



Oregon Coast Community Action

Feed • House • Warm • Educate

Dear Friends and Neighbors,

In these unprecedented times it becomes more and more important for communities to come together and support each other. If you have been affected by the COVID 19 pandemic Oregon Coast Community Action is here to help. We currently have available funding to help you get caught up and back on the right track.

- If you have had a loss of income due to COVID-19 related factors or
- You have a compromised immune system or have an elevated risk of infection as it relates to COVID 19.

If either of the above reasons apply to your situation please fill out the enclosed application and we will do our best to assist you and your household.

Please Return The Following:

- Application
 - Completed and signed
- Social Security Numbers
- Photo ID for all adults in your household
 - 2 bills with name and current address can be used in place of photo ID
- Last 30 days of income
 - TANF printout
 - Pay Stubs or wage printout showing company name, employee name and gross pay
 - Social Security Benefits Award Letter for the current year
 - Child support payment history from Oregon Department of Justice (if out of state or informal child support please fill out the Declaration of Personal Income form)
 - Unemployment payment printout showing full name
 - VA Benefits Award Letter
 - Pension statement showing gross monthly amount or 1099
 - Adoption assistance monthly award amount
 - If no income was earned within the last 30 days. Please fill out a Declaration of Personal Income form (included in packet)
- Most recent power bill which shows the service address for the account
- A statement of how COVID-19 has affected your household

COVID 2.0 Rent Relief Outreach Application

Applicant Name: _____ # In Household: _____ Phone #: _____

Physical Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ Email Address: _____

Does anyone work or volunteer for ORCCA? Check here ☐

*Please provide the legal names of **ALL** people living in your household*

1. Name <i>Disabled</i> <input type="checkbox"/> Y <input type="checkbox"/> N <i>Gender:</i> _____ <i>Veteran</i> <input type="checkbox"/> Y <input type="checkbox"/> N	Relation Self	Social Security Number/TIN#: <i>Do you have Health Insurance?</i> <input type="checkbox"/> Y <input type="checkbox"/> N	Highest Grade Completed
	Birth Date		Race
INCOME: Check all that apply for each individual <input type="checkbox"/> Wages <input type="checkbox"/> Unemployment <input type="checkbox"/> Social Security/SSI <input type="checkbox"/> VA Benefits <input type="checkbox"/> Pension <input type="checkbox"/> Child Support <input type="checkbox"/> Zero Income <input type="checkbox"/> Seasonal/Migrant Farm worker <input type="checkbox"/> Self-Employment <input type="checkbox"/> TANF <input type="checkbox"/> Other _____			Income \$
2. Name <i>Disabled</i> <input type="checkbox"/> Y <input type="checkbox"/> N <i>Gender:</i> _____ <i>Veteran</i> <input type="checkbox"/> Y <input type="checkbox"/> N	Relation 	Social Security Number/TIN#: <i>Do you have Health Insurance?</i> <input type="checkbox"/> Y <input type="checkbox"/> N	Highest Grade Completed
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If you require more space for additional household members please attach a separate sheet of paper, make sure to include all information required.

Do you rent or own your home?

☐ Own My Home ☐ Renting My Home

Monthly rent/mortgage cost: \$ _____

NON-CASH BENEFITS

Please check if you receive:

☐ Food Stamps ☐ WIC

**Do you have Sec 8, HUD or other
Housing assistance?**

☐ Yes ☐ No

- How long have you been in your present living situation? _____
- Landlord's name: _____ Phone: _____
- Your rent payment history: ☐ Poor ☐ Fair ☐ Good
- Do you have an eviction notice? ☐ Yes ☐ No
- If yes, please answer the following: ☐ 72-hour notice ☐ 30-day notice
- Have you spoken to your landlord? ☐ Yes ☐ No
- Are you able to make any payment? ☐ Yes ☐ No
- If yes, how much? \$ _____

Have you received Rent Relief assistance in the past?

☐ Yes ☐ No

ENERGY INFORMATION: Please provide the information listed below and attach copies of your heat supplier's monthly billing statements.

