HUTAC – Help Until There's A Cure a Non-Profit 501(c)(3)

Application for Emergency Rental Assistance

This program is designed to assist breast cancer Patients/Survivors in need of one month's rental/mortgage assistance to offset the unexpected expenses of their treatment. The program requires that you must be able to pay your on-going rent/mortgage once assisted, and the purpose is to help you stabilize your housing while going through or recovering from treatment.

Please print clearly and complete all sections. All required documentation must be submitted with your application. Submitting an application does not guarantee assistance. Funds are distributed on a first come, first serve basis at the sole discretion of HUTAC Board Members and this is a one-time assistance program. Based on the donations received, we help as many qualified applicants as possible.

Are you currently living in subsidized housing or receiving monthly rental assistance? No [ ] Yes [ ]
(If yes, you may not qualify for this assistance.)

Head of Household Name: _____

Current Address: _____

City, State, Zip: _____

Home Phone & Cell Phone: _____

Beginning with the Head of Household (HOH), list all adults and children in the home including age and income from all sources (includes but not limited to Social Security, Pension, Workman's Comp, TANF, Unemployment, Child Support, and Wages).

Name	***Relation to HOH***	***Age***	***Current Monthly Gross Income***	***Source of Income***	***Monthly Rent or Mortgage Amount***
1.					
2.					
3.					
4.					
5.					
6.					

Check One: Application is for assistance with Rental [ ] Mortgage [ ] Monthly Amount: $_____

Are you currently behind on your payment(s) No [ ] Yes [ ].

If so, how much rent/mortgage is outstanding: $_____. How many months in arrears? _____

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Application - Continued

Name of Landlord / Management /Mortgage Company

Name & Contact Name: _____

Current Address: _____

City, State, Zip: _____

Phone & Fax : _____

Please attach verification of your rental/mortgage amount for prior two months. Verification could include copy of rental receipt for prior two months, copy of lease/rental agreement, copies of two month's cancelled checks for amount, mortgage statement.

One-Time assistance funds are designated for those individuals affected by a breast cancer diagnosis. In order to qualify for assistance under this program, this form must be stamped or signed by a medical professional confirming applicant was or is currently being treated for breast cancer.

Medical Professional – Doctor's Medical License #: _____

Name & Facility: _____

Address: _____

City, State, Zip: _____

Phone & Fax : _____

Doctor Signature _____ **Date** _____

Print Name & Position _____

I, the undersigned applicant, do here by acknowledge that all of the information in my completed application is true and correct and that I have attached all required documentation. I understand this is a one-time assistance program and that my submitted application does not guarantee I will receive assistance.

Applicant Signature _____ Date _____

Effective 10/04/16