Connecticut AIDS Resource Coalition

Housing Assistance for PWHIV/AIDS Transitioning from Incarceration Pilot Program

Transitioning from Incarceration is a pilot program for residents of Connecticut living with HIV/AIDS who are transitioning from incarceration to permanent housing or have had difficulty finding affordable housing due to criminal history. This pilot program targets the following populations:

- PWAs leaving incarceration to permanent housing (HUD defines permanent housing as "housing which is intended to be the tenant's home for as long as they choose."
- PWAs with a history of incarceration who are leaving emergency shelters for more permanent housing;
- PWAs with a history of incarceration who are leaving transitional or congregate living programs to live independently within the community but have had difficulty locating housing due to criminal record

Applicants must apply for housing assistance through a case manager.

What can it pay for?

- First month's rent.
- Last month's rent.
- Security deposit.
- Short term rental assistance for up to six months through June, 2012 (applicants will pay 30% of income to rent).

What is available?

- First month's rent, last month's rent and security deposit within the HUD Fair Market Rent (FMR).
- Short term rental assistance: applicants will receive assistance from the time a completed application has been approved through June 1, 2012 and are required to pay 30% of their adjusted gross income to rent. Case Managers must certify, through a housing stability plan, client housing stability by the June 2012.
- This is a six month Pilot Project with no expectation of continuation or opportunity to re-apply.

Who is eligible?

Applicants must satisfy all of the following requirements to access the fund:

- HIV+ or AIDS diagnosis.
- Income cap of 200% of Federal Poverty level (by family size).
- Client's ratio of rent to income must be between 40% -80% of income to rent.

- Potential applicants must demonstrate difficulty obtaining housing due to recent (within the past 12- 24 months) incarceration and provide documentation of release date.

How to apply?
All applicants must apply through a case manager. The case manager is responsible for determining eligibility and submitting a completed application packet to CARC. Applicants must maintain contact with their case manager through the duration of the program.

Required documentation:

- Documentation of HIV status and recent (within six months) CD4 and Viral Load
- Proof of income (see below)
- Rental verification signed by landlord
- W-9 signed by landlord (IRS requirement)
- Promissory note by landlord for return of security deposit
- Ryan White client intake form, including financial eligibility form
- 2-page Use of Funds form

What constitutes income?

- Entitlements (e.g. SAGA, SSI, SSDI, TANF, VA benefits, pension, worker's comp, unemployment etc)
- Employment
- Income from all household members (e.g. spouse, roommate, children, other family members, etc)

What can be used for proof of income?

- 3 **recent** paystubs
- Notarized letter indicating income
- 1099 or most recent year's 1040
- TPQY
- SSI/SSD confirmation letter
- Letter from employer noting hours/week and hourly wage

Case Managers are responsible for maintaining client files that include the following:

- Housing Habitability Inspection (see attached form)

Client Intake Form - See attached form.
Case managers must submit the Ryan White Part A Client Intake Form.

Ryan White Part A Eligibility Worksheet and Financial Documentation - See attached form.

Release of information - See attached form.
This form is required to be updated every twelve months (annually). A current form must be submitted as necessary.

CARC Policy & Procedure Acknowledgement with copy of Client Grievance forms
The policy and procedure acknowledgement form is required to be submitted by each client. A signed copy should be given to the client for his/her records. Case Managers should use the Client Grievance forms upon request of the client.

CASE MANAGER CHECKLIST / REVIEW FORM

Client Code________________________________ Date application received:________________________________

Case Manager: ____________________________________ Agency: ____

Telephone:____ Fax:____

Agency Mailing Address: ___________________________________ City ________________Zip Code _____________

HOUSING ONLY Landlord ____

Rental Unit Address ____

CASE MANAGER CHECKLIST:

- ☐ Intake Form
- ☐ Release of Information
- ☐ Acknowledgement of CARC P&P
- ☐ Income Verification
- ☐ HIV/AIDS Diagnosis
- ☐ Housing Habitability Inspection

Housing Assistance

- ☐ Use of Funds Page
- ☐ Case Manager Signature
- ☐ Client Signature
- ☐ CM Supervisor Signature
- ☐ Security Deposit Form
- ☐ Lease or rental verification form
- ☐ W-9 (for housing assistance)

Case Manager's Certification (Initials)

____________________________I certify that the applicant is eligible for Transitioning from Incarceration Fund and has no other options or resources for payment.

