Templates for CoC and ESG-Funded Programs: Supplemental Resource to CoC Written Standards
Western PA Continuum of Care (PA-601)

Contents

Note: These templates are provided as a resource for CoC homeless service providers (specifically CoC- and ESG-funded providers), to ensure that providers have the tools to comply with HUD requirements and the CoC Written Standards. Use of these specific templates is not required by the CoC.

Grant Enrollment Approval

Head of Household:
Case Manager:

Program:		
	___ESG	___PSH
	___CoC	___RRH
		___HP

Date of Application:
Enrolled as of:
Annual Assessment Due:

 # Bedrooms approved:
Maximum rent allowed:

Description: (household members, homeless definition met, income at enrollment)

This household is approved for grant enrollment for stabilization purposes under the _____ (program component) component of _____ (funding source).

This applicant qualifies with a yearly income of $_____ under the Extremely Low-Income Limit of _____.

Approved by: _____ _____

Name, Position Name, Position

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Grant Payment Approval

Head of Household:
Case Manager:

Program: ___ESG ___PSH
___CoC ___RRH
___HP

Type: __Rental Assistance for: _____
__Financial Assistance
__Security Deposit
__Utility Deposit
__Utility Payment
__Moving costs
__Storage fees

Enrolled as of:
Payment approved on:
Annual Assessment due:

 # Bedrooms approved:
 # Bedrooms rented:
Maximum rent allowed:

Amount requested:

Lease expires on:

Send to:

Rental Address on Lease:

Description (ESG/Participant contributions, proration, payment disbursal date, extenuating circumstances, etc.)

Approved by: _____ _____
Name, Position Name, Position

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Grant Recertification Approval

Head of Household:
Case Manager:

Program: ___ESG ___CoC ___PSH ___RRH ___HP

Date of Application:
Enrolled as of:
Annual Assessment due:
Annual Assessment Completed/Recertified as of:
Exit Assessment due (2 years from Enrolled as of date):

Rental Address on lease:

Description (stabilizing factors, income at recertification, extenuating circumstances, housing situation):
* Approved application already sent to fiscal.
** This recertification extends the approval for an additional _____ (number of months) months.

This household continues to be approved for grant enrollment for stabilization purposes under the _____ (program component) component of _____ (funding source).

Details/description of housing situation (e.g., why the housing crisis has not been resolved yet):

This applicant continues to qualify with a yearly income of $_____ under the Extremely Low Income Limit of _____.

Approved by: _____ Name, Position

_____ Name, Position

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Grant Enrollment Discharge Approval

Head of Household:
Case Manager:

Enrolled as of:
Discharged as of:

Last known address:

Program:		
	___ESG	___PSH
	___CoC	___RRH
		___HP

Description (stabilizing factors, income at exit, housing situation):

Approved by: _____ _____

Name, Position Name, Position

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HMIS Data: During Enrollment/Recert/Exits

(please complete for each household member)

FULL NAME: _____ **ASSESSMENT DATE:** _____

☐ Recertification ☐ Exit Current Certification expires: _____

☐ Still member ☐ New member ☐ Left household

If not a continuing, date applicant joined/left household: _____

Current total members in household: _____

_____I have reviewed my most recent HMIS application on file and I certify that no information has changed. (Self-verification of Income and paystubs for the last 30 days are still required, even if unchanged. Please attach).

_____ _____

Applicant Signature Date

OR

_____ I have reviewed my most recent HMIS application and I certify that the following items have changed. (Self-verification of Income and paystubs for the last 30 days are required. Please attach and use extra paper if more space is needed for changes requested below.)

Item	**Past Answer**	**Current Answer**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Applicant Signature Date

_____ _____

Case Manager Signature Date

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Third-Party Verification of Income

Participant Name:_____

Instructions for Employer/Payment Source Representative:
This is to certify the income received by the above-named individual for purposes of participating in our housing assistance program. This information will be used only to determine the eligibility status and level of benefit for the household. Please complete only the selected section below that includes and authorization or release information:

***Please return this form to:
Name and Title: _____ Phone:_____

Address:_____Fax:_____

Email:_____

Participant Release:
I hereby authorize the release of the following employment information:

Participant Signature:_____Date:_____

Employer Representative to complete this Section:
The person named above is employed by _____(employer) since_____ (start date).

