Public Health Management Corporation (PHMC)
COVID-19 Shallow Rent Emergency Program

Applicant's representative may rely upon the applicant's verbal, email or text affirmation to complete the application

APPLICATION COVER PAGE

AGENCY: ____

ADDRESS: ____
Street City State Zip Code

MEDICAL CASE MANAGER /HOUSING COUNSELOR ______________________________
(Print Name)

PHONE: ____

FAX:___________________________________ EMAIL: __________________________

I attest the information and documentation submitted is accurate and verified by me.

SIGNATURE: ____________________________________DATE:_____________________

Fax the application to 215-985-2099, Attn: EFA COORDINATOR. This is a secured fax number, do NOT use any other PHMC fax number for this purpose. DO NOT SEND the application via the MAIL.

DATE OF APPLICATION: _____________

APPLICANT NAME: ______________________________________

ADDRESS:

____
STREET/APT#/CITY/STATE/ZIP CODE

____
STREET/APT#/CITY/STATE/ZIP CODE

COUNTY OF RESIDENCE: ____

DATE OF BIRTH: _____________________________ SSN: ____________________

GENDER (check one): ☐ Male ☐ Female ☐ Neither
☐ Transgender/Third Gender/Nonbinary
Sex of applicant assigned at birth (check one): ☐ Male ☐ Female

RACE & ETHNICITY: (Please note that both race and ethnicity are required of the applicant, this is based on the applicant's self-report. An applicant's response is sufficient for this purpose).

RACE (check all that apply): ☐ American Indian/ Alaska Native ☐ Asian ☐ Black /African American

☐ Native Hawaiian/Other Pacific Islander ☐ White

If applicant answered Asian, please specify the following (check all that apply):
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

If applicant answered Native Hawaiian/Other Pacific Islander, please specify the following (check all that apply):
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

ETHNICITY (check one):
☐ Hispanic/Latino(a)/Spanish Origin ☐ Non-Hispanic/Latino(a)/Spanish Origin

If applicant answered Hispanic/Latino(a)/Spanish Origin, please specify the following (check all that apply):
☐ Mexican/Mexican American/Chicano(a) ☐ Puerto Rican ☐ Cuban
☐ Another Hispanic/Latino(a)/Spanish Origin

HIV RISK (check all that apply): ☐ MSM ☐ IDU ☐ Heterosexual Contact
☐ Hemophilia/Coagulation Disorder ☐ Perinatal Transmission ☐ Blood Transfusion
☐ Not Reported or Not Identified

MEDICAL INSURANCE (check one):
☐ Private Employer
☐ Private Individual
☐ Medicare
☐ Medicaid, CHIP or Other Public Plan
☐ No Insurance/Uninsured
☐ Other
☐ Unknown
☐ Veterans Health Administration (VA), Military Health Care (Tricare), & Other Military Health Care
☐ Other Plan (Client has an insurance type other than listed above)

CURRENT LIVING ARRANGEMENT (check one):
☐ Renting (unsubsidized)
☐ Permanently living with family/friends
☐ Institutional setting
☐ Substance abuse treatment facility or detox center
☐ Foster care home or foster care group home
☐ Temporarily staying with family/friends
☐ Temporary placement in institution
☐ Jail/ prison/juvenile/detention
☐ Hotel, or motel (paid with a government voucher)
☐ Emergency shelter or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a vehicle, an abandoned building, a bus/train/subway station/airport, or anywhere outside
☐ Own home/ apartment
☐ Subsidized housing
☐ Psychiatric hospital or other psychiatric facility
☐ Hospital
☐ Transitional housing for homeless individuals
☐ McAuley House, Good Shepherd,
☐ Hotel or motel (paid w/o a government voucher)

How long have you lived there? ___________________

SUBSIDY INFORMATION:
Do you receive a housing subsidy?
☐ Yes ☐ No Source: ___________________________________

Do you receive low income housing?
☐ Yes ☐ No Source: ___________________________________

HOUSEHOLD COMPOSITION:

Family size: ___________

(This is the number of family members who live together, including the applicant. An applicant living alone (or with **only** non-relatives) counts as a family of one.

