



**RENTAL, MORTGAGE, & UTILITY ASSISTANCE APPLICATION**  
 MARICOPA COUNTY HUMAN SERVICES DEPARTMENT

Please complete the following application for rental, mortgage, and utility assistance. Part VI will need to be completed for each adult and child that lives in the household. Additionally, Part VIII will need to be completed for each utility you are seeking assistance for.

PART I: APPLICANT CONTACT INFORMATION AND ADDRESS			
<b>FIRST NAME</b>	<b>LAST NAME</b>	<b>M.I.</b>	<b>DATE OF BIRTH</b>
<b>EMAIL ADDRESS</b>		<b>EMAIL TYPE</b>	
		<input type="checkbox"/> Personal <input type="checkbox"/> Other <input type="checkbox"/> Work	
<b>PHONE NUMBER</b>		<b>PHONE TYPE</b>	
		<input type="checkbox"/> Home <input type="checkbox"/> TTY <input type="checkbox"/> Mobile <input type="checkbox"/> Other <input type="checkbox"/> Business	
<b>PREFERRED METHOD OF CONTACT</b> Please check 1 option.		<input type="checkbox"/> Any <input type="checkbox"/> Call <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Mail/Letter	
<b>CONTACT PREFERENCES</b> Please check all that apply.		<input type="checkbox"/> Do not call <input type="checkbox"/> Do not email <input type="checkbox"/> Text Opt-In	
<b>Are you experiencing homelessness?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Have you been evicted from your home?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Do you have a sheltered place to sleep?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>HOUSING TYPE</b> Please check 1 option.			
<input type="checkbox"/> Apartment <input type="checkbox"/> Foster Care <input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Group Home <input type="checkbox"/> Shelter <input type="checkbox"/> Condo/Townhouse <input type="checkbox"/> House <input type="checkbox"/> Other <input type="checkbox"/> Duplex/Triplex/Fourplex <input type="checkbox"/> Mobile Home <input type="checkbox"/> Prefer not to answer			
<b>HOUSING PAYMENT TYPE</b> Please check 1 option.			
<input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Subsidized <input type="checkbox"/> No Payment <input type="checkbox"/> Prefer not to answer			
<b>RESIDENTIAL ADDRESS</b>			
<b>STREET 1</b>		<b>UNIT/APT/LOT</b>	
<b>STREET 2</b>			
<b>CITY</b>	<b>STATE</b>	<b>ZIPCODE</b>	
<b>Is your mailing address the same as your residential address?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	



<b>MAILING ADDRESS</b> Please enter if mailing address is different from residential address.		
<b>STREET 1</b>	<b>UNIT/APT/LOT</b>	
<b>STREET 2</b>		
<b>CITY</b>	<b>STATE</b>	<b>ZIPCODE</b>

**PART II: APPLICANT DEMOGRAPHICS**

**GENDER ASSIGNED AT BIRTH** Please check 1 option.

Female  Male

**GENDER SELF-IDENTIFY AS** Please check all that apply.

Female       Transgender Female       Non-Binary/Non-Conforming       Prefer to self-describe  
 Male       Transgender Male       Do not identify with a gender       Prefer not to answer

If selected "Prefer to self-describe," please enter your response: \_\_\_\_\_

**PRONOUNS** Please check 1 option.

She/Her/Hers       They/Them/Theirs       Other  
 He/Him/His       Unknown

**RACE AND ETHNICITY** Please check all that apply.

Asian       Middle Eastern or North African  
 Black or African American       White  
 Hispanic, Latino, or Spanish       Other Ethnicity: \_\_\_\_\_  
 Indigenous Peoples, Native American, or Alaskan Native       Prefer not to answer  
 Native Hawaiian or Pacific Islander

**MILITARY STATUS** Please check 1 option.

Child of a veteran       I am a veteran  
 Spouse of a veteran (Living or Deceased)       I am not a veteran  
 I am currently on active duty       Prefer not to answer

**PARENTAL STATUS** Please check 1 option.

Two-parent household       Primary caregiver with custody  
 Single-parent household with joint custody       Primary caregiver without custody  
 Single-parent household with sole custody       Foster parent  
 Grandparent with custody of child       No children under 18

**HIGHEST GRADE COMPLETED** Please check 1 option.

Pre-K       First       Third       Fifth       Seventh       Ninth       Eleventh  
 Kindergarten       Second       Fourth       Sixth       Eighth       Tenth       Twelfth



