community action
Helping People. Changing Lives.

Housing Services Division

P: (440) 997-5957 www.accaa.org F: (440) 998-1925

SPECIAL PROGRAMS APPLICATION

Dear Applicant:

You are applying for the Special Programs offered through the Ashtabula County Community Action Agency. Please complete the attached application and return with the proof of income for everyone over 18 years of age in the household for the past 12 months (prior year's tax return, most recent paystubs, Social Security award letter, retirement etc.), as well as proof of homeownership such as a deed, tax bill or copy of the title. Keep in mind that applications are only kept on file for one year, after that you must re-apply for services.

If you have any questions please call ACCAA (440) 997-5957 ext. 550 or 554.

Sincerely,

Ashtabula County Community Action Agency

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Helping People. Changing Lives.

SPECIAL PROGRAMS

Mail to : P.O. Box 2610, Ashtabula Ohio 44005-2610 Office 6920 Austinburg Road, Ashtabula
Phone: 440-997-5957 or 1-800-252-5249 Fax: 440-998-1925

____Direction Home Eastern Ohio	**AGENCY**	Ashtabula County Only
____ United Way	**USE**	Ashtabula County Only
____ Emergency Home Repair	**ONLY**	Ashtabula & Geauga County

First Name	Initial	Last Name		
Address		Apartment		
City		State	Zip	County
Phone Number		Date of Birth		

Including yourself, list names, ages, social security numbers, and gross income for everyone living in the household over the age of 18. Include all income (SSI, SSA, SSDI, TANF, wages, unemployment, disability, veterans benefits, pensions and all other forms of income covering the past 12 months. If you need more space please use the back of this sheet.

Household Members	Social Security Number	Date of Birth	Age	Current Monthly Income
APPLICANT				

Gross income for the past 12 months? _____

Number of elderly people in the home? _____

Number of disabled people in the home? _____

Number of Veterans in the home? _____

Number of bedrooms? _____

Dwelling Type? House _____ Mobile Home _____

Multi-Unit (2 or more units) _____

Household Type: _____ Single _____ Single Male W/Children _____ Two Parent

_____ Couple _____ Single Female W/ Children _____ Other

_____ Widowed _____ Divorced

Please indicate with a number for each indivicual for each of the following that apply.

Hispanic / Latino _____ Non-Hispanic / Latino _____

American Indian / Alaskan Native _____

Asian _____

African American / Black _____

White / Caucasion _____

Bi-Racial / Multi-Racial _____

Native Hawaiian / Pacific Islander _____

Other _____

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

☐ American Indian/Alaskan Native

☐ Asian /Pacific Islander
☐ Caucasian
☐ African American

☐ Yes ☐ No

Has your household received weatherization services from any other program? If yes what program?

Describe the minor home repair or modification(include location i.e. bathroom, front porch)

_____
_____
_____
_____
_____
_____

I hereby authorize Ashtabula County Community Action Agency to share the information obtained in this application with other Social Services Agencies and/or governmental entities in order to obtain income verification of listed incomes on this application and/or to Coordinate this service with other similar services in the area.

X Sign Here _____

FOR OFFICE USE ONLY

Income eligibility Verified By: _____

Income reverified by: _____

Comments: _____

_____

CLIENT COST SHARE / SLIDING FEE SCALE AGREEMENT

THE REVISED OLDER AMERICANS ACT INCLUDES A COST SHARING REGULATION. THE OHIO DEPARTMENT OF AGING HAS ADOPTED THE FOLLOWING SLIDING FEE SCALE TO BE USED FOR SPECIFIC TITLE III CONTRACT SERVICES. THE CAREGIVER SUPPORT PROGRAM RESPITE SERVICES ARE INCLUDED IN THE COST SHARING REGULATION. THE SLIDING FEE SCALE IS BASED UPON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES POVERTY GUIDELINE. FUNDS RECEIVED FROM THE DONATION OF THE COST SHARING PERCENTAGE OF THE TOTAL SERVICE COST WILL BE USED TO PROVIDE ADDITIONAL SERVICES TO OTHER NEEDY SENIORS. US Department of Human Services defined POVERTY LEVEL FY 2022.

THE CLIENT COST SHARING PERCENTAGE IS DETERMINED BY THE YEARLY / MONTHLY INCOME OF THE"CARE RECIPIENT" (THE OLDER ADULT RECEIVING THE ACTUAL SERVICE), NOT THE FAMILY "CAREGIVER" INCOME, OR THE TOTAL FAMILY INCOME. SERVICES WILL NOT BE STOPPED BASED ON THE FAILURE OF THE CARE RECIPENT TO DONATE THE AGREED UPON PERCENTAGE OF COST SHARING.

COST SHARE		SLIDING FEE	CARE RECIPIENT	PLEASE SELECT ONE
MONTHLY FROM		INCOME TO	COST %	RANGE
$0.00	TO	$ 1,698.99	0%	
$ 1,699.00	TO	$ 1,981.99	10%	
$ 1,982.00	TO	$ 2,264.99	20%	
$ 2,265.00	TO	$ 2,547.99	30%	
$ 2,548.00	TO	$ 2,830.99	40%	
$ 2,831.00	TO	$ 3,397.99	50%	
$ 3,398.00	TO	$ 3,680.99	60%	
$ 3,681.00	TO	$ 3,963.99	70%	
$ 3,964.00	TO	$ 4,246.99	80%	
$ 4,247.00	TO	$ 4,529.99	90%	
$ 4,530.00		PLUS	100%	

CARE RECIPIENT'S SIGNATURE:

_____/_____/_____

PRINT NAME / SIGNATURE DATE

CARE GIVER SIGNATURE:

_____/_____/_____

PRINT NAME / SIGNATURE DATE

CARE COORDINATOR/PROVIDER SIGNATURE:

_____/_____/_____

PRINT NAME / SIGNATURE DATE