Annual family income: ________

(This is the sum of income of all family members who live together. It includes pre-tax money or "cash" income (earnings; unemployment compensation; Social Security; public assistance; veteran payments; survivor benefits; pension or retirement income; interest; dividends; rents; royalties; income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources). It excludes non-cash benefits including food stamps, housing subsidies and capital gains or losses).

Did you experience a loss of income as a result of COVID-19 (during the Stay-at-Home Order or after)?
☐ Yes
☐ No
If you have COVID-19 what was your date of diagnosis ____________________________

Are you currently on the HOPWA waitlist administered by the Philadelphia Office of Homeless Services?
☐ Yes
☐ No

Please describe how the applicant experience loss of income as a result of COVID-19. Applicants do NOT have to be diagnosed with COVID-19 but must be able to demonstrate that their income loss is related to COVID-19.

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Landlord Agreement and Acknowledgement Related to the COVID-19 Shallow Rent Emergency Program

I, ____[PRINT NAME], am the owner or property manager (or am authorized to sign on behalf of the owner or property manager) (the "Landlord") of the property located at ____________________________________ [INSERT ADDRESS] (the "Property"). By signing below, Landlord represents and warrants that he/she/it (if entity) is currently leasing the Property (or a unit located therein) to ______________________________ [INSERT ALL TENANT'S NAMES] (the "Tenant") pursuant to a written residential lease agreement dated ________________________ (the "Lease"). Pursuant to the Lease, the rental rate is currently __________________________ per month (the "Monthly Rent").

By signing below, Landlord is agreeing to take part in the Public Health Management Corporation (PHMC) COVID-19 Shallow Rent Emergency Program and further acknowledges and understands that Landlord is subject to the following requirements and obligations:

1. The Tenant will be receiving a grant from PHMC funded through the City of Philadelphia (the "City").
2. Landlord agrees to accept the PHMC Grant on the Tenant's behalf and for the benefit of Tenant.
3. The entirety of the PHMC Grant will be applied to the Tenant's Monthly Rent obligation under the Lease.
4. The PHMC Grant payments will be issued by the Public Health Management Corporation ("PHMC") through an Automated Clearing House ("ACH") transfer whereby the PHMC Grant funds will be direct deposited into Landlord's designated bank account.
5. Landlord agrees that as a condition to receiving the PHMC Grant funds for Tenant's benefit, Landlord will be required to do the following:

   A. Submit a copy of the executed Lease;

   B. Submit an IRS Form W-9 ; and

   C. Apply one hundred percent of the PHMC Grant to Monthly Rent due in the allotted months reducing the Monthly Rent due to Landlord from Tenant by the PHMC Grant amount; and

   D. Limit the amount charged to the Tenant over the allotted months to the Monthly Rent less the PHMC Grant amount; and

   E. Allow the Tenant a six (6) month repayment period commencing from the latest date PHMC Grant funds were received by Landlord on behalf of Tenant for any unpaid rent accrued prior to June , 2020, or for any unpaid Monthly Rent that may accrue during the period in which Landlord is receiving the PHMC Grant funds (collectively, the "Arrears"). Tenant may pay the Arrears through a written payment agreement between Landlord and Tenant; and

F. Not pursue eviction of the Tenant for non-payment of rent for a period of six (6) months following the latest date PHMC Grant funds were received by Landlord on behalf of Tenant; and

G. Not charge any late fees or penalties on unpaid Monthly Rent for the allotted months or at any time while receiving the PHMC Grant funds; and

H. If a Philadelphia rental, the landlord agrees to maintain a current, valid rental license with respect to the Property, hold a current Certificate of Rental Suitability with respect to the Property, and pay all taxes due to the City on a timely basis; and

I. Landlord will indemnify and defend the City and PHMC and save them harmless from and against any and all demands, claims, actions, suits, judgments, awards, fines, penalties, proceedings, losses, damages, liabilities and expenses (including, without limitation, reasonable and out-of-pocket fees of attorneys, investigators and experts) ("Claims") arising or alleged to arise from or in connection with the payment of the PHMC Grant, the Lease, the Tenant and/or the Property, which indemnification shall include all reasonable and out-of-pocket legal fees, costs and expenses incurred by the City and PHMC in defending such proceedings.

