Southwestern Community Services

People helping people in Cheshire and Sullivan Counties since 1965

HOUSING SECURITY GUARANTEE PROGRAM

SECURITY DEPOSIT LOAN ASSISTANCE

Information Sheet

The Housing Security Deposit Program (HSGP) is designed to provide clients security deposit assistance if they have no other means of obtaining a security deposit in order to secure rental housing.

This assistance is in the form of a guarantee certificate, NOT CASH, to the landlord and a LOAN to the client.

In order to be eligible for HSGP, you must meet the income eligibility guidelines; be able to obtain a legal lease from the landlord; be able to maintain the monthly rental fee on the unit; be able to pay the loan back within 6 to 24 months; be able to provide good landlord references; and be able to provide the following information:

- $10.00 non-refundable processing fee
- Completed application
- Verification of all income and expenses
- Positive landlord references
- Social security numbers of all household members
- Proof that you have no other way to pay your security deposit
- A signed landlord form stating their understanding of the program and their willingness to participate in the program knowing that they will not receive the cash up front.

HUD AREA INCOME LIMITS FOR 2018

AREA	INCOME LIMIT	1 PERSON	2 PERSON	3 PERSON	4 PERSON
Cheshire County	50% of Area Median	$28,500	$32,550	$36,600	$40,650
Sullivan County	50% of Area Median	$28,500	$32,550	$36,600	$40,650

Applicants may be denied if they do not submit completed applications and documentation; if they do not meet income guidelines; if it is determined they cannot afford the rental unit; if they have a prior history of damaging rental housing; if they have consistently failed to pay rent or pay on a prior HSGP loan; and/or if they cannot show the steps they are taking to make different choices.

Please drop off completed application with supporting documentation at our SCS Office in Keene or Claremont. If you have any questions, please contact a representative at (603)719.4226.

This is not an emergency program. The application process takes at least 10 to 14 business days from the time a COMPLETED application is received, with ALL documentation. If you are experiencing an emergency and need assistance immediately, please contact the local welfare office of the town you reside in, or call NH 211.

Please note: If you move into the new apartment before the process is completed, you will no longer be eligible for the program.

63 Community Way
PO Box 603
Keene, NH 03431
Phone: (603) 352-7512
Fax: (603) 352-3618

United Way
Call Toll Free: (800) 529-0005
TTY-NH: (800) 735-2964

96-102 Main Street
PO Box 1338
Claremont, NH 03743
Phone: (603) 542-9528
Fax: (603) 542-3140

Be sure to include the following documents with your application:

☐ Verification of all household income (last 30 days) ☐ One prior landlord reference

☐ Budget worksheet ☐ New landlord form

Date: / /

Applicant: _____ SSN: - - DOB: / /

Co-Applicant: _____ SSN: - - DOB: / /

Physical Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Phone: - - ☐ Home ☐ Cell ☐ Work ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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HOUSEHOLD DEMOGRAPHICS: No. of Men: _____ Women: _____ Children: _____ Total Residents: _____

☐ Single Parent (Male) ☐ Single Parent (Female) ☐ Two Parents ☐ Single Person ☐ 2+ Adults, No Children

HOUSEHOLD MEMBERS HEAD OF HOUSEHOLD FIRST Last First	SOCIAL SECURITY #	DATE OF BIRTH	TANF	GENDER	DISABLED	RACE/ETHNICITY	EDUCATION LEVEL	FOOD STAMPS	HEALTH INS.	VET	MONTHLY INCOME	MI,SA,DV,DD,PD
1.			☐	☐	☐	☐	☐	☐	☐	☐		☐
2.			☐	☐	☐	☐	☐	☐	☐	☐		☐
3.			☐	☐	☐	☐	☐	☐	☐	☐		☐
4.			☐	☐	☐	☐	☐	☐	☐	☐		☐
5.			☐	☐	☐	☐	☐	☐	☐	☐		☐
6.			☐	☐	☐	☐	☐	☐	☐	☐		☐
7.			☐	☐	☐	☐	☐	☐	☐	☐		☐
8.			☐	☐	☐	☐	☐	☐	☐	☐		☐
TOTAL INCOME:												

*MI = Mental Illness *SA - Substance Abuse *DV = Domestic Violence *DD = Developmentally Disabled *PD = Physically Disabled