<b>HIGHEST CREDENTIAL/ POSTSECONDARY LEVEL COMPLETED</b> Please check <b>1</b> option.			
<input type="checkbox"/> None completed	<input type="checkbox"/> Vocational/Technical Degree	<input type="checkbox"/> Professional Degree	
<input type="checkbox"/> High School Diploma	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Doctorate Degree	
<input type="checkbox"/> GED	<input type="checkbox"/> Bachelor's Degree		
<input type="checkbox"/> 1+ years of Postsecondary Education	<input type="checkbox"/> Master's Degree		
<b>LIVE WITH A DISABILITY</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>DISABILITY</b> If you are living with a disability, please check all that apply.			
<input type="checkbox"/> Cognitive/Learning (Includes Speech Disorders)	<input type="checkbox"/> Mobility/Physical		
<input type="checkbox"/> Head Injury (Includes Acquired and Traumatic)	<input type="checkbox"/> Spinal Cord Injury		
<input type="checkbox"/> Hearing	<input type="checkbox"/> Vision		
<input type="checkbox"/> Invisible (Includes Chronic Pain and Sleep Disorders)	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Mental Health/Psychological Condition	<input type="checkbox"/> Prefer not to answer		
<b>CURRENTLY PREGNANT</b>		<b>HAVE INSURANCE</b>	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>INSURANCE</b> If you have insurance, please check all that apply.			
<input type="checkbox"/> AHCCCS	<input type="checkbox"/> Dental	<input type="checkbox"/> COBRA	<input type="checkbox"/> Direct Purchase
<input type="checkbox"/> ALTCS	<input type="checkbox"/> SCHIP	<input type="checkbox"/> Employer Provided	<input type="checkbox"/> Unknown
<input type="checkbox"/> Medicaid	<input type="checkbox"/> VA Medical Services	<input type="checkbox"/> State Health Insurance for Adults	<input type="checkbox"/> Other
<input type="checkbox"/> Medicare	<input type="checkbox"/> Indian Health Services	<input type="checkbox"/> Military Health Care	
<b>ENGLISH PROFICIENCY</b>	<input type="checkbox"/> Little	<input type="checkbox"/> Moderate	<input type="checkbox"/> Proficient
<b>ADDITIONAL LANGUAGES</b>	<b>PROFICIENCY</b>	<b>PRIMARY LANGUAGE</b>	<b>TRANSLATOR NEEDED</b>
	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>PART III. APPLICANT EMPLOYMENT STATUS</b>			
<b>EMPLOYMENT STATUS</b> Please check <b>1</b> option.			
<input type="checkbox"/> Student w/ No Employment	<input type="checkbox"/> Employed thru Casual/Contract Work	<input type="checkbox"/> Unemployed and Job Searching	
<input type="checkbox"/> Student w/ Part-Time Employment	<input type="checkbox"/> Employed Part-Time	<input type="checkbox"/> Unemployed and not Job Searching	
<input type="checkbox"/> Student w/ Full-Time Employment	<input type="checkbox"/> Employed Full-Time	<input type="checkbox"/> Retired	
<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Furloughed		
<b>If you are currently unemployed, what caused your unemployment?</b> Please check <b>1</b> option.			
<input type="checkbox"/> Home or Family Responsibilities	<input type="checkbox"/> Relocation Unemployment (Recent Move)		
<input type="checkbox"/> Experiencing Ill Health or Disability	<input type="checkbox"/> Re-entering the Workforce (Did not work for a period of time)		
<input type="checkbox"/> Laid Off (Involuntary Unemployment)	<input type="checkbox"/> Voluntary Unemployment (Resigned to seek other opportunities)		
<input type="checkbox"/> Terminated (Involuntary Unemployment)	<input type="checkbox"/> Seasonal Unemployment		
<input type="checkbox"/> Newly Entering the Workforce (Recent Graduate)	<input type="checkbox"/> Furloughed		
<b>UNEMPLOYED SINCE (DATE)</b>		<b>QUALIFY FOR UNEMPLOYMENT BENEFITS</b>	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> I don't know
<b>JOB SEARCHING</b>	<b>MIGRANT WORKER</b>	<b>SEASONAL FARM WORKER</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	



**PART IV. PUBLIC ASSISTANCE PROGRAMS**

**Are you currently enrolled in any public assistance programs?**  Yes  No

**If "Yes," which public assistance programs are you currently enrolled in?**

- |   |   |
|---|---|
| <input type="checkbox"/> Arizona Health Care Cost Containment System (AHCCCS) | <input type="checkbox"/> Social Security Income                           |
| <input type="checkbox"/> DES Child Care Subsidy                               | <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) |
| <input type="checkbox"/> Refugee Case Assistance                              | <input type="checkbox"/> Temporary Assistance for Needy Families (TANF)   |
| <input type="checkbox"/> Social Security Disability Insurance (SSDI)          | <input type="checkbox"/> Women, Infants, and Children (WIC)               |

