CARES ACT FUNDING APPLICATION – ROANOKE COUNTY

This is an application for emergency funds to cover expenses incurred during and directly related to the COVID-19 Pandemic. You must give complete, accurate, and truthful information. If you do not provide required documentation, such as proof of residency, we will not be able to determine your eligibility for assistance. If you knowingly give false, incorrect or incomplete information, you could be prosecuted.

APPLICANT'S NAME: _____
LAST FIRST

ADDRESS: _____
STREET ADDRESS CITY ZIP CODE

HOW LONG HAVE YOU LIVED AT THIS ADDRESS: _____

PHONE NUMBER: _____ ALTERNATE NUMBER: _____

Please list all current household members:

Name	**SSN**	**Date of Birth**	**Relationship to Applicant**	**Income from employment** (per week, month?)	**Income from unemployment** (per week thru?)	**Other income** (SSI, child support, etc)

☐ YES ☐ NO Has your household experienced a loss or reduction of income directly related to COVID-19 since March 1, 2020?
What was your occupation or what industry did you work in at that time? _____
_____

Please list any **unpaid debts** you have that are in **direct response to your household income being affected by COVID-19:**

RENT/MORTGAGE AMOUNT: $_____ MEDICAL EXPENSES: $_____
ELECTRICITY: $_____ CHILDCARE: $_____
WATER: $_____ HOME INTERNET: $_____
GAS/OIL/PROPANE: $_____ FUNERAL COSTS: $_____
CAR PAYMENT: $_____ CAR INSURANCE: $_____
OTHER (PLEASE BE SPECIFIC): _____
_____
_____
_____

APPLICANT: _____ APPLICATION DATE: _____

☐ YES ☐ NO Are any of the bills listed above **past due**?
If yes, please indicate which are past due: _____

_____

YOU WILL HAVE 15 DAYS TO PROVIDE DOCUMENTATION ON UNPAID DEBTS. PLEASE SUBMIT ORIGINAL BILLS. COPIES WILL NOT BE ACCEPTED, UNLESS THE BILL IS DELIVERED ELECTRONICALLY.

Please explain how your household loss or reduction of income is directly related to COVID-19 and how this has impacted your household financially: _____

_____

_____

_____

Have you, or anyone in your household, received assistance from any other source (church, civic group, etc.), in order to pay past due bills, between March 1, 2020 – December 30, 2020? If so, please provide details (source, amount and bill):

_____

_____

_____

I certify that I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report correct information, I could be prosecuted. I understand that if I help someone complete this form in order to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.

I authorize Roanoke County Department of Social Services to contact the vendors for whom I am requesting payment. I understand that I will not personally receive payment, but payment will be made on my behalf to the vendor, if I am approved.

I understand the funds I am requesting are not guaranteed and I agree to provide any and all verifications of the above information to the Roanoke County Department of Social Services. I understand no applications will be approved without proper verification and that monies will be awarded on a first come, first served basis. I understand the decision of the Director of Social Services will be final.

By my signature below, I understand the information contained on this application will not be disclosed or used for any public assistance I may, or my family may currently receive, or have received in the past. I further understand that any information required to be reported to the Department of Social Services as outlined to meet policy guidelines for public assistance is my responsibility to report directly to my caseworker and failure to do so could result in an overpayment to my case, for which I will be held responsible to repay. Public assistance benefits include SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance to Needy Families), Medical Assistance, Child Care, and Energy Assistance.

_____ _____

SIGNATURE OF APPLICANT DATE

_____

APPLICANT'S FULL NAME (PLEASE PRINT)

County of Roanoke
DEPARTMENT OF SOCIAL SERVICES

Joyce W. Earl
DIRECTOR

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____ authorize and request that any financial institution, employer, creditor, government entity, health care provider, Virginia Division of Child Support Enforcement or any other individual provide to the local **Department of Social Services**, its agents, and representatives any and all information which may be requested regarding me, my assets, employment, income, financial condition, financial responsibilities, health insurance, and any other information which may be necessary in order for me to obtain benefits. This authorization shall remain in place until I request otherwise or my benefits are terminated.

Signature of Applicant: _____ Date: _____
Social Security Number: _____

Signature of Spouse: _____ Date: _____
Social Security Number: _____

P.O. BOX 1127 · SALEM, VIRGINIA · 24153-1127 · (540)387-6087 · FAX (540)387-6210

APPLICANT: _____ APPLICATION DATE: _____

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FOR OFFICE USE ONLY

TOTAL HOUSEHOLD INCOME: _____ TOTAL # HOUSEHOLD MEMBERS: _____

VERIFICATIONS RECEIVED: _____

_____

_____

ASSISTANCE AMOUNT REQUESTED: _____ ☐ APPROVED ☐ DENIED

IF DENIED, REASON: _____

_____

Initial&Date Pd

AMOUNT APPROVED:_____ TO BE PAID TO: _____

AMOUNT APPROVED: _____ TO BE PAID TO: _____

AMOUNT APPROVED: _____ TO BE PAID TO: _____

AMOUNT APPROVED:_____ TO BE PAID TO: _____

AMOUNT APPROVED: _____ TO BE PAID TO: _____

AMOUNT APPROVED: _____ TO BE PAID TO: _____

AMOUNT APPROVED:_____ TO BE PAID TO: _____

AMOUNT APPROVED: _____ TO BE PAID TO: _____

AMOUNT APPROVED: _____ TO BE PAID TO: _____

AMOUNT APPROVED:_____ TO BE PAID TO: _____

TOTAL ASSISTANCE AMOUNT APPROVED: $_____

_____ _____

APPROVED / DENIED BY DATE

_____ _____

PAID BY DATE