



Dear TBRA Applicant

I would like to introduce to you a relatively new program that is being administered by MATURA Action Corporation called Tenant Based Rental Assistance (TBRA). This program provides subsidized housing in tenant based housing, which means that the tenant selects private rental housing that meets occupancy standards and passes an inspection. This program is similar to the Section 8 voucher program administered by local housing authorities.

Enclosed are the MATURA TBRA Application Assessment, Addendum and Basic Intake Form. Complete applications and required documentation must be submitted to the MATURA Central Office at 207B North Elm Creston, IA 50801. Once your application is received and processed you will be notified of your eligibility status and if eligible, your application will be placed on the waiting list for the program. MATURA will maintain a waiting list of eligible applicants and will notify applicants as slots become available in the program.

In order to process your application you **MUST** submit the following items:

- Completed Application Assessment and Addendum and Basic Intake Form
- Proof of Income for the previous 60 days (2 months)
- Copies of photo ID's for adults over 18 in the household
- Copies of social security cards for ALL persons in the household

If you have questions concerning how to complete this application, you can contact Kristie Davidson at 641-782- 8431 ext 217 or Katie Christensen at 641-782-8431 ext 216.

**ICAA TBRA
APPLICATION Addendum**

All applicants must complete the AGENCY NAME Basic Intake Form and this addendum for the ICAA TBRA Application.

ASSET INFORMATION

List the type and source of any family assets. Provide both the current cash value and the estimated annual income from the asset.

Member's Full Name	Type and Source of Asset (e.g.bank accounts, investments)	Cash Value of Asset	Annual Income from Asset

EXPENSE INFORMATION check on calculator to see if this applies

- Yes No Does your household have un-reimbursed medical expenses in excess of 3 percent of annual income?
- Yes No Does your household pay child care expenses for children under the age of 13 that enable a family member to work or go to school?
- Yes No Does your household pay care expenses for the care of a family member with disabilities that enable a family member to work?

APPLICATION CERTIFICATION: I/we understand that the above information is being collected to determine if I/we are eligible to receive rental assistance. I/we authorize the [Program Administrator] to verify all information provided on this application.

Head of Household Signature	Date	Spouse Signature	Date
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1. HEAD OF HOUSEHOLD CONTACT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____ COUNTY: _____

STREET ADDRESS: _____ CITY: _____ STATE: Iowa ZIP CODE: _____

MAILING ADDRESS (if different than street address) _____ CITY: _____ STATE: Iowa ZIP CODE: _____

HOME PHONE NUMBER: _____ CELL NUMBER: _____ E-MAIL ADDRESS: _____

2. HOUSEHOLD MEMBER INFORMATION (A legend for completing this section is at the bottom of the page.)

NAME (FIRST AND LAST)	RELATION TO HEAD OF HOUSEHOLD	DATE OF BIRTH	GENDER (circle one)	SOCIAL SECURITY NUMBER or I-94 NUMBER	DISABILITY (circle one)	HEALTH INSURANCE	HISPANIC, LATINO, OR OF SPANISH ORIGIN?	RACE	MILITARY STATUS (circle one)	HIGHEST LEVEL OF EDUCATION	EMPLOYMENT (WORK STATUS)
1			MALE FEMALE OTHER		PHYSICAL MENTAL BOTH NONE		YES NO		VETERAN ACTIVE NONE		
2			MALE FEMALE OTHER		PHYSICAL MENTAL BOTH NONE		YES NO		VETERAN ACTIVE NONE		
3			MALE FEMALE OTHER		PHYSICAL MENTAL BOTH NONE		YES NO		VETERAN ACTIVE NONE		
4			MALE FEMALE OTHER		PHYSICAL MENTAL BOTH NONE		YES NO		VETERAN ACTIVE NONE		
5			MALE FEMALE OTHER		PHYSICAL MENTAL BOTH NONE		YES NO		VETERAN ACTIVE NONE		
6			MALE FEMALE OTHER		PHYSICAL MENTAL BOTH NONE		YES NO		VETERAN ACTIVE NONE		
7			MALE FEMALE OTHER		PHYSICAL MENTAL BOTH NONE		YES NO		VETERAN ACTIVE NONE		
8			MALE FEMALE OTHER		PHYSICAL MENTAL BOTH NONE		YES NO		VETERAN ACTIVE NONE		

HOW MANY HOUSEHOLD MEMBERS ARE: A U. S. Citizen _____ Homebound _____ A disconnected youth (age: 14-24) who is neither working or in school _____