By signing below, Landlord understands and agrees that the foregoing conditions and obligations must be complied with as a condition to receiving the PHMC Grant for the benefit of Tenant. If Landlord fails to comply with any of the above PHMC requirements, Landlord understands and agrees that he/she/it is obligated return the entirety of the PHMC Grant funds received by Landlord to the City within thirty (30) days of demand by the City. If Landlord does not return the PHMC Grant within the aforesaid thirty (30) day period, any amounts not returned will accrue interest at the rate of ten percent (10%) per day, but not more than the maximum rate allowed by law, and the City may exercise any right, power or remedy permitted by law in an effort to collect such amounts, and Landlord shall be responsible for the payment of reasonable attorney fees and out-of-pocket costs incurred by the City related to such collection efforts. Intending to be legally bound, the Landlord represents and warrants it has the authority to execute this Landlord Agreement and has executed this Landlord Agreement the date and year set forth below.

DATE: ____________________

LANDLORD:
If Individual:____ [**Sign and Print Name**]

____ [**Title if Applicable**]

If Entity:____
[**Insert Company Name with Signature**]

____ [**Title**]

CONSENT FOR SERVICE FORM AND AFFADVIT

Be signing this consent form and affidavit, I attest to the fact that I am applying for the PHMC COVID-19 Emergency Rental Assistance Program because I am experiencing a COVID-19 related loss of income.

I agree to cooperate with referring and administering agency staff in providing additional information, as required, to complete the application. I have answered the questions on the application form and have submitted all necessary documentation to support my request for assistance.

Applications are considered by the requirements outline in PHMC's Shallow Rent Program Guidelines. Staff at the medical case management agency will provide any assistance needed by applicants in the application and appeal process.

CONFIDENTIALITY STATEMENT

Assigning an "individual identification number" to the application and maintaining records in a locked file assures the applicant's privacy. Records are maintained for seven years and then destroyed. Application forms are open to inspection only to those professionals who are licensed or fund the activities of this program and for internal contract review, when necessary. Neither this agency nor its representatives will reveal the applicant's personal health or medical information to anyone without a release form in accordance with Pennsylvania Act 59.

The agency completing this application reserves the right to deny or limit service based on its professional judgment of needs. A negative decision will be discussed with you. You have the right to appeal this decision. The agency will make every effort to provide satisfactory service in every respect; however, if you should experience an unusual difficulty, please contact the agency's Executive Director who will act promptly to assist you. In regard to any of the above items, you may request a detailed copy of the agency's relevant appeals process. You may also request to appeal the decision by contacting the Health Information Helpline at 215-985-2437.

This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or if authorization by the confidentiality of HIV-related information Act, 35 P.S. Section 7601. Et Seq. A general authorization for the release of medical or other information is not sufficient for this purpose.

APPLICANT STATEMENT

I understand that it is a federal offense to knowingly make a false statement in this affidavit (Title 17. United States Code, Section 10140). Applicant has read information carefully to be sure information contained herein is true and complete before submitting.

I understand that the information provided in this affidavit or any other document related thereto does not represent any commitment or obligation to be awarded or provided through PHMC's COVID-19 Emergency Rental Assistance Program.

I give consent/authorization PHMC and the Philadelphia Department of Public Health, Activities Coordinating Office and their respective agents, employees, and assigns, to share, disclose, analyze, and discuss all documentation and information provided within this application and in subsequent communications related to the PHMC COVID-19 Emergency Rental Assistance Program.

I consent to participate in the program, and I also give consent/authorization to PHMC and their respective agents, employees, and assigns, to contact my landlord, if I am selected to receive assistance.

I have been offered, read and signed a copy of the agency's release form in accordance with Pennsylvania Act 59.

Applicant
Signature____

Date________________

Medical Case Manager or
Housing Counselor Signature ____

Date________________