Person named above is paid $_____ (pay rate) on a _____ (frequency) basis and is currently working an average of _____ (average hours) hours per _____ (week, month, etc.).

Additional compensation please specify (if any): _____

Probability of continued employment: _____

Signature: _____ Date: _____

Name, Title: _____

Address and Phone: _____

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Self-Certification of Income

Applicant Name: _____

This is to certify the income status for the above named individual. Income includes:

- The full amount of **gross income** earned before taxes and deductions.
  - The net income earned from the operation of a business (i.e., total revenue minus business operating expenses). This also includes any withdrawals of cash from the business or profession for your personal use.
  - Monthly interest/dividend income credited to an applicant's bank account available for use.
  - The monthly payment amount received from Social Security, annuities, retirement funds, pensions, disability and other similar types of periodic payments.
  - Any monthly payments in lieu of earnings, such as unemployment, disability compensation, SSI, SSDI, and worker's compensation.
  - Monthly income from government agencies excluding amounts designated for shelter, and utilities, WIC, food stamps, and childcare.
  - Alimony, child support and foster care payments received from organizations or from persons not residing in the dwelling.
  - All basic pay, special day and allowances of a member of the Armed Forces excluding special pay for exposure to hostile fire.

__ I certify, under penalty of perjury, that I currently receive the following income:

Source: _____ Amount: _____ Frequency: _____

Source: _____ Amount: _____ Frequency: _____

Source: _____ Amount: _____ Frequency: _____

Applicant Signature: _____ Date: _____

OR

__ I certify, under penalty of perjury, that I do not have any income from any source at this time.

Applicant Signature: _____ Date: _____

Staff Verification & Due Diligence (REQUIRED)

I understand that third-party verification is the preferred method of certifying income for grant assistance. I understand self-declaration is only permitted when I have attempted to but cannot obtain third party verification. *Documentation of attempt made for third-party verification:*

_____

_____

Staff Signature: _____ Date: _____

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Homeless Certification

Applicant Name: _____

This is to certify that the above named individual or household is currently homeless based on the check mark, other indicated information, and signature indicating their current living situation.

Check only one box and complete only that section.

Living Situation: place not meant for human habitation (e.g., cars, parks, abandoned buildings, streets/sidewalks)

__ The person(s) named above is/are currently living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus station, airport, or campground.

Description of current living situation (attach additional pages if needed and pictures if applicable):

_____

_____

Authorized Agency Representative Signature: _____ Date: _____

OR

Living Situation: Emergency Shelter

__ The person(s) named above is/are currently living in (or, if currently in hospital or other institution, was living in immediately prior to hospital/institution admission) a supervised publicly or privately operated shelter as follows:

Emergency Shelter Program Name: _____

Authorized Agency Representative Signature: _____ Date: _____

OR

Living Situation: Transitional Housing

__ The person(s) named above is/are currently living in a transitional housing program for persons who are homeless. The persons(s) named above is/are graduating from or timing out of the transitional housing program. Immediately prior to entering transitional housing the person(s) named above was/were residing in emergency shelter OR a place unfit for human habitation.

Transitional Housing Program Name: _____

Authorized Agency Representative Signature: _____ Date: _____

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Self-Certification of Housing Status

Applicant Name: _____

This is to certify that the above named individual or household is currently homeless or at-risk of homelessness, based on the following and other indicated information and the signed declaration by the applicant.

Check only one:

__ I [and my children] am/are currently homeless and living on the street (i.e., a car, park, abandoned building, bus station, airport, or campground).

__ I [and my children] am/are the victim(s) of domestic violence and am/are fleeing from abuse.

__ I [and my children] am/are being evicted from the housing we are presently staying in and must leave this housing within the next ____ days.

I certify that the information above and any other information I have provided in applying for ESG assistance is true, accurate and complete.

Applicant Signature: _____ Date: _____

Staff Verification & Due Diligence (REQUIRED)

I understand that third-party verification is the preferred method of certifying homelessness or risk for homelessness for an individual who is applying for grant assistance. I understand self-declaration is only permitted when I have attempted to but cannot obtain third party verification.