LEGEND FOR COMPLETING THE HOUSEHOLD MEMBER SECTION:	RELATION TO HEAD HH	DATE OF BIRTH	GENDER	SOCIAL SECURITY OR I-94 NUMBER	DISABILITY	HEALTH INSURANCE	RACE	MILITARY STATUS	HIGHEST LEVEL OF EDUCATION	EMPLOYMENT (WORK STATUS)
	• Head of household • Spouse • Child • Foster child • Grandchild • Sibling • Parent • Grandparent • Other relative • Not related	• Date format: 99 / 99 / 99	• Male • Female • Other	• SSN format: 999-99-9999 • I-94 format: 999999999 99 (11 numbers)	• Physical • Mental • Both (physical and mental) • None	• Medicaid • Medicare • State Children's Health Insurance Program • State Health Insurance for Adults • Military Health Care • Direct purchase • Employment based • None	• American Indian • Alaska Native • Asian • White • Black or African American • Native Hawaiian and Other Pacific Islander • Other • Multi-race (2 or more of above)	• Veteran • Active military • None	• 0-8th grade • 9th-12th grade/non-graduate • High School graduate (or equivalency diploma) • 12th grade + some post-secondary school • College graduate (2 or 4 yrs) • Graduate of other post-secondary school	• Employed (full-time) • Employed (part-time) • Migrant seasonal farm worker • Unemployed (short term, 6-months or less) • Unemployed (long term, more than 6-months) • Unemployed (not in labor force) • Retired

3. HOUSEHOLD TYPE (check one)
- | | | | |
|---|---|---|--|
| <input type="checkbox"/> SINGLE PERSON | <input type="checkbox"/> SINGLE PARENT FEMALE | <input type="checkbox"/> TWO PARENT HOUSEHOLD | <input type="checkbox"/> MULTIGENERATIONAL HOUSEHOLD |
| <input type="checkbox"/> TWO ADULTS NO CHILDREN | <input type="checkbox"/> SINGLE PARENT MALE | <input type="checkbox"/> NON-RELATED ADULTS WITH CHILDREN | <input type="checkbox"/> OTHER: _____ |

4. HOUSEHOLD INCOME SOURCES (check all that apply)

For each household income source you check, you must include proof of income documentation with this application.
For EMPLOYMENT INCOME, provide copies of your check stubs for the 30 days preceding this application, or provide a copy of your federal income tax return.
For SELF-EMPLOYMENT INCOME or FARM INCOME, provide a copy of your federal income tax return.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> EMPLOYMENT INCOME (SALARY/WAGES) | <input type="checkbox"/> SSI (SUPPLEMENTAL SECURITY INCOME) | <input type="checkbox"/> PRIVATE DISABILITY INSURANCE | <input type="checkbox"/> CASH CONTRIBUTIONS FROM FAMILY OR FRIENDS |
| <input type="checkbox"/> SELF-EMPLOYMENT OR FARM INCOME | <input type="checkbox"/> SSDI (SOCIAL SECURITY DISABILITY INCOME) | <input type="checkbox"/> WORKERS' COMPENSATION | <input type="checkbox"/> ALIMONY OR OTHER SPOUSAL SUPPORT |
| <input type="checkbox"/> SOCIAL SECURITY RETIREMENT INCOME | <input type="checkbox"/> VA SERVICE CONNECTED DISABILITY COMPENSATION | <input type="checkbox"/> UNEMPLOYMENT INSURANCE/BENEFITS | <input type="checkbox"/> GENERAL RELIEF/ASSISTANCE |
| <input type="checkbox"/> PENSION | <input type="checkbox"/> VA NON-SERVICE CONNECTED DISABILITY PENSION | <input type="checkbox"/> TANF/FIP ASSISTANCE | <input type="checkbox"/> CHILD SUPPORT |

Does your household have savings over \$15,000 (include: all savings and checking accounts, CDs, and other investments)? YES NO

Did anyone in your household file a tax return and receive the EITC (Earned Income Tax Credit) benefit last year or this year? YES NO

THIS SECTION IS FOR AGENCY USE ONLY DOCUMENTED HOUSEHOLD INCOME (ANNUAL) \$ _____ SELF-DECLARED HOUSEHOLD INCOME (ANNUAL) \$ _____

5. HOUSEHOLD NON-CASH BENEFITS (check all that apply)

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> SNAP (FOOD ASSISTANCE PROGRAM) | <input type="checkbox"/> HCV (HOUSING CHOICE VOUCHER) | <input type="checkbox"/> HUD-VASH (VETERANS AFFAIRS SUPPORTIVE HOUSING) | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> WIC (WOMEN, INFANTS, & CHILDREN) | <input type="checkbox"/> PUBLIC HOUSING | <input type="checkbox"/> CHILDCARE VOUCHER | |
| <input type="checkbox"/> LIHEAP | <input type="checkbox"/> PERMANENT SUPPORTIVE HOUSING | <input type="checkbox"/> AFFORDABLE CARE ACT SUBSIDY | |

6. HOUSEHOLD HEATING AND ELECTRIC COMPANIES

You must include a copy of a recent HEATING SERVICE BILL and ELECTRIC SERVICE BILL with this application.

