Dear applicant,

Thank you for asking for the support of our organization ***Rebuilding Together El Paso Inc.*** After your application has reached us, it will be reviewed by the committee responsible for defining whether you qualify for our program or not. Our organization must follow the rules defined by the City of El Paso.

To qualify, you must:

- **Be the owner of the home for which you are asking for assistance**
- **Be at least 62 years of age or**
- **Be disabled, in case younger than 62**
- **Have a salary, pension, or social security income that falls under the guidelines which HUD has set in place to determine whether a person is of low income**
- **Live within the El Paso City Limits**

If the above requirements do not apply to you we ask that you don't send in your application, as we will be unable to provide you with assistance. However, if you do fall within these parameters, please send your completed and signed application to the following address:
Rebuilding Together El Paso Inc.
6400 Airport Rd., Bldg. A, Ste. G
El Paso, TX 79925
Please be aware that our resources are limited for making repairs. Also please keep in mind that assistance is not immediate. We will focus on making repairs which affect your safety, health, and well-being. We do not have the resources to help you with payments for the home, utilities, clothes, or furniture.

Sincerely,
Rebuilding Together El Paso
915-832-7010

Application Form for Home Repairs

Application # ___________ Date Received ______ (for official use only

District : ______ Year Built : ______. Value : ________

Flood zone Y/N : ______

Please print (MUST be filled out COMPLETELY and SIGNED , or it will be returned.

To be filled out by the homeowner or in his/her name

Last Name: _______________________________ First Name: ___________________________

Address: ____ Zip Code: ______________

Phone #: _______________ Alternative Phone # : ___________. Date of Birth: __________

Family Composition:
Are you the homeowner: ___ Yes ____ No Is the homeowner male: _____ female ______
Is the homeowner veteran: ___ Yes ____ No Is the homeowner disabled*: ____ yes ____ no
If so, are you a grandparent head of the household (Grandchildren in home): ______ yes ______ no
How many years have you lived in the home: _____ In which year was the home built :_______
Do you have a home insurance : ____ Yes ____ No
List the number of people in your home and their age (including yourself):
Number of males ________ Ages ________ Number of females _______ Ages ___________
Number who are severely disabled _______ (See definition on back of this form).
Number adults working: _______ Full time _____ Part Time ______
How often did you fall in your bathroom last 12 months : ______
How did you hear about Rebuilding Together : ____ Neighbor/Friend ______ Referral ________ Other : ________

Income:

List the amount of money and source that you receive each month from the following recourses:

Pension(s) : $ ________ Social Security $ ________ Food Stamps $ _______ SSI $ _________
VA compensation : $ ________ other (please specify) $ ________ from : ________________

List the amount of money and source that anyone living in your house receives each month:
Social Security : $ ________ Disability Check $ ________ VA Compensation $ _______
Food Stamps : $ ________ other (please specify) $ ________ Suppl. Soc. Sec. (SSI) $ _______

Add the **TOTAL INCOME YOU AND ALL OTHERS** living in your home receive per month listed above and put the total amount here:
TOTAL HOUSEHOLD INCOME: $ ____________ PER MONTH

Does your home need painting ? ____ Interior ____ Exterior ____
In your opinion, what repairs are most necessary in your home? Please list and explain:
____
____
____
____
____
____
____
____

CERTIFICATION FORM FOR USE WITH PRESUMED BENEFIT CONTRACTS

***Severely disabled :** The census definition states that persons are classified as having a severe disability if they : (a) use a wheel chair or have used another special aid for six months or longer; (b) are unable to perform one or more "functional activities" or need assistance with an activity of daily living (ADL) or instrumental activity of daily living (IADL); (c) are prevented from working at a job or doing housework; (d) have a selected condition including autism , cerebral palsy, Alzheimer's disease. senility or dementia, or mental retardation. Also, persons who are under 65 years of age who are covered by Medicare or who receive SSI are considered to have a severe disability.

Your application will be reviewed by Rebuilding Together's Home Review Committee to determine if you qualify under its guidelines (See cover letter sent with this application for details). You will receive notification if you do or not do qualify for assistance. Please keep in mind that even if you qualify, our assistance is contingent upon funds available and the extend of the work that we can do.

Rebuilding Together is an all-volunteer non-profit organization that relies on grant funding and donations. Qualified applicants will be placed on a Qualified Prospect List until funds become available. When funds become available, a home visit will be scheduled to review the repairs requested on your application. An adult family member must be present when a member of the Home review committee comes to your home.

Do you have/own animals, such as dogs, cats, etc.? Yes _____ No ______
Please be advised that by signing this application you agree to be responsible for moving them from the premises until Rebuilding Together completes the scheduled repairs on your home. Be advised that NO WORK will be done by Rebuilding Together or Contractors with any of your animals on the work site.

Also, please be advised that falsifying any information on this application may result in immediate termination of Rebuilding Together's services you may receive.

You must sign and date this application to be considered for assistance and to give your consent to performs on inspection if selected for assistance.