*** FOR OFFICE USE ONLY ***

Approved: _____

Denied: _____

Intake by: _____ Date: _____ Contacted by: ☐ Phone ☐ Office Visit

Referred by: _____ Appointment date: _____

Area moving to: _____ State Guarantee: NH

PRESENT LIVING SITUATION: ☐ Rent ☐ Staying w/Family or Friends ☐ Shelter ☐ Halfway House ☐ Own

Name and location of shelter or halfway house, if applicable: _____

Landlord and address for apartment you are leaving: _____

Monthly Rent: $ _____ How long at this address? _____ No. of Bedrooms: _____

Includes: ☐ Heat ☐ Hot Water ☐ Electric ☐ Cooking Gas

Cost Estimates: Gas _____ Electric _____

Why are you moving? ☐ Eviction ☐ Leaving of own accord ☐ Foreclosure

Reason: _____

_____

LAST 3 TO 5 YEARS RESIDENTIAL HISTORY

Previous Address: _____

Landlord: _____ Phone: _____

How long in residence: _____ Reason for leaving: _____

Reference checked: ☐

Previous Address: _____

Landlord: _____ Phone: _____

How long in residence: _____ Reason for leaving: _____

Reference checked: ☐

Previous Address: _____

Landlord: _____ Phone: _____

How long in residence: _____ Reason for leaving: _____

Reference checked: ☐

NEW APARTMENT INFORMATION

Landord: _____ Phone: _____

Apartment Address: _____

Monthly Rent: $ _____ Includes: ☐ Heat ☐ Hot Water ☐ Electric No. of Bedrooms: _____

Amount of Security Deposit: $ _____ Lease Type: _____

Date of intended occupancy: _____

Do you receive a subsidy (ex: Section 8 or Housing)? ☐ Yes ☐ No If yes, what is your portion? $ _____

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APPLICANTS' AUTHORIZATION TO FURNISH INFORMATION

I/We authorize any relative, physician, lawyer, banker, check cashing service, employer, former employer, insurance company, health care provider, mental health professional, pharmacy, hospital, emergency care facility, ambulance service, police, Sheriff, State Police, firefighter, EMT, Red Cross, Salvation Army, or any persons or organizations with information concerning my/our circumstances to furnish such information to Southwestern Community Services.

I/We further authorize the Internal Revenue Service, Social Security Administration, any State or County Division of Health and Human Services, Division of Children Youth and Families, Bureau of Elderly and Adult Services, NH Legal Assistance, and City/Town Welfare Department, shelter/housing provider, Department of Employment Security, Veterans' Administration, other departments of Southwestern Community Services, or any non-profit agency or any city/town departments, to release information from their files to Southwestern Community Services Housing Stabilization Services for the purpose of verifying information submitted to us.

Applicant's Signature _____ Date _____

Co-Applicant's Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

PURPOSE OF THIS NOTICE

Southwestern Community Services has always maintained the privacy of your personal information. We are now required by the federal Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and HIPAA regulations, 45CFR Part 160 & 164, to provide you with you this Notice of our privacy practices, our legal duties, and your rights concerning your private health information. Southwestern Community Services must follow the practices described in this Notice as long as this Notice is in effect. This Notice will take effect on 8/21/14 and will remain in effect until it is replaced. Southwestern Community Services reserves the right to revise or change this Notice at any time. Any such revisions will affect information we already have about you and any information we receive in the future. If there is any significant change in our privacy practices, this Notice will be changed and the new Notice will be available upon your request. A copy of the current Notice will also be available on our website, www.scshelps.org. You may request a copy of this Notice at any time. If you have any questions regarding this Notice, or if you wish to receive another copy, please contact:

HIPAA Privacy Officer/Director of Human Resources
Southwestern Community Services
63 Community Way
Keene, NH 03431
603.352.7512
www.scshelps.org

Uses and Disclosures of Your Health Information

Southwestern Community Services uses and discloses your personal health information for purposes of treatment, payment and healthcare operations. For example:

TREATMENT: We may use or disclose your personal health information to provide, coordinate, assess, or manage your healthcare treatment between health care providers.

HEALTHCARE OPERATIONS: We may use or disclose your personal health information in connection with the administration of your medical plan, including such operations as claims adjudication, professional review, underwriting, coordination of benefits with other plans providing coverage, fraud and abuse detection programs, audit services, quality assessment and improvement activities, and other general administrative activities.

PAYMENT: Your medical information may be used or disclosed to determine and remit proper payment for covered services under your medical plan.

DIRECT CONTACT: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. *You also have the right to refuse to provide authorization for this office to contact you regarding these matters.*

DISCLOSURES REQUIRED BY LAW: **Southwestern Community Services** may use or disclose your health information when it is required to do so by law. For example, your health information may be disclosed to comply with a court order, an administrative order, a subpoena, a discovery request, report information related to victims of abuse or neglect, to a law enforcement official for a law enforcement purpose, or other lawful process.

PUBLIC HEALTH: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability. Your health information may be disclosed to a person subject to the jurisdiction of the FDA (Food & Drug Administration) for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products.

HEALTH OVERSIGHT ACTIVITIES: We may use or disclose your health information for oversight activities authorized by law, including audits, civil, administrative or criminal investigations, or other activities necessary for appropriate oversight.

RESEARCH: We may use your personal health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

GOVERNMENT FUNCTIONS: Your health information may be used or disclosed to carry out specialized government functions, such as protection of public officials, for national security, to correctional institutions, or to another agency administering a public benefits program.

DECEDENTS: Your health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

OTHER DISCLOSURES: **Southwestern Community Services** does not use or disclose your personal health information for marketing purposes nor does it sell your information for any purpose. Any use of your personal health information for any purpose other than referenced above will require your written authorization. You may revoke any such authorization in writing. Upon receipt of the written revocation, we will stop using or disclosing protected health information about you, except to the extent that we have already taken action in reliance on the Authorization.

SPECIAL SITUATIONS

DISCLOSURE TO HEALTH PLAN SPONSOR:

Your personal health information may be disclosed to the sponsor of your group health plan for the purpose of administering benefits under the plan.

OTHER DISCLOSURE:

- Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:
- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

WORKER'S COMPENSATION:

Southwestern Community Services may provide your personal health information for worker's compensation or similar programs which provide benefits for work related injuries or illness.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding the personal health information we maintain about you:

RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your health information which **Southwestern Community Services** maintains. To inspect and/or copy your health information, please submit your request in writing to the HIPAA Privacy Officer at the address or telephone number given above. If you request a copy of information, we may charge a fee for the costs of copying, mailing or other supplies needed to fulfill your request.

RIGHT TO AMEND

If you feel that the health information we maintain about you is incorrect or incomplete, you may ask to amend the information by contacting the HIPAA Privacy Officer at the address or telephone number given above. You may request an amendment for as long as the information is maintained by **Southwestern Community Services**. Your request, submitted in writing to the HIPAA Privacy Officer, may be denied if it does not include a reason to support the request. In addition, it may be denied if you request to amend information that:

- is not part of the health information kept for or by **Southwestern Community Services**;
- was not created by us unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information you would be permitted to inspect or copy; or
- the information you seek to amend is complete and accurate.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an "accounting of disclosures" if any such disclosure was made for any purpose other than treatment, payment or healthcare operations. To request an accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer listed above. Your request must state a time period which may not be longer than six (6) years and may not include dates prior to August 21, 2014.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. *However, we are not required to agree to your request.* Your request to limit or restrict use of your health information must be made in writing to the HIPAA Privacy Officer listed above and the request must include the information you wish to limit, whether you wish to limit use, disclosure, or both, and to whom the limits may apply, for example, disclosures to your spouse.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you concerning your health information only in certain ways or at certain locations. For example, you may request that we only contact you at work, at home or by mail. Any such request must be in writing to the HIPAA Privacy Officer noted above. Where possible, we will accommodate all reasonable requests.

RIGHT TO A PAPER COPY OF THIS NOTICE

Even if you have received this Notice electronically, you are entitled to receive a paper copy of this Notice. A request for a copy of the Notice should be sent to the HIPAA Privacy Officer at the address above. You may also obtain a copy of this at our website, www.scshelps.org.

HOW TO FILE A COMPLAINT

If you believe your privacy rights have been violated by **Southwestern Community Services**, you may file a written complaint addressed to the HIPAA Privacy Officer, **Southwestern Community Services**, 63 Community Way, Keene, NH 03431. The complaint must be in writing. Or you may file a written complaint with the federal government by contacting the Secretary of the Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201. *You will not be penalized or retaliated against for filing a complaint.*

My signature acknowledges that I have received a copy of this notice.

Name (please print) Date

Signature

TOTAL HOUSEHOLD INCOME

Please list all sources of income for all household members. Include documentation with this application.

TYPE OF INCOME	AMOUNT	TYPE OF INCOME	AMOUNT

TOTAL MONTHLY INCOME: $ _____

MONTHLY EXPENSES: Please list all regular monthly expenses. For the housing section, please use figures for the **new** apartment, not the one you are residing in. Fill in all blanks. Put -0- or N/A if it does not apply to you.