Documentation of attempt made for third-party verification:

_____

_____

_____

Staff Signature: _____ Date: _____

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Chronic Homelessness Definition

This tool provides some sample recordkeeping tools for the Chronic Homelessness Definition. To review the exact language, please refer to 24 CFR Parts 91 & 578 and the HUD Exchange.

Recordkeeping Documentation Options Explained

3rd Party Documentation	 Documentation from HMIS/Comparable Database *Records must show entries/exits at Shelters.* *An answer of "Yes" to the question as to whether the individual is chronically homeless (Universal Data Element 3.917) is not sufficient.*	 Written observation by an outreach worker or Written referral by another housing	 Documentation from Institutions like Hospitals, Correctional Facilities, etc. *Must include records about stay the length of stay, signed by Clinician or other appropriate staff.*
Self Certification	 Signed certification by the individual seeking assistance describing how they meet the definition, which must be accompanied by the intake worker's documentation of the living situation and the steps taken to obtain evidence to support it. Remember that for each Project: • 100% of households served can use self-certification for 3 months of their 12 months, • 75% of households served need to use 3rd Party documentation for 9 months of their 12 months, and • 25% of households served can use self-certification as documentation for any and all months.		

When do you need third party documentation?

✓ Preferred to record all occasions of homelessness to document Chronic Homelessness.

✗ Not necessary to record breaks in homelessness, these can be based on self reports.

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Chronic Homelessness Documentation Checklist

An individual is defined by HUD as "Chronically Homeless" if they have a disability and have lived in a shelter, safe haven, or place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last three years (must total 12 months). Breaks in homelessness, while the individual is residing in an institutional care facility will not count as a break in homelessness. Additionally, an individual who is currently residing in an institutional care facility for less than 90 days and meets the above criteria for chronic homelessness may also be considered chronically homeless. Lastly, a family with an adult/minor head of household who meets the above-mentioned criteria may also be considered chronically homeless, despite changes in family composition (unless the chronically homeless head of household leaves the family).

Client Name:	**Date of Birth:**
Number in Household:	**Client Head of Household:** ☐ Yes ☐ No

Part 1: Current Housing Status

Client must currently be in one of these locations in order to be considered chronically homeless.

Client is currently residing:

☐ In Emergency Shelter
☐ On the Streets/Place not Meant for Human Habitation
☐ In the Safe Haven
☐ In an Institutional Care Facility (Where they have been for fewer than 90 days)

Start Date: _____ **End Date:** _____

Location Name/Address:

Current Housing Status Notes:

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Ending Homelessness in Western PA

Part 2: Housing History

	Month # 1	Month # 2	Month # 3	Month # 4	Month # 5	Month # 6	Month # 7	Month # 8	Month # 9	Month # 10	Month # 11	Month # 12
mm/yy	(Current)											
Where? *Check all that Apply*	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)
Doc. Type *Check One*	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence
Doc. Att.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

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Part 2: Housing History (continued)	
Break Mo./Yr. & Description or N/A	Break 1: Break 2: Break 3: If there are additional breaks please detail and attach.
Notes	
Self-Cert. Check	Does the documentation include more than 3 Months of Self-Certifications? * ☐ Yes ☐ No ** Please be advised that if you answered **YES**, that for at least 75% of the households assisted by a recipient in a project during an operating year, no more than 3 months can be self-certified.* ***Please check with you project administrator to ensure your project has not exceeded its self-certification cap.***

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Part 3: Disability Status

The term homeless individual with a disability' means an individual who is homeless, as defined in section 103, and has a disability that:

- *Is expected to be long-continuing or of indefinite duration;*
  - *Substantially impedes the individual's ability to live independently;*
  - *Could be improved by the provision of more suitable housing conditions; and*
  - *Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;*
- *Is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or*
- *Is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.*

The head of household has been diagnosed with one or more of the above eligible disabilities:

☐ Yes ☐ No

Documentation Attached:

☐ Written verification of the disability from a licensed professional;

☐ Written verification from the Social Security Administration;

☐ The receipt of a disability check; or

☐ Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, accompanied by supporting evidence.

Part 4: Staff and Client Certifications

Client Certification: *To the best of my knowledge and ability, all the information provided in this document is true and complete. I also understand that any misrepresentation or false information may result in my participation being cancelled or denied, or in termination of assistance. It is my responsibility to notify _____ of any changes in my housing status or address in writing during program participation. I understand that my application may be cancelled if I fail to do so.*

Client Name: (Printed)	**Client Signature:**	**Date:**

Staff Certification: *To the best of my knowledge and ability, all of the information and documentation used in making this eligibility determination is true and complete.*

Staff Name: (Printed)	**Staff Signature:**	**Date:**
Staff Role:	**Agency:**	

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Physician's Verification of Disability

To: _____ Date: _____
(Primary care Physician, Psychiatrist, etc.)

Address: _____

Patient Information

Applicant: _____Contact: _____

RELEASE * Applicant I authorize the above named professional to disclose any requested and necessary information to _____.

Applicant Signature _____Witness Signature _____

The above-named client is applying for a supportive housing program through _____. We ask your cooperation in providing the following information and return to the office by mail or by fax as soon as possible. Your prompt attention of this information will help to assure timely processing for the requested assistance. The applicant needs to consent to this release of information as shown below.

The guidelines require that we have a written verification from a state licensed qualified source that can diagnose and treat the individual applying for services. A qualifying disability is:

- A physical, mental, or emotional impairment and
- Expected to be of long continued indefinite duration, substantially impedes (is an obstacle) the individual's ability to live independently and the individual's ability to live independently could be improved by more suitable housing conditions.

Examples include developmental disabilities, substance use disorder, serious mental illness, post-traumatic stress disorder, cognitive impairments resulting from brain injury, chronic physical illness or disability, diseases of acquired immunodeficiency syndrome (AIDS).

Does the participant meet the above eligibility requirements? ☐ **Yes** ☐ **No**

_____ _____
(Physicians Signature) **(Date)**

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Housing Plan: Goal Plan

HOUSEHOLD NAME: ______________________________ **DATE CREATED:** ____________________

	Short term/ Long term	Target Date	Complete Date
Goal: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Goal: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Goal: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Goal: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________
Step: ____________________	________	________	________

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Housing Plan: Services and Supports

HOUSEHOLD NAME: _____

Provider	Past Involvement	Current Involvement	Referral Desired	Referral Made	N/A
Emergency Pantry					
Public Housing Authority					
Baby Pantry					
WIC					
Social Security Administration					
Behavioral Health					
Intellectual Disabilities					
Veterans Assistance Office					
County Assistance Office					
Representative Payee					
Domestic Violence Services					
Independent Living Services					
Office of Vocational Rehabilitation					
Area Agency on Aging					
Transportation					
Early Intervention					
CCIS (Childcare assistance)					
Drug and Alcohol Services					
Family Unification Program/Foster Youth to Independence Initiative Voucher program (through PHA)					
Other					
Other					

Housing Plan: Crisis Plan

HOUSEHOLD NAME: _____

Emergency Situation	**Immediate Response**
_____	_____
_____	_____
_____	_____
_____	_____

Emergency Contact(s):

Name: _____ Contact Info: _____

Name: _____ Contact Info: _____

If thoughts of harming yourself or someone else Crisis @ _____

Domestic Violence Services @ _____

Other:

Housing Plan: Financial Subsidy Plan

HOUSEHOLD NAME: _____ **DATE CREATED:** _____

RE-ASSESSMENT DATE: _____ **EXPECTED DURATION:** _____

Grant funding for: ☐ Rent ☐ Utility ☐ Other

Payment disbursed to: _____

Payment mailing address: _____

_____

Monthly Due date: _____

Account number: _____

			Agreed Terms		(office use only)	
	To be paid in Calendar month:	**Total Amount Due**	**Grant contributes**	**Applicant contributes**	Grant	App.
Arrears or Deposit Amount Due						
Monthly Payment 1 (possibly prorated)						
Monthly Payment 2						
Monthly Payment 3						

I understand that payment of the agreed upon subsidy(ies) to the landlord is dependent on availability of funding and potential income changes.

_____ _____

Applicant Signature Date Staff Signature Date

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Exit Plan

HOUSEHOLD NAME: _____ **DATE CREATED:** _____

About Us

Head(s) of Household:	
Address:	
Health Insurance	

Emergency/Medical Contacts

Role/Relationship	Name	Telephone Number

Plan to Maintain Housing

We will continue to pay our rent by making sure we do the following things:

_____

_____

_____

We will make sure that we do not get kicked out of our home by doing/not doing the following things:

_____

_____

_____

We are ready to live with greater independence and without Housing Program supports because:

_____

_____

_____

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The areas in our life that we are still working on are:

_____

_____

_____

We are going to work on these areas by:

_____

_____

_____

Signs that our housing is becoming unstable are:

_____

_____

_____

If our housing is becoming unstable, we will:

_____

_____

_____

Signs our housing is unstable are:

_____

_____

_____

If our housing is unstable we will:

_____

_____

_____

Should we ever receive an eviction notice or be told by our landlord that we need to leave, we will:

_____

_____

_____

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We are confident that we have the skills to:

Task	Yes	No	N/A
Clean the apartment			
Go grocery shopping			
Pay rent			
Speak with landlord			
Do laundry			
Budget			
Pay other bills			
Be responsible tenants			
Set goals & take action			
Problem-solve with a level head			
Keep emotions in check when frustrated/angry			
Follow crisis plan when necessary			
Make appointments and keep them			
Follow doctor instructions			
Follow psychiatrist instructions			
Take medicine			
Refill medicine			
Have fun without creating problems			
Fill the days with things that make us happy			
Invite guests over and know when to ask them to leave			
Seek out help when we need it			
Keep our apartment			

Our Support Network

The following people are considered to be part of my support network, and we recognize that our Housing Program support worker will no longer be part of my support network:

Role/Relationship	Name	Telephone Number

We would like our exit plan shared with our support network and other social service organizations as deemed appropriate by my case manager. _____Yes _____No

_____ _____

Participant Signature Date Case Manager Signature Date

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Minimum Habitability Standards for Permanent Housing: ESG

Instructions: Place a check mark in the correct column to indicate whether the property is approved or deficient with respect to each standard. The property must meet all standards in order to be approved. A copy of this checklist should be placed in the Participant file.

Passes	Fails	**Standard** *(24 CFR part 576.403(c))*
		Structure and materials: The structure is structurally sound to protect the residents from the elements and not pose any threat to the health and safety of the residents.
		Space and security: Each resident is provided adequate space and security for themselves and their belongings. Each resident is provided an acceptable place to sleep.
		Interior air quality: Each room or space has a natural or mechanical means of ventilation. The interior air is free of pollutants at a level that might threaten or harm the health of residents.
		Water Supply: The water supply is free from contamination.
		Sanitary Facilities: Residents have access to sufficient sanitary facilities that are in proper operating condition, are private, and are adequate for personal cleanliness and the disposal of human waste.
		Thermal environment: The housing has any necessary heating/cooling facilities in proper operating condition.
		Illumination and electricity: The structure has adequate natural or artificial illumination to permit normal indoor activities and support health and safety. There are sufficient electrical sources to permit the safe use of electrical appliances in the structure.
		Food preparation: All food preparation areas contain suitable space and equipment to store, prepare, and serve food in a safe and sanitary manner.
		Sanitary condition: The housing is maintained in sanitary condition.
		Fire safety:
		1. There is a second means of exiting the building in the event of fire or other emergency. 2. The unit includes at least one battery-operated or hard-wired smoke detector, in proper working condition, on each occupied level of the unit. Smoke detectors are located, to the extent practicable, in a hallway adjacent to a bedroom. 3. If the unit is occupied by hearing-impaired persons, smoke detectors have an alarm system designed for hearing-impaired persons in each bedroom occupied by a hearing-impaired person. 4. The public areas are equipped with a sufficient number, but not less than one for each area, of battery-operated or hard-wired smoke detectors. Public areas include, but are not limited to, laundry rooms, day care centers, hallways, stairwells, and other common areas.

Approved	Deficient	Inconclusive	**Lead-Based Paint Standard** *(24 CFR 35, Parts A, B, H, J, K, M, and R)*
			All painted surfaces are free of deteriorated paint.
			If not, all deteriorated surfaces do not exceed two square feet per room and/or is more that 10% of a component?