**If on SNAP, are all household members listed under your SNAP case?**  Yes  No

**If you selected "No," please list each household member not included on your SNAP Case (full name).**

**PART V. COVID-19 IMPACT**

**Have you been financially impacted by COVID-19?**  Yes  No

**If you selected "Yes," how have you been financially impacted by COVID-19?**

- Experienced a reduction or loss of income  Expenses unexpectedly increased

**Experienced a reduction or loss of income: What caused a reduction or loss of income?** Please check all that apply.

- A job offer made prior to COVID-19 was rescinded
- I was terminated from employment/laid off
- I was furloughed
- My work schedule was reduced by my employer
- I am self-employed and my business has been affected/closed
- I had to quarantine because I am at higher risk for severe illness from COVID-19
- I had to quarantine due to COVID-19 illness or exposure
- I had to care for someone else who was quarantined due to COVID-19 risk or exposure
- I had to care for a dependent child or disabled/vulnerable adult
- Other (please describe): \_\_\_\_\_

**Expenses unexpectedly increased: How have your expenses unexpectedly increased?** Please check all that apply.

- I have day care expenses due to school or day care closures for a dependent adult or child
- I have medical expenses due to COVID-19 illness not covered by insurance
- I am unable to attend senior/community centers to obtain previously received basic living necessities
- Other (please describe): \_\_\_\_\_





**PART VII. RENTAL AND MORTGAGE ASSISTANCE**

**Are you seeking rental or mortgage assistance?** Please check 1 option.

Rental Assistance  Mortgage Assistance

**If seeking MORTGAGE ASSISTANCE, what is your policy number?**

**SEEKING ASSISTANCE WITH**  Monthly Payment  Move-In Deposit

**If seeking RENTAL ASSISTANCE, have you received an eviction notice?**  Yes  No

**If seeking MORTGAGE ASSISTANCE, have you received a foreclosure notice?**  Yes  No

**MONTHS SEEKING ASSISTANCE AND AMOUNT DUE** Please check all that apply.

MONTH	AMOUNT DUE	MONTH	AMOUNT DUE
<input type="checkbox"/> January	January: \$	<input type="checkbox"/> July	July: \$
<input type="checkbox"/> February	February: \$	<input type="checkbox"/> August	August: \$
<input type="checkbox"/> March	March: \$	<input type="checkbox"/> September	September: \$
<input type="checkbox"/> April	April: \$	<input type="checkbox"/> October	October: \$
<input type="checkbox"/> May	May: \$	<input type="checkbox"/> November	November: \$
<input type="checkbox"/> June	June: \$	<input type="checkbox"/> December	December: \$

**If seeking assistance with a MOVE-IN DEPOSIT, what is your move-in address?**

<b>STREET 1</b>		<b>UNIT/APT/LOT</b>
<b>STREET 2</b>		
<b>CITY</b>	<b>STATE</b>	<b>ZIPCODE</b>



**PART VIII. UTILITY ASSISTANCE** Please complete for **each** utility seeking assistance for.

**Which utility are you seeking assistance for?** Please check **1** option.

- Gas                       Water                       Electric                       Sewer                       Trash

**UTILITY STATUS** Please check **1** option.

- Currently Shut Off     Notice of Delinquency/Disconnect     Past Due (In Arrears)     Utility Payment Current

**UTILITY COMPANY**

**SEEKING ASSISTANCE WITH**

- Utility Payment                       Utility Deposit

**If seeking assistance with a UTILITY PAYMENT, what is the amount due for your most recent bill?**

\$

**If seeking assistance with a UTILITY DEPOSIT, what is the amount due for your utility deposit?**

\$

**MONTHS SEEKING ASSISTANCE** Please check all that apply.

- |                                   |                                 |                                    |
|-----------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> January  | <input type="checkbox"/> May    | <input type="checkbox"/> September |
| <input type="checkbox"/> February | <input type="checkbox"/> June   | <input type="checkbox"/> October   |
| <input type="checkbox"/> March    | <input type="checkbox"/> July   | <input type="checkbox"/> November  |
| <input type="checkbox"/> April    | <input type="checkbox"/> August | <input type="checkbox"/> December  |

**NAME LISTED ON UTILITY ACCOUNT**

**ACCOUNT NUMBER**

**If seeking assistance with a UTILITY DEPOSIT, what is your MOVE-IN address?**

**STREET 1**

**UNIT/APT/LOT**

**STREET 2**

**CITY**

**STATE**

**ZIPCODE**









**PART XI. APPLICANT SIGNATURE**

I authorize Maricopa County Human Services Department and/or its delegate agency to contact any source necessary to establish the accuracy of the information given by me. Further, I authorize any landlord, mortgage, or utility company, to which payment of credit on my behalf may be made, to release information regarding my account including, but not limited to, billing information to Maricopa County Human Services Department and/or its delegate agency.

I attest that the information I have provided in this application is true and correct to the best of my knowledge. This includes information regarding household members, income, property, contact details, and all other items provided. I am aware that I may be required to submit additional documentation at a later date, which may be used to determine my eligibility for services.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature