



# 2021 SAFE AT HOME Homeowner Application

**Rebuilding Together East Bay-North**  
732 Gilman St, Berkeley, CA 94710  
Telephone: 510-644-8979  
EMAIL: [Info@RTEBN.org](mailto:Info@RTEBN.org)  
Website: [www.RTEBN.org](http://www.RTEBN.org)

Dear Applicant,

You may remember us as "Christmas in April." Only our name has changed; our Safe At Home Program services are the same. Our repairs are focused on your health, safety, and thermal comfort.

To qualify for our services, you must meet the income guidelines listed below:

- You must own, and live in your home in Berkeley, Albany, Emeryville, or Richmond (you can still have a mortgage on your home, even a reverse mortgage); and,
- You must be age 62 or over, -OR- have a certified disability, and,
- Your home must need renovations or repairs that will improve your safety, accessibility, and thermal comfort; and,
- You must meet the income guidelines listed below:

<b>Number in Household</b>	<b>Income no more than:</b>
1	\$73,100
2	\$83,550
3	\$94,000
4	\$104,400
5	\$112,800
6	\$121,150

Our selection of applicants is not made based on race, color, religion, national origin, sex, marital status, sexual orientation, gender identity, or veteran status.

Although repairs are free, we require that you do not sell, rent, or transfer ownership of your home to anyone else for three years after our work is completed.

We also require that all able-bodied family and friends over the age of 14 help on workdays in some way.

Our organization has limited resources and receives applications from more homeowners than we can help. If your application is denied, please re-apply the following year. We do not maintain a waiting list.

If you meet these initial guidelines, we will send our team to come and assess your home for possible repairs or improvements and develop a scope of work based on your needs. If there is more work than we can do, we will try and bring in other non-profit organizations, and pool our resources to help you.

We may not be able to do everything in one day, or one year. We may refer you to other City of Berkeley programs if you are a Berkeley resident.

Please feel free to contact our Rebuilding Together East Bay-North office if you have any questions, at 510-644-8979, or email [Info@RTEBN.org](mailto:Info@RTEBN.org)

**Thank you!**

Please complete the following. If you need assistance in filling this out, please call us at (510) 644-8979 and someone from our team will help you. **To be considered for our services, this application and all required attachments must be provided to us. Use the Checklist at the end of this document to help you successfully complete the application.**

**I. APPLICANT INFO:** Please answer the following questions so we can process your application.

Applicant Name (Must be on the property title)	Age	Disabled?	What is the disability?	Veteran?	Ethnicity*
Street Address (you must live here)		City		Zip Code	
Phone Number		Email Address			
Co-Applicant Name, if any (must be on the title)	Age	Disabled?	What is the disability?	Veteran?	Ethnicity*
Street Address (you must live here)		City		Zip Code	
Other Residents in the Household	Age	Disabled?	Relationship	Ethnicity*	
*Use the following code for each ethnicity; you MUST indicate the ethnicity of each person in the home.					
	Total each			Total Each	
1. American Indian or Alaskan Native			7. American Indian/ Alaskan Native and White		
2. Asian			8. Asian and White		
3. Black/African American			9. Black/African American and White		
4. Native Hawaiian or other Pacific Islander			10. American Indian or Alaskan Native and Black/African American		
5. White			11. Other multi-ethnic		
6. Hispanic			12. Unknown multi-ethnic		
Have you sent us an application before?				Yes	No
Has your house ever been worked on by Rebuilding Together, or Christmas in April?				Yes	No
Are you participating in the City of Berkeley Senior Home Loan program?				Yes	No
May we share your application information with other agencies that could help you, or provide other home services?				Yes	No
Will you be able to attend the required orientation meeting for homeowners online through Zoom?				Yes	No

**II. LOCAL CONTACTS: Please list the names and phone numbers, and email if known, of any family members and friends who live in the area.**

Name	Telephone	Cell Phone	Relationship

**III. SPECIAL NEEDS:** Do you or other household members have mobility challenges we should be aware of in assessing the repairs needed? **For example, you require a walker or wheelchair.** Please explain:

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**IV. Your Friends and Family Volunteers:** If your home is selected, we ask that you or your family and friends help by working with us on such things as cleaning the house and removing breakable objects and wall hangings ahead of time.

**Do you have people who can help us with your repairs?** Yes\_\_\_\_\_ No \_\_\_\_\_

**AGREEMENT**

I/We certify that the information in this application is true and correct to the best of my/our knowledge.

I/We authorize Rebuilding Together East Bay North to check any references and verify any information that I /We have provided in this application.

I/We also understand that this information will be kept confidential and will be used strictly for the purpose of determining my/our eligibility for the program unless specifically requested.

Signature of Applicant: \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Co-Applicant: \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**V. FINANCIAL INFORMATION – Major Debts, Income, and Assets**

Applicants must list information for all residents living in the home. This will include mortgage, pensions, rental income, Social Security, and/or other income held by the applicant, co-applicant, and residents. Resident’s rental payment is included as a source of income, as in the case of housemates or sub-letters. The personal property of tenants is not included in the financial disclosure.