CERTIFICATION STATEMENT

I certify that I have evaluated the property located at the address below to the best of my ability and find the following:

☐ Property meets all of the above standards.

☐ Property does not meet all of the above standards.

COMMENTS:

ESG Recipient Name: _____

ESG Subrecipient Name: _____

Program Participant Name: _____

Street Address: _____

Apartment: _____

City: _____ State: _____ Zip: _____

Evaluator Signature: _____ Date of review: _____

Evaluator Name: _____

Approving Official Signature (if applicable): _____ Date: _____

Approving Official Name (if applicable): _____

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Landlord/Agency Rental Agreement

This Agreement made between _____(Landlord), _____(Landlord's address), and _____ (agency), shall be in effect from today through the tenant's duration in the _____ program. WHEREAS, landlord owns said property at _____ (Property Address) and WHEREAS _____ (tenant) resides at said property. Tenant shall occupy said rental property under the terms and conditions specified in the attached lease executed on _____ (date) between landlord and tenant.

THEREFORE, it is agreed by the parties hereto as follows:

1. Agency rep will provide to the landlord rent subsidy payments on behalf of the tenant in accordance with the project requirements and the terms of this agreement.
    a. The landlord recognizes that the amount of rent subsidy is affected by the tenant's income and length of time in program, participation/ compliance and funding available therefore the amount of rent subsidy is subject to change.
    b. The Landlord cannot change the rent amount or any other term of the lease with the tenant while this agreement is in place.
    c. Tenant is responsible for payment of any portion of rent not covered by the subsidy. This payment shall be made directly to the Landlord. The landlord will be made aware of subsidy amount & tenant responsibility.
    d. If rental arrearages are being paid by _____ (agency) to stop an eviction proceeding, the landlord agrees to cease such proceedings upon promise of payment.
    e. The landlord understands that rental subsidy(ies) for recurring rent will be issued on the _____ (day of month) of every month unless the due date falls on a weekend or holiday (refer to attached payment schedule) and mailed via _____ directly to the Landlord.
    f. **(IF APPLICABLE**) Landlord understands the option to enroll (at no cost) in

Electronic Funds Transfer (EFT) in which rental subsidy will be electronically deposited directly into the specified account of the Landlord on the _____ of every month unless the _____ falls on a weekend or holiday (refer to attached payment schedule)

g. **(IF NOT USING ELECTRONIC FUNDS TRANFER**) Rental subsidy will be paid via _____ (method) on the _____ of every month unless the _____ falls on a weekend or holiday (refer to attached payment schedule)

2. The landlord must maintain the housing unit in accordance with Lead Safe Housing Rules and HUD Habitability Standards or this agreement may be terminated.
3. While this agreement is in place, the landlord must furnish _____ (agency) with a copy of any notice to vacate given to the tenant, or any complaint used under state or local law to commence an eviction action against the tenant.
4. This agreement terminates automatically if:
   a. The lease is terminated by the landlord or the tenant;
   b. _____ (agency) terminates program assistance for the tenant; or
   c. The tenant moves from the housing unit.
5. Any and all lease/rental agreements shall be between tenant and landlord only. _____ (agency) is not a party to the lease nor does _____ (agency) assume any liability for rent owed, damages occurred, or other obligations of tenant.

I understand this Agreement and that _____(agency) is not a party to my lease.

_____ _____

Landlord Signature Date Staff Signature Date

(Valid only after signed by both parties)

EQUAL HOUSING OPPORTUNITY

Lease Review Sheet

HOUSEHOLD NAME: _____

What is the exact address of the property you will be living in?		
How long is the lease for?	Start Date	End Date
What is the amount of rent $ If returned, the security goes back to:	Security Deposit Amount $	
What day of the month is rent due? Is there a late fee?	After how many days?	Amount $
Who do you pay rent to? Name Phone	Address Email	
What types of payments can be used for rent? (if cash, get a receipt!)		
Who do you contact for repairs or problems? Name Phone	Address Email	
Are there any other fees?	Amount Paid $	For What?
What utilities are included in your rent?		
What costs are you responsible for? (if utility, switch into your name ASAP!)		
Are pets allowed?		