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CLIENT INTAKE
Transitioning from Incarceration Pilot Program

Service Site___________________________________Case Manager__________________________________

CLIENT INFORMATION:
Client
Name:______________________________________
Address:____________________________________ Apt#:_______ Town:________________ ZIP:________
Social Security#:______________________________ DOB:___________
Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Lives with Significant Other ☐
U.S. Citizen: Yes☐ No☐ Place of birth:__________________ How long in the US?_________________
Immigration status: Documented ☐, Undocumented ☐, N/A ☐. Other info_____________________________

CLIENT CHARACTERISTICS

*Gender:	Male ☐ Female ☐ Transgender ☐ Unknown/Unreported ☐
*Hispanic/Latino /a ethnicity:	Hispanic or Latino/a ☐ Non-Hispanic and Non-Latino/a ☐ Unknown/Unreported ☐
*Self-reported Race:	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/ or Alaskan Native ☐ More than one race ☐ Unknown/unreported ☐
Transmission Category:	Men who have sex with men (MSM) ☐ Injection Drug Users (IDU) ☐ MSM and IDU ☐ Heterosexual Contact ☐ Perinatal ☐ Transfusion ☐ Other (specify)________________
*HIV Status:	HIV + (not AIDS) CDC Defined AIDS ☐
Education:	(K-8) ☐ High School (circle last grade completed) 9, 10, 11, 12 GED ☐ AA/AS ☐ BA/BS ☐ MA/MS ☐ Ph.D ☐ Other (specify)______________________

LIVING ARRANGEMENT (check one)
*Shelter ☐ Streets (no regular nighttime residence)☐ Transitional Housing/living program ☐
Medical facility (hospital, nursing home, rehabilitation center) ☐ Substance Use Treatment Program ☐
Mental Health Treatment Program ☐ Prison/jail ☐ Living with family or friends ☐
Rental housing ☐ Monthly rent:$_________ Subsidy:$ _________ Client's Portion:$ _________
What utilities is client responsible to pay?________________________
Is client housed in a facility/program? If yes, please enter name of facility/program:______________________
Contact Person for facility/program:_____________________________________ Telephone#_______________

HOUSEHOLD COMPOSITION (list all except Client)

Name	Age	Relationship to Client	Aware of HIV status?
1.			☐
2.			☐
3.			☐
4.			☐
5.			☐
6.			☐

HEALTH INSURANCE/MEDICAL COVERAGE (check one)
Medicare ☐ Title XIX (Medicaid) ☐ CADAP ☐
Veterans Administration ☐ Other Public ☐ Employer Health Plan ☐
Other Private ☐ Other ☐ Unknown/unreported ☐ No Insurance ☐

Is client a veteran? Yes☐ No☐ **Did client serve before ‘80 or serve for > 24 consecutive months? Yes☐ No☐
Is client eligible for VA medical care? Yes☐ No☐

EMPLOYMENT
Employer:________________________ Address:____
Occupation:_______________ Employed how long:______________ Full-time(F) ☐ or Part-time(P) ☐

FINANCIAL/BENEFIT INFORMATION
Please checkmark all sources of income:

- ☐ Employment
- ☐ Family Member(s) Income (Work and Other)
- ☐ Unemployment Compensation
- ☐ Workers Compensation
- ☐ Social Security Disability Insurance (SSDI)
- ☐ Pension
- ☐ Supplementary Security Income
- ☐ SAGA Cash
- ☐ TANF (Temporary Aid to Needy Families)
- ☐ State Supplement for the Disabled
- ☐ Food Stamps
- ☐ WIC
- ☐ Other (specify source)____________________

Pending Benefits (List date of application):

- ☐ CADAP________________________________
- ☐ Title XIX_______________________________
- ☐ Unemployment Compensation____________
- ☐ Workers Compensation__________________
- ☐ Social Security Disability__________________
- ☐ Pension__________________________________
- ☐ Supplemental Security Income____________
- ☐ MLIA ________
- ☐ TANF (Temporary Aid to Needy Families)_____________
- ☐ State Supplement for the Disabled____________________
- ☐ WIC____
- ☐ Food Stamps______________________________________
- ☐ Other____

ELIGIBILITY WORKSHEET(use for eligibility determination)

I. Indicate household/family source(s) of income, frequency, and amount:
(complete for all items checked on section III, page 1; please attach documentation)

SOURCE(S) OF INCOME	SPECIFY HOUSEHOLD MEMBER	INCOME($)	WEEKLY(W); BIWEEKLY(B); MONTHLY(M)	ANNUAL AMOUNT($)
Client work income	Client			
Family member(s) work income				
Unemployment Compensation				
Workers Compensation				
Social Security Disability Insurance (SSDI)				
Pension				
Supplementary Security Income				
SAGA (State Administered Gen'l Asst)				
TANF (Temporary Aid to Needy Families)				
State Supplement for the Disabled				
Other(specify)				
Total:		$	Total:	$

II. Indicate any medical out-of-pocket expenses that should be taken into account as adjustments in determining income(e.g. copayment, insurance premiums, deductibles, etc):

TYPE OF EXPENSE	DATE PAID	OUT-OF-POCKET EXPENSE($)
	_____/_____/_____	
	_____/_____/_____	
	_____/_____/_____	
TOTAL OUT-OF-POCKET EXPENSES:		$

Medical expenses taken into account must be within a 12-month period of time and can only be used to calculate and pay for future RW bills.

III. Subtract II from the total of I above and indicate adjusted income: $_________________________

IV. What is family /household size?(# of people): _____________

V. Eligibility Determination:
What is 200% of the poverty level for this household/family size? $_________________________
(Compare this with III (adjusted income):
If adjusted income is less, then the client is eligible for CARC Short Term Housing Assistance:
☐ Eligible ☐ Ineligible Date_________________

VI. Household Income (has to be completed):
Equal to or below FPL ☐ 101-200% FPL ☐ 201-300% FPL ☐ 301 – 400% FPL ☐ Greater than 400

AUTHORIZATION TO RELEASE INFORMATION

This is to certify that I hereby give my consent to, and authorize:

____ ____

(Name of agency) (Case manager/counselor)

to release a copy of the following information in their possession, including oral disclosure, consisting of but not limited to the following:

*(**INSTRUCTIONS**: Client must initial to signify approval, or write "NO" to signify disapproval. All blanks must be filled in or marked "N/A", not applicable)*

______Medical records, including HIV related information
______Psychiatric, psychological, psychotherapy or other counseling records
______Alcohol and/or drug treatment related information
______Criminal Justice/Incarceration
______Financial
______Employment
______Academic
______Other: ____

OF: ____ Date of Birth:____________________
(Client name)

TO:____ ________________________________
(Name of agency) (Case manager/counselor)

____
(Address of agency)

In addition, I have been given the opportunity to review an attached list of the provider network member agencies and also authorize release of information, including oral disclosure between agencies, of the above-cited information to access services within the provider network, as follows:

(Initial to signify approval, or write "NO" to signify disapproval)
________This agency only
________Entire network of service providers (not valid without attached list of service providers)
________Other agencies, as noted:____

All records are confidential pursuant to Connecticut General statutes 19a-581-590 and 592. I understand that the records to be released may contain confidential HIV/AIDS related information. I understand that I may revoke this authorization for release at any time by notifying the above authorized person in writing, except to the extent that information has already been shared. If not revoked by me, I understand this release is valid for one year from the date it was signed. This release shall be considered invalid without an attached copy of network providers.

____ ______________________
(Signature of client or legal representative) (Date signed)

PROHIBITION OF REDISCLOSURE: This information is disclosed to you from records whose confidentiality is protected by Federal and State law. Regulations prohibit making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Please honor a mechanically reproduced copy of this release

CARC
Policy and Procedure Acknowledgement

I have received a copy (or have had read to me) the following CARC policies and procedures: 1) Client Consent and Agreement; 2) Notice of Privacy Practices; 3) Client Bill of Rights; 4) Grievance Procedure and 5) Release of Information Procedure

1. Client Consent and Agreement

Policy: CARC requires that a signed informed consent agreement be signed between the agency submitting an application to CARC and the client. This agreement must be submitted to CARC as part of an application for services. This form authorizes the information on the application to be submitted. Applications cannot be reviewed without the client's express permission.

2. Notice of Privacy Practices

Policy: All records are confidential as per CT state law. Client information is made available to funding agencies without written permission for quality assurance and reporting purposes. Information obtained by the funding agencies for quality assurance and reporting purposes will utilize a coded client identifier when reported. All other client data will be maintained at CARC's office in a secured location with access limited to provider designated staff and quality assurance staff from funding sources. Additional CARC office practices regarding confidentiality are spelled out on our website at: www.ctaidscoalition.org. A copy of the CT state law is provided below.

Sec. 19a-581. Definitions. (8) **"Confidential HIV-related information"** means any information pertaining to the protected individual or obtained pursuant to a release of confidential HIV-related information, concerning whether a person has been counseled regarding HIV infection, has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify a person as having one or more of such conditions, including information pertaining to such individual's partners;
(9) "Release of confidential HIV-related information" means a written authorization for disclosure of confidential HIV-related information which is signed by the protected individual or a person authorized to consent to health care for the individual and which is dated and specifies to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information is not a release of confidential HIV-related information, unless such authorization specifically indicates its dual purpose as a general authorization and an authorization for the release of confidential HIV-related information and complies with the requirements of this subdivision…

Sec. 19a-583. Limitations on disclosure of HIV-related information. (a) No person who obtains confidential HIV-related information may disclose or be compelled to disclose such information, except to the following:
(1) The protected individual, his legal guardian or a person authorized to consent to health care for such individual; (2) Any person who secures a release of confidential HIV-related information; (3) A federal, state or local health officer when such disclosure is mandated or authorized by federal or state law; (4) A health care provider or health facility when knowledge of the HIV-related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual or when confidential HIV-related information is already recorded in a medical chart or record and a health care provider has access to such record for the purpose of providing medical care to the protected individual; (5) A medical examiner to assist in determining the cause or circumstances of death; (6) Health facility staff committees or accreditation or oversight review organizations which are conducting program monitoring, program evaluation or service reviews; (7) A health care provider or other person in cases where such provider or person in the course of his occupational duties has had a significant exposure to HIV infection, provided …. criteria are met (8) Employees of hospitals for mental illness operated by the Department of Mental Health and Addiction Services information. Disclosure shall be limited to as few employees as possible and only to those employees with a direct need to receive the information to achieve the purpose authorized by this subdivision;…

3. Client Bill of Rights

As a participant in CARC's programs, you have the right . . .

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and or mental ability.
- To participate in creating a plan with the case manager submitting your application to CARC.
- To be informed about services and options available to you.
- To withdraw your voluntary consent to participate in the program, but you will no longer be eligible for our services.
- To have your medical records and case management records be treated confidentially.
- To have information released only in the following circumstances: (a) When you sign a written release of information; (b) When there is a medical emergency; (c) When a clear and immediate danger to you or to others exists; (d) When there is possible child or elder abuse; (e) When ordered by a court of law.
- To file a grievance about services you are receiving or denial of services.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

As a participant in our program you have the responsibility...

- To treat the staff of this agency with respect and courtesy.
- To participate as much as you are able in creating a plan for stable living with your case manager.
- To let your case manager know any concerns you have about your needs.
- To provide to the best of your ability the required documentation outlined in the program application.
- To stay in communication with your case manager by informing him/her of changes in your address or phone number and responding to the case manager's calls or letters to the best of your ability.
- To not subject agency case managers, staff, or other clients to physical, sexual, verbal and/or emotional abuse or threats.

4. Grievance Procedure

Policy: If an applicant for CARC's programs is denied assistance or deemed ineligible, the client has the right to file an appeal/grievance.

Procedure: The client should instruct his/her case manager to complete a copy of CARC's appeal/grievance policy form. This form and step-by-step instructions must be used to file an appeal/grievance. All case managers have a copy of this form, which is also available on-line at www.ctaidscoalition.org.

5. Release of Information Procedure

Policy: The Connecticut AIDS Resource Coalition will not release client information, unless required by law, without a completed release of information form. A client will be informed in writing of the reason for the request and will be presented with a release of information form. (CARC requires a completed release of information in order to receive an application from a client, but will not release any information without one specifically allowing CARC to do so. A release of information will be provided at the time a request to release information is made to the client.)