HOUSING

Rent/Mortgage $ _____
Electricity $ _____
Gas/Oil/Heat $ _____
Telephone/Cell Phone $ _____
Cable $ _____
Internet $ _____

Have you applied for fuel assistance? _____
Benefit amount for last year: _____
Have you applied for electric assistance? _____
Discount % amount: _____

FOOD AND HOUSEHOLD

Food $ _____
Non-Food Grocery $ _____
Diapers $ _____
Laundry $ _____
Childcare $ _____

Do you receive food stamps? _____
If yes, how much? _____
(Please provide documentation)
Do you receive WIC? _____

PERSONAL

Doctor/Dentist $ _____
Medications $ _____
Meals Out/Delivered $ _____

Do you receive Medicaid/Medicare? _____

TRANSPORTATION

Auto Payment $ _____
Gas $ _____
Auto Insurance $ _____

OTHER

Rent-to-Own $ _____
Loans/Credit Cards $ _____
Other $ _____
TOTAL $ _____

PAST DUE BILLS

Rent $ _____
Electricity $ _____
Gas/Oil/Heat $ _____
Telephone $ _____
Cable $ _____
Other $ _____
TOTAL $ _____

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HOUSING STABILIZATION SERVICES
LANDLORD REFERENCE FORM

To Whom It May Concern:

Our mutual Tenant/Client has applied for assistance from our program. He/She has provided your name as a current/former landlord. We are requesting information regarding their rental history. Please take the time to answer the questions provided, as well as providing any additional comments. Please be advised that all information will be held in the strictest confidence.

1. Name(s) of tenant(s): _____
2. Address of apartment: _____
3. Applicant resided at your premises from ____/____/____ to ____/____/____.
4. Amount of rent paid per month/week: $ _____
5. Type of tenant: ____ Excellent ____ Good ____ Fair ____ Poor
6. Was rent paid in full? ____ Yes ____ No If not, amount in arrears: $ _____
7. Rent payment history: ____ Excellent ____ Good ____ Fair ____ Poor
   Excellent = always on time Good = if late or behind, always called and caught up quickly
   Fair = always struggling, but kept at it Poor = late, behind, little effort
8. Did tenant's household cause any significant damage? ____ Yes ____ No
9. Housekeeping: ____ Excellent ____ Good ____ Fair ____ Poor
   Excellent = always clean and tidy Good = clean, not always tidy
   Fair = needs reminders for clean, give up on tidy Poor = unclean and untidy
10. Neighbor/Landlord relations: ____ Excellent ____ Good ____ Fair ____ Poor
    Excellent = cooperative, honest, tactful, open, good communication skills with everyone
    Good = talks to neighbors/landlord for resolution, tries to work things out, fair in conflicts
    Fair = tries to talk to neighbors but gives up; avoids issues
    Poor = doesn't try to talk, complains instead, petty, spiteful, creates or maintains feuds
11. Did/does the tenant have animals? ____ Yes ____ No If yes, what? _____
12. Neighbor complaints? ____ Yes ____ No Sanitary conditions maintained? ____ Yes ____ No
13. Animal well cared for? ____ Yes ____ No Damages? ____ Yes ____ No
14. Did any unauthorized person(s) live in the unit for more than 2 weeks? ____ Yes ____ No
15. Would you rent to this applicant again? ____ Yes ____ No
16. Are you related to the tenant or any member of their household? ____ Yes ____ No

Comments: _____

_____

_____

_____ _____ _____

Landlord's Signature Date Phone Number

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Please Note: The next three pages are for the potential (new) Landlord

HOUSING SECURITY GUARANTEE PROGRAM (HSGP)
ADMINISTERED BY SCS, INC. HOUSING STABILIZATION SERVICES

Dear Property Owner/Agent:

Welcome, and thank you for taking the time to learn about our program!

The HOUSING SECURITY GUARANTEE PROGRAM provides guarantees of rental security deposits to eligible persons in accordance with RSA 126-A:50, which in part, states:

> "The inability of individual citizens to amass sufficient funds for housing security deposits contributes significantly to the problem of homelessness in the State of New Hampshire."

As the administrating agency we provide a Letter of Guarantee for the security deposit after a tenant has signed a security deposit loan agreement. We then collect the guaranteed amount from the tenant in monthly installments, designed to help the tenant work the security deposit expense into their household budget.

WHEN DO YOU RECEIVE THE ACTUAL CASH FOR THE SECURITY DEPOSIT?