Do you have a disconnect notice? YES NO
 Are you currently disconnected? YES NO

7. HOUSING STATUS (check one)

- OWN RENT OTHER PERMANENT HOUSING HOMELESS If homeless, what is your housing situation? _____ OTHER: _____

8. HOUSING TYPE (check one)

- HOUSE MOBILE HOME 2, 3, OR 4 UNIT APT. 5 OR MORE UNIT APT. RENT A ROOM OTHER: _____

9. MAIN SOURCE OF HOME HEATING (check one)

- ELECTRIC PROPANE WOOD/COAL/CORN NATURAL GAS FUEL OIL OTHER: _____
- If propane, do you have an empty or low tank (20% or less)? YES NO

10. LANDLORD, PROJECT, COMPLEX INFORMATION

NAME _____

ADDRESS _____

PHONE NUMBER _____

MORTGAGE OR RENT COSTS PER MONTH: \$ _____

CERTIFICATION STATEMENT

I certify under penalty of perjury the above information is true. I give permission to the agency processing this application to acquire additional information and to share information with other organizations for the purposes of providing services to assist my household. This sharing of information is to be conducted with maximum respect for the confidentiality of the information contained in this application.

I am hereby making application for the Low-income Home Energy Assistance Program (LIHEAP) and/or the Weatherization Assistance Program. I further certify the following: I declare that I am the only person in the household who has or will apply for this program(s). I understand that this information will be used, upon request, in determining eligibility for other agency programs or services. Any willful misrepresentation of the information on this form is subject to a penalty of law. I assure that any LIHEAP energy payments received will be used solely for home energy costs. I understand that by signing (either in written form or electronically) this application, I am authorizing the weatherization of my house at no cost to me or my family. This application does not guarantee any weatherization work being done on my house.

I hereby give permission to the State of Iowa, the U.S. Department of Energy, U.S. Department of Health and Human Services, and the agency processing this application to obtain additional information from my energy supplier about my household energy usage and payment history. I also give permission to the State of Iowa to release application information to my energy supplier and to provide details about my account and energy use to the LIHEAP and Weatherization Assistance Program.

IF YOU RENT, ANSWER THE FOLLOWING:

- Are your heating costs included in your rent? YES NO
- Do you receive rent assistance? YES NO
(Is your rent based on a percentage of your income?)

I understand this statement.

SIGNATURE DATE

MATURA Action Corporation
TBRA Application Assessment

PROGRAM PARTICIPATION:

Is any member of this household currently working with the FaDSS Program YES NO
 Is any child in this home currently enrolled in Head Start? YES NO
 Has a child been applied for Head Start and been placed on a waiting list? YES NO

Number of Adults in the household who have a High School Diploma or GED _____

Are any members of the household a veteran or active military YES NO
 Do any adult household members have trouble reading or writing? YES NO

If yes, please note that staff can assist them in reading forms, leases and agreements.

Have any adults household members NEVER been employed before YES NO
 Have any adults experienced multiple periods of unemployment YES NO
 Are any household members currently unemployed? YES NO

If employed, who is employed? Are they employed part-time or full-time? Where employed?

Name	Part-time / Full-time	Employer

HOUSING:

Is your current housing subsidized? (Public, income based or section 8) YES NO
 Is this family Homeless? (lacking a regular place to sleep) YES NO
 Is this family facing eviction? YES NO
 Are the current housing costs more than the household's monthly income? YES NO
 Is the current housing too small for the household size? YES NO
 Are there three children or more in the household? YES NO
 Is your current housing substandard, unsafe or not in your family's best interests? YES NO

If yes, please explain: _____

Is there a conflict of interest between your current housing and your employment? YES NO

**MATURA Action Corporation
TBRA Application Assessment**

HOUSEHOLD CIRCUMSTANCES:

Are there any children in the home with special needs?

If so, how many children have special needs? _____

Has anyone in the household had alcohol or substance abuse issues?

Past issues? YES NO Current Issues YES NO

Has your family experienced issues related to child abuse? YES NO

Has your family experienced issues related to domestic violence? YES NO

Do any adults in the household have a disability or chronic illness? YES NO

Has this family been receiving public assistance for more than 3 years? YES NO

Will your family reach their 60 month lifetime limit in the next 12 months? YES NO

Is your family having difficulties finding or securing child care? YES NO

Does this family lack reliable transportation? YES NO

Please tell us what other programs you are utilizing. Check ALL that apply

- | | |
|--|--|
| <input type="checkbox"/> AEA | <input type="checkbox"/> WIOA (Workforce Innovation & Opportunity Act) |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Promise Jobs |
| <input type="checkbox"/> Voc-rehab | <input type="checkbox"/> Head Start |
| <input type="checkbox"/> WIC | <input type="checkbox"/> LIHEAP |
| <input type="checkbox"/> Public Health | <input type="checkbox"/> Medicaid/ Title XiX |
| <input type="checkbox"/> In-home counseling | Other _____ |
| <input type="checkbox"/> Parents as Teachers | |

Please share any additional information that affects this application.
