YOU FIND OUT ABOUT THIS PROGRAM:

☐ FLYER/MAILER
☐ NEWSPAPER
☐ WEBSITE
☐ FRIEND/NEIGHBOR
☐ OTHER (describe): _____

DO YOU HAVE A REVERSE MORTGAGE? If yes, you do not qualify for this program.

☐ YES ☐ NO

DO YOU OWN YOUR HOME (OR ARE YOU IN THE PROCESS OF BUYING YOUR HOME)?

☐ YES ☐ NO

IS THIS YOUR PRIMARY PLACE OF RESIDENCE?

☐ YES ☐ NO

DO YOU HAVE HOMEOWNER'S INSURANCE? IF SO, NAME OF INSURER?

If no, insurance must be in place before any work can begin.

☐ YES ☐ NO INSURER: _____

ARE YOUR PROPERTY TAXES CURRENT?

☐ YES ☐ NO

IS THIS A PRE-MANUFACTURED OR MOBILE HOME? IF SO, WHAT YEAR?

☐ YES ☐ NO YEAR: _____

IF THIS IS A PRE-MANUFACTURED OR MOBILE HOME, IS IT ON A FOUNDATION?

☐ YES ☐ NO

IS THE HEAD OF HOUSEHOLD A SINGLE PARENT OF A MINOR CHILD (under the age of 18)?

☐ YES ☐ NO

MONTHLY MORTGAGE PAYMENT AMOUNT, IF ANY, AND CURRENT PRINCIPAL BALANCE:

MONTHLY MORTGAGE PAYMENT _____

CURRENT PRINCIPAL BALANCE _____

FOR EACH TYPE OF INCOME THAT YOUR HOUSEHOLD RECEIVES, PLEASE LIST BELOW THE SOURCE AND AMOUNT OF INCOME RECEIVED DURING THE PAST 12 MONTHS.

Sources for income include cash, employment, unemployment, alimony payments, DES benefits (TANF) social security, pension, annuity, trust fund, royalty payments, property rental, property sale, military allotments and interest from savings, stocks, bonds, certificate of deposit if over $50 per month each.

FAMILY MEMBER	SOURCE OF INCOME	HOW VERIFIED	AMOUNT
		TOTAL INCOME	

Form D: Owner Occupied Housing Rehab Intake Application

BRIEFLY DESCRIBE THE NATURE OF PROBLEMS AND REQUESTED REPAIRS TO YOUR HOME:

DO YOU HAVE A DISABILITY THAT REQUIRES HOME MODIFICATIONS TO MAKE IT MORE ACCESSIBLE?

☐ YES ☐ NO

PLEASE DESCRIBE:

DO YOU HAVE APPLIANCES IN NEED OF REPAIR OR REPLACEMENT?

☐ YES ☐ NO

PLEASE DESCRIBE:

Form D: Owner Occupied Housing Rehab Intake Application

PRIVACY ACT NOTICE STATEMENT The information on this form is being collected to determine your eligibility for assistance under the Community Development Block Grant program. It will be used to manage the CDBG Program, to protect the Government's financial interest, and to verify the accuracy of the information furnished. It may be released to appropriate Federal, State, and local agencies (or their agents) when relevant, to civil, criminal or regulatory investigators and prosecutors.

PERMISSION I give permission to Coconino County Community Services to release information in my application as necessary to obtain services on my behalf by making necessary referrals to community and state agencies. As necessary, my family and significant others may be contacted in regard to this application.

AUTHORIZATION TO RELEASE FINANCIAL, CREDIT, AND PERSONAL INFORMATION

I hereby consent to the inspection, copying and obtaining by interview any and all information concerning my financial status, credit and character by Coconino County Community Services, or any representative thereof. Such information shall include, but is not limited to, all financial records, documents and reports from banks, mortgage companies, credit agencies, law enforcement agencies, and interviews with employers, landlords, neighbors, and personal references, etc.

- I hereby consent to the sharing of information (as necessary) with Coconino County Community Services' partner agencies.
- I hereby consent to allow my property and family to be photographed and/or filmed for any purpose associated with the Coconino County Community Services Housing Rehabilitation Program.
- I understand and agree that all photographs and/or film are the sole property of Coconino County Community Services and I will not claim any royalty or other sum due for use of such photographs and/or films.

CERTIFICATIONS I certify that the information in this form is true and complete to the best of my knowledge and belief. I understand that I can be fined up to $10,000, or imprisoned up to five years if I furnish false or incomplete information. I also understand that in the event the information is found to be incorrect, I may become ineligible for the assistance provided.

I certify that the property listed at the address on the application for rehabilitation is to be occupied by the owner as the principal residence.

Signature (Head of Household)	Date
Signature (Spouse/Co-head of Household)	Date
Signature of Person assisting with this form, if applicable	Date