______________________________ ______________
Name of Applicant (Please print) Date

____
Signature of applicant

Submitted by: _____ self
_____ Agency Social Worker
_____ Other

Agency/Organization Name: ______________________________ Phone: ________

Please mail Application to: **Rebuilding Together El Paso Inc.**
Attention: Home Review Committee
6400 Airport Rd. Ste. G, El Paso, TX 79925

ATTACHMENT A3

Page 4 of 5

PRESUMED BENEFIT ELIGIBILITY CERTIFICATION

CLIENT NAME:	DATE OF BIRTH

(Including nicknames or other names used)

ADDRESS

CURRENT STREET:	CITY/ STATE:	ZIP CODE:

PHONE NUMBER______________________________ **EMAIL**______________________________

GENDER:
☐ Male ☐ Gender Variant/ Non-conforming
☐ Female ☐ Prefer Not to Say

ETHNICITY:
☐ Hispanic
☐ Not Hispanic

IS THE CLIENT DISABLED? ☐ Yes ☐ No

IS THE CLIENT A VETERAN OR ACTIVE MILITARY?
☐ Veteran ☐ Active Military ☐ Not applicable

RACE:
☐ White
☐ Black/African American
☐ Black/African American & White
☐ Asian
☐ Asian & White
☐ Other
☐ American Indian/Alaskan Native
☐ American Indian/Alaskan Native & White
☐ Native Hawaiian/ Pacific Islander
☐ Native Hawaiian/ Other Pacific Islander
☐ Other Multi- Racial

IS THIS A FEMALE HEADED HOUSEHOLD?
☐ Yes ☐ No

PRESUMED BENEFIT:
☐ Elderly (62 or older) ☐ Homeless ☐Abused Child ☐ Battered Spouse
☐ Illiterate Adult ☐ Migrant Farm Worker ☐ Severely Disabled Adults ☐ Persons with AIDS

The information provided on this form is subject to verification by HUD at any time, and Title 18 Section 1001 of the U.S Code states that a person is guilty of a felony and assistance can be terminated for knowingly and willingly making a false or fraudulent statement to a department of the United States. I hereby certify that all information within this certification is true and correct to the best of my knowledge. I understand that this information is for use in determining my qualification for a program supported in part by federal funds. I authorize that this information on this document can be verified on a later date.

Signature of client or legal guardian/ Parent	Date Signed

FOR AGENCY USE ONLY
Address within City Limits? ☐ Yes ☐ No
Staff Member Making Verification/Date___________________________________
This information is confidential and will not be disclosed to anyone other than the Employer + DCHD Compliance

Members of Household, including self, living at address on other side of page:
(This should include *all persons* related by blood, marriage, or adoption residing in one dwelling.) Please list employers or other sources of income (for example, income received from Social Security, retirement benefits or child support payments). # = Phone number

1. NAME	**AGE**	**RELATIONSHIP TO CLIENT**
EMPLOYER/INCOME SOURCE	**#**	**EMPLOYER'S ADDRESS**
2. NAME	**AGE**	**RELATIONSHIP TO CLIENT**
EMPLOYER/INCOME SOURCE	**#**	**EMPLOYER'S ADDRESS**
3. NAME	**AGE**	**RELATIONSHIP TO CLIENT**
EMPLOYER/INCOME SOURCE	**#**	**EMPLOYER'S ADDRESS**
4. NAME	**AGE**	**RELATIONSHIP TO CLIENT**
EMPLOYER/INCOME SOURCE	**#**	**EMPLOYER'S ADDRESS**
5. NAME	**AGE**	**RELATIONSHIP TO CLIENT**
EMPLOYER/INCOME SOURCE	**#**	**EMPLOYER'S ADDRESS**
6. NAME	**AGE**	**RELATIONSHIP TO CLIENT**
EMPLOYER/INCOME SOURCE	**#**	**EMPLOYER'S ADDRESS**
7. NAME	**AGE**	**RELATIONSHIP TO CLIENT**
EMPLOYER/INCOME SOURCE	**#**	**EMPLOYER'S ADDRESS**
8. NAME	**AGE**	**RELATIONSHIP TO CLIENT**
EMPLOYER/INCOME SOURCE	**#**	**EMPLOYER'S ADDRESS**
9. NAME	**AGE**	**RELATIONSHIP TO CLIENT**
EMPLOYER/INCOME SOURCE	**#**	**EMPLOYER'S ADDRESS**

(Additional household information may be entered on a separate page)

I hereby certify that all information within this certification is true and correct to the best of my knowledge. I understand that I am applying for federal assistance intended to benefit only low and moderate income persons. I am aware that making a false statement to obtain benefits to which I am not entitled may subject me to both civil and criminal penalties, as well as forfeiture of my benefits. I authorize that information on this document be verified with the employers or other income sources at a later date, and authorize said employers or other sources to release this information.

____
Signature of client if over 18 or parent/legal guardian

____
Date Signed