EQUAL HOUSING OPPORTUNITY

Is smoking allowed? If so, what are the rules regarding smoking?
Is there a limit to how many nights a guest may stay? Number of nights allowed:
Can additional people move in with you? If so, what must be done?
What is required if you want to move? What type of notice is required?
Additional Important Information:

EQUAL HOUSING OPPORTUNITY

Apartment Walkthrough

HOUSEHOLD NAME: _____ DATE OF WALKTHROUGH:_____

Make Sure to take photos of any concerns! Documenting the condition of a rental property before you move in is a great way to help ensure that your security deposit is returned if you decide to move. This can be a very simple thing to do. In the top row is the name of each room in your apartment. The column on the left side of the page has some basic items you should check for in each room. Walk through each area of the apartment and note any issues.

	Living Room	Kitchen	Bathroom	Bedroom 1	Bedroom 2	Other
Ceilings/Walls Look for cracks/ holes/peeling/ paint/water stains						
Floors Look for rips/holes/stains/burn marks/wear						
Windows Note if latches are in working order/ if there are cracks in the glass						
Electrical Make sure outlets and switches are in working order. Make sure light fixtures are in working order or if they are chipped or cracked.						
Appliances Note if they are in working order and if they have any scratches or dents.						
Safety Check that all locks work. Make sure there are smoke detectors in the unit and that they work.						

EQUAL HOUSING OPPORTUNITY

Appointment Form

Participant Name: _____

Date: _____ **Time:** _____

In Attendance: _____

Things to go over during appointment:

_____

_____

_____

_____

To do:

_____

_____

_____

_____

_____

_____ _____
Participant Signature Date

_____ _____
Case Manager Signature Date

EQUAL HOUSING OPPORTUNITY

Group Meeting Time Tracking

Date: _____ Duration: _____

Household: _____ Location: _____

Staff Present:

Name	Signature	Agency/Unit	Check if providing casenote
			☐
			☐
			☐
			☐
			☐
			☐
			☐

Purpose/Summary: _____

_____

_____

_____

EQUAL HOUSING OPPORTUNITY

Time Tracking Log for Match

Participant Name: _____

Date	Casework Activity Code	Summary	Duration of time for activity (1/4 hour increments)

Total: _____

Rate: _____

CASEWORK ACTIVITIES

A. Outreach & Engagement
B. Documenting Eligibility
C. Housing Search
D. Housing Inspection
E. Placement
F. Moving Arrangements
H. Transition to Stability
I. Transition to Termination
G. Indiv. Housing Plan
G2. Goals
G3. Progress Notes
G4. Monitor
G5. Negotiation w/ Landlord
G9. Legal Services Ref.
G7. Negotiation/ Mediation w/ Utilities
G8. Credit Repair Ref.

I attest that the information provided is true and accurate to the best of my knowledge.

Caseworker Name: _____ Caseworker Agency: _____

Caseworker Signature: _____

Supervisor Signature: _____

EQUAL HOUSING OPPORTUNITY

Chart Review

Participant: _____ **Date Reviewed**: _____ **Initials**: _____

Contract Year(s): _____ **Program**: COC ESG HAP H4G PHARE

Documentation:	Yes:	No:	N/A:	Comment:
Case Notes	☐	☐	☐	_____
Chronic Status	☐	☐	☐	_____
DCED Housing Status Checklist	☐	☐	☐	_____
Disability Status	☐	☐	☐	_____
Exit Form	☐	☐	☐	_____
Financial Subsidy Plan	☐	☐	☐	_____
Fair Market Rent (FMR)	☐	☐	☐	_____
Goal Plan	☐	☐	☐	_____
HMIS Client Consent	☐	☐	☐	_____
Homeless Status	☐	☐	☐	_____
Income Verification	☐	☐	☐	_____
Income Elig. Worksheet	☐	☐	☐	_____
Inspection	☐	☐	☐	_____
Intake(s)	☐	☐	☐	_____
Lease	☐	☐	☐	_____
Landlord Agency Agreement	☐	☐	☐	_____
Recertification	☐	☐	☐	_____
Releases	☐	☐	☐	_____
Rent Reasonableness	☐	☐	☐	_____
VI-SPDAT	☐	☐	☐	_____

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