Applicant(s) must submit current verification of each source of income for themselves, and any person in the home who does not pay rent to the homeowner.

Please attach a copy of the first page of your last income tax return, as well as a second form of verification, such as a recent benefit statement from Social Security, or a copy of a pay stub, for each person living in the home.

For debts, a copy of your latest mortgage statement, and any other current payment slip will work.

Loans or Creditors	Amount owed	Monthly Payment	Balance	Delinquent? If yes, please explain.
Mortgage	\$	\$	\$	
Alimony/Child Support you pay	\$	\$	\$	
Taxes, Insurance	\$	\$	\$	
Other:	\$	\$	\$	
<b>TOTAL DEBTS</b>	\$	\$	\$	
Type of Income	Applicant's Annual income	Co-Applicant's annual Income	All Other Non-Renter's Annual Income	Total Combined Household Income
Current employment	\$	\$	\$	\$
AFDC	\$	\$	\$	\$
Retirement/Pension	\$	\$	\$	\$
Social Security Disability	\$	\$	\$	\$
Social Security	\$	\$	\$	\$
Child Support /Alimony	\$	\$	\$	\$
Rental Income	\$	\$	\$	\$
Veteran's Assistance	\$	\$	\$	\$
Other Income	\$	\$	\$	\$
<b>INDIVIDUAL TOTALS</b>	\$	\$	\$	\$
ASSETS*	Applicant	Co-Applicant	Combined Assets	
Property Value	\$	\$	Checking Balance	\$
Automobile Value	\$	\$	Savings Account Balance	\$
Rental Property	\$	\$	Stocks, Bonds, and other Funds	\$
Other Major Assets	\$	\$	Cash on Hand	\$
<b>SubTotals</b>	\$	\$	<b>SubTotals</b>	\$
			<b>TOTAL ASSETS</b>	\$

\*Assets are not counted as income and will not disqualify you.

**V. FINANCIAL INFORMATION (continued) – Annual Debts/Living Expenses**

ANNUAL Expenses	Applicant	Co-Applicant	Other Resident(s)	Total Combined Expenses
PG&E (Gas & Electric)	\$	\$	\$	\$
EBMUD (Water & Sewer)	\$	\$	\$	\$
Telephone (land line)	\$	\$	\$	\$
Cell phone	\$	\$	\$	\$
Cable TV/Satellite TV	\$	\$	\$	\$
All Credit Card payments	\$	\$	\$	\$
Other Annual Expenses	\$	\$	\$	\$
<b>TOTALS</b>	\$	\$	\$	\$

**VI. YOUR HOME -- Details**

	Year Built	# Bedrooms	# Bathrooms	# Stories
<b>Your House</b>				

Please attach proof of payment for current property taxes.

**Homeowner's Insurance Company:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**VII. Health and Safety Home Repairs Needed**

Please list your TOP priorities for health and safety repairs. Our primary goal is to make your home safer, more accessible, and address thermal comfort from drafts and heat loss in winter. Rebuilding Together does not guarantee that all requested items can, or will, be addressed if your home is selected. We will prioritize the health and safety problems to the best of our ability. You are encouraged to reapply for work not completed this year.

- 
- Issue #1
- 
- Issue #2
- 
- Issue #3
- 
- Issue #4
- 
- Issue #5

**HOMEOWNER  
RELEASE FROM**

**CONSENT TO RELEASE INFORMATION**

**AGREEMENT AND  
LIABILITY**

In the event that my application is selected to be in the Safe At Home Program:

**I give permission** for Rebuilding Together East Bay-North, its employees, agents, directors, donors, volunteers and participating trade workers to perform repairs on my home located at: \_\_\_\_\_

**I understand** that Rebuilding Together East Bay-North, its employees, agents, directors, donors, volunteers and participating trade workers are part of a volunteer initiative, and that guarantees cannot be made as to the specific work that will be done.

**I understand** that the general plan for the repairs to my home will be explained to me, and that I will sign a Scope of Work for my home. I further give Rebuilding Together East Bay-North, its employees, agents, volunteers and participating trade workers full authority to determine the extent of the repairs(s) to be performed on my home, even if they should fail to notify me of any change to the original plan.

**I understand** that the repairs will be performed free of charge by volunteers, and/or participating trades workers, and that Rebuilding Together East Bay-North, its volunteers, employees, agents and participating trade workers disclaim all warranties, expressed or implied concerning the repair(s).

**I agree** that I will cooperate fully with Rebuilding Together East Bay-North representatives, employees, agents, and volunteers for the improvements to my home.

**In consideration of the repair(s)**, I further hold Rebuilding Together East Bay-North, its officers, directors, employees, agents, donors, volunteers, participating trade workers, and other affiliates, collectively and individually, harmless from any and all claims and liabilities arising at any time as a result of the repairs, including, without limitation, any rights or causes of action resulting from personal injury or death, or damage to my property, directly, or indirectly arising from any improperly performed repair(s) or defects in material or workmanship.