I, ____, understand the above policies.

____

Client Signature Date

____

Case Manager Signature Date

This is valid for 1 year from date of signature.

Connecticut AIDS Resource Coalition
Transitioning from Incarceration Pilot Program
APPEAL/GRIEVANCE POLICY

Purpose: **If an applicant for the** Transitioning from Incarceration Pilot Program is denied assistance or deemed ineligible, the following appeal/grievance procedure is available to that applicant.

Process: The following is the procedure that Connecticut AIDS Resource Coalition (CARC) asks clients to follow to file an appeal/grievance:

1.) Client should inform their primary case manager of their desire to appeal/grieve.

2.) The case manager will contact CARC and request an appeal/grievance form. (Attached)

3.) Client will complete top half of form stating why he/she believes he/she is eligible based on the published criteria for the fund. (Attached)

4.) The CARC Housing/Client Assistance Administrator will review the form with his/her immediate supervisor to determine if there is new or different information presented that would allow for eligibility based on the published criteria.

5.) If there is new information that overturns the Housing/Client Assistance Administrator's original decision, an acceptance letter will be sent to the case manager. If there is not new information that qualifies the client, the application will continue to be denied and the case manager will be informed.

6.) If the client is still not satisfied and would like to take a last and final step, he/she must re-submit the form with additional information or explanation to the Executive Director of CARC for final determination.

7.) All decisions of the Executive Director are final and binding.

Connecticut AIDS Resource Coalition
Transitioning from Incarceration Pilot Program
APPEAL/GRIEVANCE POLICY FORM

Top half to be filled out by client

Today's Date: ____

Client Name: ____

Grievance: (Please be as specific as possible) ____

____

____

____

____

(Use additional sheets if necessary. Attach all supporting documentation.)

Case Manager's Name ____

____
Client Signature

Bottom half to be filled out by CARC staff

Received __________________

Reason for Denial given on Application:

Applicant's rent less than 40% of income
Rent exceeds 80% of household income
Request exceeds maximum amount of assistance
Lack of long-term planning/solution to housing problem
Failure to comply with program requirements

Re-determination decision and reason: ____

____

____

Supervisor's Signature and Date ____

Executive Director's Comments: ____

____

____

CARC _will not_ reimburse programs that have paid housing expenses for clients _without PRIOR written approval._

To Calculate income using **Weekly** Paychecks	To Calculate income using **Bi-weekly** paychecks.
Add together 3 pay stubs	Add together 3 pay stubs
Divide by 3 to find average weekly amount	Divide by 3 to find average bi-weekly amount
Multiply by **52** (pay periods), then divide by 12 (months)	Multiply by **26** (pay periods), then divide by 12 (months)
Result is Monthly income	Result is Monthly income

5. **IRS requirement – W-9 and MISC-1099**

   The IRS requires that any organization providing payments to landlords must report payments over $600 per year to the IRS. This is done by having a Landlord fill out a W-9 form prior to receiving payment. At the year's end, a MISC-1099 is sent to the Landlord with a copy going to the IRS. CARC's housing assistance checks simply have the name Housing Assistance Fund or Emergency Housing Fund on them, with no other identifying information.

   Landlords need only be made aware that the client is participating in a rental assistance program and as such, are required to provide their Tax ID number to assure that they continue to receive payments. While some clients have explained to their landlord that they qualify for housing assistance due to a disability, under no circumstance should the client feel that they have to reveal their HIV status or any other diagnoses. Under the Americans with Disabilities Act, a landlord has no right to ask WHAT their disability is.

   CARC uses a separate phone line for our Client Assistance Funds and we make this number available for any landlords seeking more information on why they are required to complete the W-9. We will not explain what our funds are, who administers them, or how a person qualifies.

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CARC Transitioning from Incarceration Pilot Program – USE OF FUNDS

Please fill out the following two pages and attach all necessary supporting documentation. Failure to submit a complete application and required documentation may result in request being denied and returned to applying case manager.