You are paid the guaranteed amount in one of two ways:

1) When the guaranteed amount has been paid in full by the tenant to this agency, that amount will be transferred to the landlord as the tenant's security deposit.
2) When the tenant defaults on the rental agreement and the landlord makes a claim for rent due and repairs for damages above and beyond normal wear and tear, then, as the administering agency, we will verify the claim and pay up to the guaranteed amount to the landlord.

HOW ARE CLAIMS MADE?

Call to alert us that the tenant has moved. Indicate if you expect to make a claim. Send the claim in writing. Verification is required and a move-out inspection will be made if the claims are for damages. To make a claim for rent-due, include copies of rent receipts/or ledger pages showing that rent was not paid as agreed upon, or copies of The Legal Eviction along with this claim. To make a claim for damages above normal wear and tear, include copies of the bills. Claims must be made within 30 days of vacancy!

WHAT IF A TENANT FAILS TO MAKE PAYMENTS?

The property owner will be paid any legitimate claim up to the amount guaranteed. Every guarantee is fully underwritten. The administering agency assumes the responsibility of collecting from the tenant. The underwriter covers the balance of the Guarantee not paid by the tenant.

WHAT IF THE BUILDING CHANGES OWNERS?

The guarantee is assigned to an approved apartment and stays that apartment and the tenant signing the Guarantee.

WHAT IF THE TENANT MOVES TO ANOTHER APARTMENT BUILDING OR COMPLEX?

The agency, the tenant and the property owner must agree to a new Guarantee. Please contact this agency if you are planning to relocate the tenant.

IS INTEREST OWED THE TENANT ON THE GUARANTEE?

Interest does not begin accruing until funds have been sent to the property owner.

If you have any further questions please feel free to call: (603)719.4226.

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Please Note: This form is to be completed by (new) landlord

LANDLORD FORM

INFORMATION ONLY

The person named below: _____ has applied to our program for a security deposit and/or rental guarantee. We need the following information before they can be considered for assistance.

Please fill in the following:

Address of available unit: _____

Monthly Rent: $ _____ Tenant Portion: $ _____ Security Deposit: $ _____

Utilities included (please list each): _____

Number of bedrooms: _____ Date of move-in: _____

Type of lease: ☐ 1 year ☐ 6 months

NOTE: A lease must be available for tenant to be eligible. Tenants at will are not eligible for this program.

THIS IS NOT THE LETTER OF GUARANTEE!

Signing this form indicates your willingness to work with our Guarantee program(s). If the tenant is approved you will receive for your signature a form Guarantee Agreement. The Guarantee will only go into effect when signed by the tenant, landlord/agent, and the administering agency.

Please check one: I ☐ have ☐ have not used the Housing Security Guarantee Program prior to this.

Please print the following information on who should receive the Guarantee for signature and subsequent payments on the Guarantee.

Print name: _____ Telephone: _____

Mailing Address: _____

Fax Number: _____ Social Security Number or Tax Payer ID: _____

I certify the accuracy of the above information, that I have read and understand the information sheet on the Housing Security Guarantee Program and agree to work with the Guarantee programs administered by the agency.

Signature: _____ Date: _____

Please note: As this document IS NOT the official Security Deposit Guarantee, do not let the tenant move in until the actual Guarantee is signed by all parties.

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MAHC/SCHC
HOUSING SECURITY GUARANTEE PROGRAM
APARTMENT INSPECTION FORM

Tenant Name: _____

Apt. Location: _____

Landlord Name: _____

Address: _____

Phone Number: ( ) _____ - _____

Does the apartment have the following?

☐ Yes	☐ No	Smoke detectors	☐ Yes	☐ No	CO detectors
☐ Yes	☐ No	Screens on windows	☐ Yes	☐ No	Heating
☐ Yes	☐ No	Air-conditioning	☐ Yes	☐ No	Access to fire escape
☐ Yes	☐ No	Free of vermin/rodents	☐ Yes	☐ No	Shower
☐ Yes	☐ No	Tub	☐ Yes	☐ No	Stove
☐ Yes	☐ No	Refrigerator	☐ Yes	☐ No	_____

Please use the following space to make notes of defects: _____

_____

Please check every room and make notes of broken or cosmetic damage:

Kitchen: _____

_____

Living room: _____

_____

Bathroom: _____

_____

Bedrooms: _____

_____

Other: _____

_____

_____ _____ _____ _____

Landlord Signature | Date | Tenant Signature | Date