What is your primary heating source? ☐ Electric ☐ Propane ☐ Oil ☐ Wood ☐ Pellets ☐ Other _____

Name of energy/Heat supplier: _____ Account# _____

*****Certification and Authorization for Release of Information*****

I/we authorize Oregon Coast Community Action (ORCCA) and Oregon Housing and Community Services to obtain information from any and all federal, state, county or city agencies, employers, landlords (past, present and prospective) and utility providers to verify statements given in this application. I/we understand that any knowing or unknowing failure to provide accurate income or household information may result in denial of service. I/we understand that completion of this application is not a guarantee of benefit and that the decision to assist is based on (but not limited to): need, order of application, previous assistance, income qualification and available funding.

Note: This Release of Information will expire **10** years from date of signature, unless otherwise documented.

THIS APPLICATION PROCESS IS NOT CONSIDERED CURRENT UNTIL YOU HAVE COMPLETED A HOUSING ASSESSMENT WITH A HOUSING SPECIALIST.

Signature _____ Date _____

Printed Name _____

Signature _____ Date _____

Printed Name _____

Please put a check mark next to all that apply to your situation:

- | | |
|---|--|
| <input type="checkbox"/> Loss of Job or wages to you or your family due to COVID | <input type="checkbox"/> Actively looking for work unable to find due to COVID |
| <input type="checkbox"/> A member of family being positive or symptomatic | <input type="checkbox"/> Childcare been affected due to schools closing |
| <input type="checkbox"/> Your employer closing or temporary shutting down from the pandemic | <input type="checkbox"/> Increase of mental due to COVID. |
| <input type="checkbox"/> Concerns of safety at workplace | <input type="checkbox"/> Considered a vulnerable individual, health concerns, age, disabled/handicap or fleeing from domestic violence |
| <input type="checkbox"/> Self- quarantine | |

Please briefly Describe your current Situation:



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DECLARATION OF PERSONAL INCOME

This form is to be used for:

- 18 and older applicants or household members having no income
- Receiving regular payments
(Example: funds through and informal child-support agreement)
- Receiving other income or benefits that qualify as income for Energy/Housing/Dental assistance
(Example: odd jobs or cash assistance from friends or family)

COMPLETE THIS FORM AND ATTACH A COPY OF YOUR 3 PAGE FOOD STAMP PRINT OUT

Name: _____

Relationship to applicant: _____

Applicant name (if different) _____

SECTION 1-OTHER SOURCE OF INCOME

Please check all of the following that apply. Do you receive income from the following?

☐ Odd Jobs ☐ Family or Friends ☐ Local Churches ☐ Child Care ☐ Child Support

Other (Please Explain) _____

SECTION 2-INCOME

If you have no income, how long have you had a zero income? _____

How much money have you received in the last 90 days? _____

Last 30 Days \$ _____ 2 Months Ago \$ _____ 3 Months Ago \$ _____

SECTION 3- RENT, FOOD, & UTILITIES

How do you pay for your rent? _____

Do you have a Section 8 Voucher? Yes or No Do you live in low income housing? Yes or No

How do you pay for food? _____

How do you pay for your utilities? _____

I certify that the information is complete and accurate to the best of my knowledge. I understand that I am signing this statement under penalty of denial of service now and in the future and prosecution if I give false information that will result in my receipt of Energy/Housing/Dental services for which I am not eligible.

Signature: _____ Date: _____



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Signature: _____ Date: _____



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NW Social Service Connections

Notice to Clients of Uses & Disclosures Privacy Notice

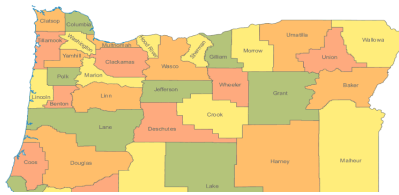
- Our agency enters personal and demographic information about you into a computerized record-keeping system.
- The information is used to plan delivery of services & to provide statistical information for setting goals.
- Information you provide will be used for administrative and operational purposes to improve, provide & coordinate services that can be offered you.
- Information you provide will be used for functions related to payment or reimbursement for services, monitor program effectiveness, and to prepare reports and statistical information without personal identifying information.
- If you have safety concerns, you may not want personal information entered into the system, you should discuss this with a staff member.
- Personally identifying information may be seen by staff members who provide you with services, select community service providers when appropriate, and a small number of people (ie: system administrators or program funders) who maintain the computerized record-keeping system, except as required by law.
- You will not be denied services, if you refuse to consent to share data.
- You have the right to see your record and to ask that it be corrected.
- You have the right to file a grievance if you feel you have been harmed in some way by the use of the computerized data system.

