



COVID-19 Rise Above Assistance Program

Thank you for your interest in applying for the COVID-19 Rise Above Assistance Program. The Rise Above Assistance program serves eligible Ashtabula County individuals and families who have experienced a **substantial COVID-19 impact** and who fall below 200% of the Federal Poverty Guideline. (Please see next page for further eligibility criteria.)

Name: _____ Phone: _____ Email: _____

Can we text you at this number? ____Y ____N

Which COVID-19 support(s) are you applying for? (Please select all that might apply).

- | | |
|--|---|
| <input type="checkbox"/> Shelter-In-Place Supports | <input type="checkbox"/> Health & Wellness Supports |
| <input type="checkbox"/> Housing Assistance | <input type="checkbox"/> Employment Supports |
| <input type="checkbox"/> Transportation Assistance | <input type="checkbox"/> Other: _____ |

How has your family been impacted by COVID-19? (Must provide written verification)

- Loss of Income (unemployment, loss of hours/wages, etc.)
- Isolation/Quarantine Health Order
- Other: _____

Please submit all of the following documentation to apply for this program. Additional documentation may be required for each program. For questions about the application or the program, please call 2-1-1.

- Copy of Photo ID for Head of Household
- Release of Information
- Community Services Block Grant Customer Application
- Zero-Income Declaration Form (as needed)
- Proof of COVID-19 Impact
 - o May include: paystubs/print-outs showing decrease in income, unemployment letter, layoff notice, bank statements, doctor's note or health department note of isolation/quarantine, etc.

Signature

Date

Intake Specialist Name: _____