DEVELOPMENTAL DISABILITIES RESOURCE BOARD
FY2017 Emergency Housing Assistance Program (EHAP)

Referring Agency Information

Agency Name:	**Date of Application:**
Agency Contact Person for this application:	**Agency phone number**:

List All Members In Household

LAST NAME	FIRST	Person with a Developmental Disability	DMH NUMBER (If Applicable)	DATE OF BIRTH	RELATIONSHIP
Applicant		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

Household Information

Applicant mailing address:	**Telephone Number:**

Explain specific circumstances that caused this housing emergency:

List action items that will assist the applicant with goals toward self-sufficiency. If the individual with the qualifying disability does not have an active case with the St. Louis Regional Office or DDRB, there must be an action item to re-open their case to be eligible for future EHAP requests.

1.

2.

3.

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Income Worksheet

All information below will need to be verified by supporting documentation to receive financial assistance.

List all income received from the following sources:			**Family/Household Member Who Receives the Income**	**Enter Monthly Amount**
Employment Income	☐ Yes	☐ No		
TANF	☐ Yes	☐ No		
Food Stamps	☐ Yes	☐ No		
Social Security - Retirement	☐ Yes	☐ No		
Social Security - Disability	☐ Yes	☐ No		
Social Security – Disability	☐ Yes	☐ No		
Social Security - Disability	☐ Yes	☐ No		
Social Security – Survivor Benefits	☐ Yes	☐ No		
Unemployment	☐ Yes	☐ No		
WIC	☐ Yes	☐ No		
Other Unearned Income	☐ Yes	☐ No		
Child Support	☐ Yes	☐ No		
VA Pension	☐ Yes	☐ No		
Retirement Income	☐ Yes	☐ No		
Other _____	☐ Yes	☐ No		
Other _____	☐ Yes	☐ No		
			Total Monthly Income	
			Total Annual Income	
Number of People in the Home:			Total Adjusted Annual Income	

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Type of Assistance	Vendor Name/Address/Phone	Cost of Service

My signature certifies the following:

1. The above information is true and complete.
2. I am at risk for becoming homeless or already homeless.
3. Assistance will provide me with decent, safe, and sanitary housing.
4. I understand that falsification or failure to report significant changes can result in denial of services both now and in the future.
5. I understand that I may be required to participate in a referral service to qualify for this or future emergency housing assistance through the Developmental Disabilities Resource Board of St. Charles County.

_____ _____

Signature of Applicant Date

FOR OFFICE USE ONLY	**Total Requested**:		**Total Paid by DDRB**:
Approved by:	**Received:**	**Entered:**	**Payment Date:**

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Action Item Outcomes – (Required if applicant has accessed EHAP funds in the past)	**Date of Previous EHAP Request:**
Restate action items from previous EHAP Request: 1. 2. 3.	
Provide outcome of the above listed action items: 1. 2. 3.	