THIS IS NOT A COMPLETE STATEMENT OF YOUR INFORMATION RIGHTS.

For a complete statement of your information rights, please ask a staff person for a copy of our Privacy Policy. If you have any questions about our computerized record-keeping system and how it might affect you, feel free to talk about your concerns with a staff member.

Participant's Signature

Date



Member Counties: Baker, Benton, Clatsop, Columbia, Coos, Curry, Douglas, Gilliam, Grant, Harney, Hood River, Josephine, Klamath, Lake, Lincoln, Linn, Malheur, Marion, Morrow, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler, Yamhill

Rural Oregon Continuum of Care (ROCC) HMIS Client Consent to Release of Information for Data Sharing in Rural Oregon Balance of State

Rural Oregon Continuum of Care Homeless Management Information System (HMIS) is a computer system that is used to collect and share information on homelessness and social services throughout Rural Oregon Balance of State. The information gathered by **agency name** and HMIS allows agencies to plan and deliver services that help people in need. By sharing information with each other, agencies are able to simplify service delivery by coordinating services and referrals across agencies.

Maintaining the privacy and safety of those using our services is very important to us. The HMIS runs in compliance with all Federal and State laws and codes, including Health Insurance Portability and Accountability Act (HIPAA). Every person and agency that is authorized to read or enter information into the database has been trained on client confidentiality policies and has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights ended and may be subject to further penalties.

Services will not be denied should you choose not to share information. Information will still be collected and entered because of our federal and state requirements. **Certain minimum client information is shared throughout our HMIS in order to avoid creating duplicate client records.** Authorized HMIS persons at participating community agencies will be able to see the following data elements of all client records:

- First Name
- Last Name
- Date of Birth
- Veteran Status
- Gender
- Social Security Number (required for specific services)

Please read the following statements and consult with your agency staff if you have any questions:

I UNDERSTAND THAT:

- I will not be denied services if I decline to share my data beyond the minimum requirements.
- The release of my information does not guarantee that I will receive assistance.
- The partner agencies will share my basic identifying information (Name, DOB, Veteran Status, Gender, SSN) in order to improve service delivery and reduce duplicate data collection.
- Any details about the programs I participate in or information I share with agency staff will not be disclosed to any third party unless I give written authorization or it is otherwise required by law. We must still report some information because of our federal, state or funder requirements.
- This authorization will remain in effect for 7 years unless I revoke it in writing by signing a written statement or Revocation form.
- I understand that I may cancel my consent to data sharing at any time. However, doing so will not change information that has already been given out or actions already taken. Revocation will be effective as of that date.
- I have the right to see my HMIS record, ask for changes, and to have a copy of my record from this agency upon written request.

- I have the right to file a complaint if I feel I have been harmed in some way by the use of HMIS.
- I have the right to receive a copy of the HMIS Notice to Clients of Uses and Disclosures.

Maintaining the privacy and safety of those using our services is very important to us. Your record will only be shared if you give us permission to do so. There may be risks and/or benefits for you to consider before you decide whether or not to consent to the release of information.

By writing your initials below, you agree to share the following level of information for yourself and all household members listed below with other Rural Oregon Balance of State HMIS partner agencies.

____ 1) In addition to the minimum required data elements (Name, DOB, Gender, Veteran Status, SSN), **I agree to share** additional demographic information (including Race and Ethnicity), program enrollment and exit Information, information about the nature of my situation, services and referrals I receive, and contact information via the Rural Oregon Balance of State HMIS with other Rural Oregon Balance of State HMIS partner agencies.

____ 2). Beyond the minimum required data elements (Name, DOB, Gender, Veteran Status, SSN), **I DO NOT agree to share** any additional information through the Rural Oregon Balance of State HMIS with other Rural Oregon Balance of State HMIS partner agencies.

