Cass County Health Department
COVID-19 Response Fund
Household Assistance

Cass County Health Department is proud to play a role in helping individuals and families who have experienced a loss of income related to the COVID- 19 pandemic.

Important Notes: The forms below are being provided for **information use only** at this point. Cass County Health Department is temporarily closed to walk-in clients so **be sure to call the Cass County Health Department to** begin the telephone screening process. **Do not** drop off any documentation unless you have been instructed by the Cass County Health Department to do so.

To be eligible for support, individuals/households must be Cass County residents with an income at or below 80% of Area Median Income (AMI) and have a need for any of the following assistance:

-Rental assistance
-Food access

Area Median Income is determined by the U.S. Department of Housing and Urban Development. Below is a guide to determine eligibility based on income and family size.

FY 2019 Income Limit Category	Persons in Family							
	1	2	3	4	5	6	7	8
Low (80%) Income Limits ($) Explanation	37,150	42,450	47,750	**53,050**	57,300	61,550	65,800	70,050

Individuals/households must also demonstrate a loss of earned income related to the COVID-19 pandemic due to medical reasons (isolation or quarantine directive), business closure or layoff or school closures.

Each household may be eligible for up to $400 in emergency funding. Checks will be issued and made payable to the landlord for all rental assistance applications and to the individual applicant for food assistance.

To Apply

1. Call Bryanna Kampwerth at CCHD (217-452-3057 ext. 1343) to schedule a telephone appointment.
2. Return the completed forms via email (alternative arrangements will be made for people without email access).

Required Documentation:

_____ Application **See below**

_____ Picture ID for ALL adult members (18 yrs. and older) in the household

_____ Loss of Income Form. **See Below.** (The loss of income happened on or after March 16, 2020 AND that the loss must be COVID-19 related). Client must also provide notice from employer regarding loss of hours, layoff, etc.

_____ Proof of Household income if NOT included on Loss of Income Form

____Copy of current lease (if applying for rent assistance)

APPLICATION FOR ASSISTANCE

I am requesting assistance and/or services from the Cass County Health Department on behalf of myself and eligible members of my household.

POLICY

CCHD has received funding to provide assistance in rental assistance and/or food support for individuals and families impacted, and affected by COVID-19.

The Coronavirus Relief Program will provide assistance for eligible individuals/families living at or below 100% of AMI (Area Median Income; see Appendix). In order to qualify, applicants must be residents of Cass County, and be able to verify income loss related directly to the COVID-19 pandemic. Program funds will be distributed on a "first come, first serve" basis until available funding is expended.

YOUR RIGHTS

You shall not be excluded on the basis of age, sex, race, color, religion, disability, national origin, familial status, gender identity or sexual orientation from participation in, or be denied the benefits of or be subjected to discrimination under any program or activity of CCHD.

Information concerning you will be treated confidentially in accordance with the policies and procedures established by CCHD in conjunction with current statutes for sharing information.

YOUR OBLIGATIONS

You must provide the staff of CCHD with complete and accurate information regarding your receipt of any assistance benefits or other income received by you or members of your household and information regarding your household composition. You will be required to document/verify all information.

COMPLAINTS AND APPEALS PROCESS

CCHD will maintain a Coronavirus Relief Program Applicant Complaint file. The file will be used for tracking and recording applicant complaints relayed to the agency.

Complaints must be submitted in writing and should be forwarded to the CCHD Administrator in which the application for services was submitted.

The written complaint must contain:

- Applicant's full name, complete address and telephone number(s);
- A detailed statement of the nature of the complaint, including date and time of the action;
- Name(s) of staff involved in the aggrieved action;
- Applicant's signature

RELEASE OF INFORMATION

By my signature below, I hereby authorize the release of pertinent medical, financial, social, employment, and psychological information to CCHD for the purpose of verifying my eligibility for services. I further authorize CCHD to release any and all pertinent information to other social agencies, federal agencies, missions, etc., as may be necessary to help determine my eligibility for CCHD assistance or other available services.

VERIFICATION OF STATEMENT

I certify that my answers are correct, and complete, to the best of my knowledge, and I have reported all my household income and other financial resources as well as provided employment, medical, and other documentation needed to determine program eligibility. I understand that intentionally making false or misleading statements or intentionally misrepresenting, concealing, or withholding facts may result in paying CCHD the value of the benefits improperly issued to me and may subject me to civil or criminal prosecution under state and federal law.

_____ _____

Signature of Applicant **Date**

_____

Phone Number

FOR CASS COUNTY HEALTH DEPARTMENT STAFF USE ONLY

_____ conducted an interview with _____

on _____ and determined the following:

_____ I approve assistance for this individual in the amount of _____.

_____ I do not approve assistance for this individual at this time.

_____ _____

CCHD Staff Signature **Date**

COVID - 19
VERIFICATION OF LOSS OF INCOME

Employer:_____

Employee:_____SSN:_____

Dear Employer:
We are asking for your cooperation in providing us with facts regarding the above named employee's work record. We appreciate your cooperation in this matter, as this information is essential to determine client's eligibility for Coronavirus Relief Program Assistance.

Section I – GENERAL INFORMATION

Job Title: _____
Number of Hours Worked Per Week: _____ Number of Days Worked Per Week: _____
How often is/was the employee paid? Day Week Bi-Weekly Monthly
Rate of pay: $ _____ per _____ Day Week Other
Date current employment began: _____
Is/was employment seasonal? YES NO If yes, season begins: _____ ends: _____

Section II – LOSS OF INCOME (Termination)

Date employment ended: _____ Was this termination due to the COVID-19 Pandemic? YES NO
Is the loss of income Permanent or Temporary? YES NO If temporary, when do you expect the employee to return to work? _____

Date employee received final check: _____ Gross amount: $ _____
Will employee receive any vacation pay, retirement refund, or other? YES NO
If yes, what type? _____ Date received: _____ Amount: $ _____

Section IIB – LOSS OF INCOME (Decrease in Hours, Layoffs, etc.)

Was this employee's hours decreased: YES NO
Was the decrease in hours or layoff related to COVID-19 Pandemic? YES NO

Was this employee laid off? YES NO If so, date of layoff? _____
Is the loss of hours/income Permanent or Temporary? _____ If temporary, when do you expect the employee to return to full work-hour capacity? _____

Section III – RECORD OF PAY RECEIVED

List the employee's most recent pay dates and gross pay amounts (please list most recent check first) or attach a printed wage history for the month(s) of

Date	Gross Payment Amount

In signing this employment verification form I authorize Cass County Health Department to receive the above requested information.

_____ _____
Client Signature Date