I. Personal Household Information

Household Size: ________________# and age(s) of adults___________________________________

and age(s) of children _________________________________

Monthly rent payment_________________ ÷ Income _______________________ = _________________%

II. Is the applicant currently receiving, on a waiting list or been denied for other forms of housing assistance?

	Receiving (date)	Waiting List (date)	Ineligible (date)
Section 8	_____________	____________________	____________________
RAP	_____________	____________________	____________________
Shelter + Care	_____________	____________________	____________________
Mutual Housing	_____________	____________________	____________________
Other	_____________	____________________	____________________

If the person is not currently receiving or on a waiting list for other housing assistance, explain why: _________________

____

____

____

Describe the steps to be taken by applicant to keep current housing affordable when assistance is terminated: _______

____

____

____

Clearly describe the housing stability plan): ____

____

____

____

____

III. Please specify the use of funds requested.

A. First/last month's rent: Month(s)________________Amount: $ _________________

B. Ongoing rental assistance of $_______________ ____________________**to** _________________
(Not to exceed 6 months) Month/Year Month/Year

D. Security Deposit (not to exceed 2 month's rent) ________________________________

Attach all of the following information. Applications submitted without complete documentation will be denied

_______**Verification of income for all members of household** (i.e. current W-2s, child support, alimony, 3 **recent** pay stubs, Social Security entitlement paperwork, State Supplemental paperwork).

_______**Lease, or rental verification** from landlord or property manager which verifies tenancy OR

rent receipts/canceled rent checks for 3 immediate previous months OR documentation of mortgage payment.

_______**Statement from property owner/landlord to return Security Deposit to CARC upon tenant's departure.**

_______**Signatures:** client signatures on release form, application form (below); case manager and supervisor signatures on application form (below).

IV. Rental Unit/Landlord/ Manager Information (Person or agency to whom check will be made out)

____
Rental Unit Address

____
Name of Landlord/Manager Telephone/Fax

____
Mailing Address City State Zip Code

I acknowledge that all information contained in this application is true and correct to the best of my knowledge. I authorize my case manager to discuss the information contained in this application with representatives of the Transitioning from Incarceration Program. I also promise to immediately inform my case manager of any and all changes to my income or housing situation.

____
Client Signature Date

____
Case Manager Signature, Telephone Date

____
Agency Mailing Address City State Zip Code

____
Supervisor's Signature Date

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RENTAL VERIFICATION (First/Last Month's Rent)

I, ____ do hereby state that
(Landlord name)

____is/will be my tenant at
(Tenant name)

____
(Address of apartment site)

Individuals that will also be living at this address are____
(Specify adult or child)

_______________________________________ ____
(Specify adult or child) (Specify adult or child)

_______________________________________ ____
(Specify adult or child) (Specify adult or child)

They will reside at this address on______________________paying a monthly rent of $_______________
(Date moving in)

The lease calls for: ( )First month and security ( )First month/last month/security

The first/last month's rent of _______________ is for the month of _______________________
(Amount of rent)

Security deposit of ________________________ was paid on _____________________________

All of the following must have landlord's initials:

( ) Copy of lease attached

( ) Copy of Security Deposit receipt attached, or Rental Verification (Security Deposit) form also attached

( ) W-9 Form completed and attached

( ) I understand that my tenant is applying for financial assistance and that **these funds cannot be used for security deposit under any circumstances.** Documentation that the security deposit has been paid accompanies this form.

( ) I understand that these funds will pay for first month's rent only if the lease calls for first month's rent and security deposit.

( ) I understand that I will be issued a tax form Misc.1099 at year's end and that this assistance is reportable income.

____

(Landlord/Property Manager's Signature/Date)

RENTAL VERIFICATION (Security Deposit)

I, ____ do hereby state that
(Landlord name)

____ is/will be my tenant at
(Tenant name)

____
(Address of apartment site)

Individuals that will also be living at this address are ______________________________
(Specify adult or child)

______________________________ ______________________________
(Specify adult or child) (Specify adult or child)

______________________________ ______________________________
(Specify adult or child) (Specify adult or child)

They have resided at this address since ________________ paying a monthly rent of $____________
(Date moving in) (Amount of rent)

They require a **Security Deposit** in the amount of $______________________

All of the following must have landlord's initials:

( ) Promissory note stating that the Landlord will return the Security Deposit to the Housing Assistance Fund if the tenant leaves the apartment in good standing.

( ) Copy of lease attached

( ) W-9 Form completed and attached

____
(Landlord/Property Manager's Signature/ Date)

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