Please list the names and dates of birth of all household members participating in services:

Client/Parent or Guardian Name (please print)

Client/Parent or Guardian Signature Date

If applicable:

Additional Adult's Name (please print)

Additional Adult's Signature

Date

Agency Personnel Name (please print)

Agency Personnel Signature

Date



OREGON COAST COMMUNITY ACTION

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OREGON COAST COMMUNITY ACTION RELEASE OF INFORMATION

I authorize the following programs to use and disclose the specific information described below regarding:

Name of Participant: _____ **DOB:** _____

FROM / TO Oregon Coast Community Action 1855 Thomas Ave. Coos Bay, OR 97420 541-435-7080 541-435-7101 (fax)	TO / FROM: Landlord (Facility/Person) (Address) (City, State & Zip Code) (Phone) (Fax)
---	--

Purpose of disclosure:

For purposes of housing case management and securing stabile, permanent housing

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to ORCCA, 1855 Thomas Ave., Coos Bay, OR 97420, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. This Authorization will expire on _____ (date), 7 years from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. By signing this Authorization, I am directing you to disclose my information to another person or organization that may not have or obey the same obligations to protect privacy that you do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized re-disclosure and loss of protection under state and federal law.

Participant's Printed Name

Participant's Signature

Date

Witness Signature

Relationship to Participant

Date



OREGON COAST COMMUNITY ACTION

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OREGON COAST COMMUNITY ACTION RELEASE OF INFORMATION

I authorize the following programs to use and disclose the specific information described below regarding:

Name of Participant: _____ DOB: _____

FROM / TO Oregon Coast Community Action 1855 Thomas Ave. Coos Bay, OR 97420 541-435-7080 541-435-7101 (fax)	TO / FROM: NW Social Service Connections (aka: Service Point CMIS/HMIS)
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Purpose of disclosure:

To allow Oregon Coast Community Action to enter individual and household data into the named database systems

You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to ORCCA, 1855 Thomas Ave., Coos Bay, OR 97420, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. This Authorization will expire on _____ (date), 7 years from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

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Participant's Printed Name

Participant's Signature

Date

Witness Signature

Relationship to Participant

Date



OREGON COAST COMMUNITY ACTION

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OREGON COAST COMMUNITY ACTION RELEASE OF INFORMATION

I authorize the following programs to use and disclose the specific information described below regarding:

Name of Participant: _____ **DOB:** _____

FROM / TO Oregon Coast Community Action 1855 Thomas Ave. Coos Bay, OR 97420 541-435-7080 541-435-7101 (fax)	TO / FROM: EHA Covid Cares (Facility/Person) (Address) (City, State & Zip Code) (Phone) (Fax)
---	---

Purpose of disclosure:

For purposes of housing case management and securing stabile, permanent housing

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to ORCCA , 1855 Thomas Ave., Coos Bay, OR 97420, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. This Authorization will expire on _____ (date), 10 year from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. By signing this Authorization, I am directing you to disclose my information to another person or organization that may not have or obey the same obligations to protect privacy that you do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized re-disclosure and loss of protection under state and federal law.

Participant's Printed Name

Participant's Signature

Date

Witness Signature

Relationship to Participant

Date



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Letter of Rent Past Due

(to be completed and signed by landlord)

Date: _____

Tenant's Name: _____

Address: _____

Dear _____,
(Tenant)

You are behind in your rent which is due on the _____ day of each month, for the month/months of _____ at the rate of \$_____/per month for a total of \$_____ past due not including deposits, late fees or other fees.

Unless the past due amount is paid in full/or written confirmation that it will be paid by: _____ your tenancy will be terminated and court proceedings will be started.

I understand that this paper is not a commitment of financial assistance from Community Action but is the first step in reaching that determination to help prevent homelessness in the Coos/Curry County areas.

If Community Action offers assistance, by signing this form and accepting payment from Community Action, Landlord certifies that he/she will not take action to evict, in regard to non-payment of rent, until _____.
(30 days from Rent Due date)

Sincerely,

Landlord Signature

To the best of my knowledge, this unit was built in _____ (year).

Unit type (circle one): house duplex triplex apartment mobile home space rent

How many bedrooms is the unit? _____

The tenant is responsible for the following utilities: _____.