**No inducements or promises** have been made to me to secure my signature on this release other than the intention of Rebuilding Together East Bay-North to perform repairs and improvements.

DATE: \_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_\_

\_\_\_\_\_  
HOMEOWNER

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
HOMEOWNER

\_\_\_\_\_  
WITNESS

(Berkeley residents only)

The Single Family Rehabilitation Program is a collaboration of the City of Berkeley and community-based agencies to provide health and safety home rehabilitation services to Berkeley residents. The Program includes the following service agencies:

- City of Berkeley Senior Disabled Rehabilitation Loan Program
- Center for Independent Living
- Rebuilding Together East Bay-North

I, (name of applicant) \_\_\_\_\_ authorize

(name of agency) \_\_\_\_\_,

to release information contained in this application to the Single Family Rehabilitation Program.

Upon the approval of my application to the Single Family Rehabilitation Program, I understand that the information shared will be necessary and appropriate for coordinating and verifying home rehabilitation services on my behalf through the Single Family Rehabilitation Program. This information may include demographic data, income documentation, and rehabilitation information about my property. I understand this may include sharing information about past rehabilitation projects completed on my property by one or more of the agencies listed above.

I understand that this does not automatically entitle me to any home rehabilitation services other than the repairs noted in this application. I understand that information shared will remain confidential and will only be used for the purposes described above.

My signature below acknowledges my understanding and consent to the release of information as described above. I understand that I have the right to revoke this consent in writing at any time, except for information already released.

Applicant's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness/Agency Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dear Applicant,

Thank you for your recent application for services. In order for us to determine your eligibility, your application must be current and complete. Please assist us with processing your application by submitting the required documentation below along with your application.

Mail copies of the documents to 732 Gilman Street, Berkeley CA, 94710. Or email to [info@rtebn.org](mailto:info@rtebn.org)

Update 2021:

Have you had both appointments for your vaccine? \_\_\_\_\_

If not, when is it scheduled? \_\_\_\_\_

Is this your first or second appointment? \_\_\_\_\_

Please include a copy of any documents given to you or a household member from a COVID-19 vaccine to this application!

Update 2021 #2: HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION is now added for you to have on hand. We do not require this document to be filled out for services. The reason this is added to all applications is due to PG&E becoming less reliable, and many of our community members face new life-threatening circumstances due to a loss of power. If you face these or similar circumstances, please fill out the HIPAA Authorization Form and call RTEBN staff.

**Thank you!**

- \_\_\_ Current ID (driver's license or state issued ID)
- \_\_\_ Disability verification letter if you are disabled
- \_\_\_ Veteran status letter if you are a veteran
- \_\_\_ Current income verification, such as retirement, pension, social security income, etc.
- \_\_\_ Bank Statements (2 most recent)
- \_\_\_ Tax return (most recent year filed, or dated signature swearing you do not file)
- \_\_\_ Proof of home ownership such as deed or title.
  - Check this box to allow to the RTEBN team to verify homeownership with the Assessor's office if the deed or title paperwork is not accessible to you.
- \_\_\_ Receipt for paid property tax (current)
- \_\_\_ Verification for current Homeowners Insurance
- \_\_\_ COVID-19 Vaccine Documents. (If you need a copy of your vaccination record, first try the health provider where you received the vaccine. If you're unable to get documentation from the provider, contact your state board of health for assistance.)





# HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

## I. My Authorization

I authorize the following using or disclosing party:

\_\_\_\_\_

**To use or disclose the following health information:** (check one)

- All of my health information

- My health information relating to the following treatment or condition:

\_\_\_\_\_

- My health information covering the period from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

- Other: \_\_\_\_\_

**The above party may disclose this health information to the following recipient:**

Name (or title) and organization \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**The purpose of this authorization is:** (check all that apply)

- At my request

- Other: \_\_\_\_\_

- To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.



- To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

**This authorization ends:** (check one)

- On (date) \_\_\_\_\_

- When the following event occurs: \_\_\_\_\_

## II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

**Signature of Patient:** \_\_\_\_\_

Date: \_\_\_\_\_

### **If the patient is a minor or unable to sign, please complete the following:**

- Patient is a minor: \_\_\_\_\_ years of age

- Patient is unable to sign because: \_\_\_\_\_

**Signature of Authorized Representative:** \_\_\_\_\_

Date: \_\_\_\_\_

Print Name of Authorized Representative: \_\_\_\_\_

Authority of representative to sign on behalf of the patient:

- Parent    - Legal Guardian    - Court Order    - Other: \_\_\_\_\_

### III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

- I consent to have the above information released.

- I do not consent to have the above information released.

**Signature of Patient or Authorized Representative:** \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

### IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

- I consent to have the above information released.

- I do not consent to have the above information released.

**Signature of Patient or Authorized Representative:** \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