Printed Name (landlord): _____ **(please print clearly)**

Address where check is to be sent: _____

Phone: _____

Updated: 7/25/2019

ORCCA
Short-Term Rent Assistance Addendum

ORCCA
1855 Thomas Ave.
Coos Bay, OR. 97420

Phone: 541-435-7080, Ext. 370
Fax: 541-435-7101
Email: housing@orcca.us

Date:	Tenant(s)					
Tenant's Unit Address:						
Make check payable to:						
Mailing Address:						
Name of Manager:			Manager Phone Number:			
			Manager Fax Number:			
Manager Email Address:						
Deposit & first month's rent on separate checks?	Yes	No	N/A	W-9 On File?		Funding Source:
				Yes	No	State Federal
ORCCA serves a third-party rent payor. ORCCA will not be responsible for any damages to the unit or other charges. If the tenant(s) vacates housing prior to the program end date, ORCCA cannot continue to issue rent payments. Payment may take up to two weeks to process. Documents, including a most up to date W-9 released by the IRS, must be returned within 24 hrs to ensure timely payment.						
Rent pymt. of \$ _____ /mo. will be paid on behalf of the tenant from _____ through _____						
An amount of \$ _____ will also be paid on behalf of the tenant toward prorated rent from _____ to _____						
An amount of \$ _____ will also be paid on behalf of the tenant toward rent arrears						
An amount of \$ _____ will also be paid on behalf of the tenant toward utility balances						
An amount of \$ _____ will also be paid on behalf of the tenant toward late fees						
An amount of \$ _____ will also be paid on behalf of the tenant toward a security deposit						
An amount of \$ _____ will also be paid <u>by</u> the tenant toward a security deposit.						
Any prepaid rent or deposit balance is returned to the tenant upon the conclusion of their tenancy.						

Landlord Signature: _____ Date: _____

A copy of this payment addendum will be provided to the tenant for their record.

ORCCA Signature: _____ Date: _____



ORCCA Short-Term Rent Assistance Agreement

Tenant(s): _____

Unit
Address: _____

Landlord/Owner: _____

The owner/landlord agrees to accept rental payments from Oregon Coast Community Action based on the same terms as stated in the tenant(s) lease/rental agreement. This rental assistance will be paid by our agency for the term and in the amounts listed on the Oregon Coast Community Action Short-Term Rent Assistance Addendum.

If at any point, the tenants' rental or lease agreement is being terminated for cause during the assistance period, the landlord/owner will inform Oregon Coast Community Action in writing immediately.

If a no-cause notice to vacate is issued (i.e. sale of unit, transition to owner's primary residence) during the assistance period, the landlord/owner will inform Oregon Coast Community Action in writing immediately.

Landlord/owner agrees that the remaining balance of prepaid rent and/or security deposit will be returned to the tenant upon the conclusion of their tenancy. Oregon Coast Community Action may request a final account ledger to document the return of these funds to the tenants.

Oregon Coast Community Action serves a third-party rent payor. Oregon Coast Community Action will not be responsible for any damages to the unit or other charges.

Landlord/Owner (Signature)

Landlord/Owner (Print)

Date

Case Manager (Signature)

Case Manager (Print)

Date

ORCCA

1855 Thomas Ave.
Coos Bay, OR. 97420
www.orcca.us

housing@orcca.us
541-435-7080 ext 370



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ORCCA Grievance Process

Our Policy

Oregon Coast Community Action (ORCCA) is committed to fair, respectful and unbiased treatment of participants of our services and programs. We do not discriminate on the basis of gender, age, religion, race, sexual preference or disability.

Community Grievance Procedure

If you are seeking resolution to a complaint regarding ORCCA Programs, services or staff, you must initiate the Grievance Procedure, as follows:

1. First, discuss your complaint directly with the staff person involved in the incident.
2. If you are not satisfied that your complaint has been resolved, or if you cannot discuss the complaint with that person, discuss your concern with the appropriate supervisor.
3. If you still are not satisfied that your complaint has been resolved, submit your concern, orally or in writing, to the Program Director within thirty (30) days of the step(s) taken above. The Director shall notify the funding source (if required) within ten (10) days of receiving the request.
4. If the complaint is not referred out, the Program Director will meet with you and the involved staff to hear the issue. The Program Director will inform you and the funding source (if required), in writing, of the review determination within thirty (30) days of the determination.
5. If you are still not satisfied that your complaint has been resolved, you may appeal to the Executive Director in writing, describing your remaining concern and what you are requesting. The Executive Director, in consultation with Human Resources, will issue a written decision, which will be final.

Due to grantor's requirements, specific programs may have a more detailed grievance procedure that must be followed. If this applies to your grievance you will be provided with the additional grievance procedure and information.

Client Signature: _____ Date: _____

Case Manager Signature: _____