FLAP 1

- HOUSING ASSESSMENT QUESTIONNAIRE
- FILE CHECKLIST
- FILE REVIEW
- DIVERSION RESOURCE CHECKLIST
- IDENTIFICATION DOCUMENTATION
- CLIENT ASSESSMENT SUMMARY
- CLIENT APPLICATION
- PREVENTION SCREENING
- HOUSING BARRIERS
- SELF-DECLARATION OF INCOME
- MAINSTREAM RESOURCES
- BANK VERIFICATION/ASSETS FORM
- MONTHLY EXPENSE STATEMENT
- HUD 5 CALCULATION ELIGIBILITY FORM

Family Crisis Support Services, Inc.

630 Park Avenuen NW
Suite 4
Norton, VA 24273

Phone: 276-325-4181 or E-Mail: fcssinc@comcast.net Fax: 276-325-4182

Diversion Resource Checklist

About this tool: Families and individuals experiencing homelessness may require a wide range of services that no single agency has the resources or expertise to provide. Consequently, homeless providers should encourage their clients to participate in benefit and service programs for which they are eligible

Client Name: ____

Client Case Number: _______________

Intake Date: _____________________

Resources	Already Contacted? Yes/No	Notes/Comments
DSS		
HUD		
WATER UTILITIES		
ELECTRIC UTILITIES		
APPCAA		
CATHOLIC CHARITIES		
PEOPLE INC.		
FOOD BANK		
HEALTH WAGON		
HEALTH DEPARTMENT		
MEOC		
OTHER		

Family Crisis Support Services, Inc.

Questionnaire for Client Summary

1. What led you to seek assistance?

2. What events lead you to being in this situation?

3. Have you ever been homeless in the past? If yes, please explain what happened.

4. What are your goals? i.e. a job, continuing education, etc.

5. When did you last have a job? What led you to being unemployed?

6. Have you been working on getting your disability? If yes, where are you in the process?

7. Have you ever been assisted with paying your rent or utilities?

8. Do you have any past due rent, utilities, or criminal charges that would prevent you getting into housing?

9. Do you have any children? Do you have custody of your children? If yes, please provide documentation.

10. Will you be homeless without assistance? Yes No

11. Client perceives their life has value and worth (Please choose one):
    - Strongly disagree
    - Somewhat disagree
    - Neither agree/disagree
    - Somewhat agree
    - Strongly agree
    - Client doesn't know
    - Client refused

12. Client perceives they have a tendency to bounce back after hard times (Please choose one):
    - Strongly disagree
    - Somewhat disagree
    - Neither agree/disagree
    - Somewhat agree
    - Strongly agree
    - Client doesn't know
    - Client refused

13. Client perceives they have support from others who will listen to problems (Please choose one):
    - Strongly disagree
    - Somewhat disagree
    - Neither agree/disagree
    - Somewhat agree
    - Strongly agree
    - Client doesn't know
    - Client refused

14. Client's frequency of feeling nervous, tense, worried, frustrated, or afraid (Please choose one):
    - Strongly disagree
    - Somewhat disagree

- Neither agree/disagree
- Somewhat agree
- Strongly agree
- Client doesn't know
- Client refused

15. General health status (Please choose one):
    - Excellent
    - Very good
    - Good
    - Fair
    - Poor
    - Client doesn't know
    - Client refused

Any additional information that you would like to let us know?

Client Signature: ____ Date: ____________________

Staff Signature: ____ Date: ____________________

VHSP FILE CHECKLIST

NAME:_______________________________________ DATE:______________________

FAMILY I.D.:____________________ HMIS #:__________________

☐ RAPID REHOUSING **OR** ☐ HOMELESS PREVENTION

◇ **FLAP 1** ◇

- ☐ FILE CHECKLIST
- ☐ COPY OF IDENTIFICATION DOCUMENTATION
- ☐ CLIENT INTAKE ASSESSMENT SUMMARY
- ☐ CLIENT APPLICATION
- ☐ PREVENTION SCREENING FORM
- ☐ HOMELESS BARRIERS
- ☐ SELF-DECLARATION OF INCOME
- ☐ MAINSTREAM RESOURCES CHECKLIST
- ☐ BANK VERIFICATION/ ASSETS FORM
- ☐ MONTHLY EXPENSE STATEMENT
- ☐ HUD 5 CALCULATION ELIGIBILITY FORM
- ☐ ELIGIBILITY DOCUMENTATION/APPOINTMENT FORM
- ☐ HOUSING ASSESSMENT QUESTIONNAIRE

◇ **FLAP 2** ◇

- ☐ CONFIDENTIALITY & NON-DISCLOSURE POLICY
- ☐ NONDISCRIMINATION POLICY
- ☐ HMIS RELEASE
- ☐ CONSENT TO EXCHANGE INFORMATION
- ☐ PROGRAM OVERVIEW FORM
- ☐ TERMINATION OF SERVICES

◇ **FLAP 3** ◇

- ☐ VHSP HOMELESS CERTIFICATION FORM
- ☐ VHSP RE-CERTIFICATION FORM
- ☐ VHSP RAPID REHOUSING ELIGIBILITY FORM
- ☐ VHSP PREVENTION ELIGIBILITY FORM
- ☐ COPY OF UNLAWFUL DETAINER
- ☐ HUD 5 CALCULATOR TO DETERMINE ELIGIBILITY

◇ **FLAP 4** ◇

- ☐ RENT REASONABLENESS CHECKLIST
- ☐ UTILITY ALLOWANCE FORM
- ☐ BASIC HABITABILITY CHECKLIST
- ☐ LEAD BASED PAINT ASSESSMENT
- ☐ LANDLORD COMMUNICATION
- ☐ LEASE AGREEMENT
- ☐ W-9 FORM
- ☐ LANDLORD LETTER
- ☐ LANDLORD RENTAL ASSISTANCE AGREEMENT
- ☐ COPY OF LEASE AGREEMENT

◇ **FLAP 5** ◇

- ☐ VENDOR FORMS
- ☐ PAYMENT LOG
- ☐ COPY OF CREDIT AUTHORIZATION
- ☐ COPY OF CHECKS/RECEIPTS

◇ **FLAP 6** ◇

- ☐ CLIENT CASE NOTES
- ☐ HOUSING PLAN
- ☐ HMIS PROGRAM EXIT/EXIT INTERVIEW

☐ FILE PASSED REVIEW ☐ FILE DID NOT PASS REVIEW NEEDS CORRECTED

____ ________________

Executive Director's Signature **Date**

Actions Needed to Correct File

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Date file needs to be corrected: ____________________________

Case Manager Signature: ____

Executive Directors Signature: ____

Client Assessment Intake Summary

PLACE IDENTIFICATION DOCUMENTATION

Family Crisis Support Services, Inc.

630 Park Ave NW
Suite 4
Norton, VA 24273

Phone: 276-325-4181 E-Mail: fcssinc@comcast.net Fax: 276-325-4182

Date: ______________________ **Intake Staff Name:** __________________________

HMIS#

DV#

First Name: ____________________________ **Middle Name** ___________________

Last Name: __________________________ **SSN#**: _______________________

Current / Previous Address: ____

Date of Birth: _____________________ **Age:** _____ **Client Telephone number:** ______________________

Referral Source: ____

Zip Code: ______________ **Locality of Last Residence**: ☐ Wise ☐ Norton ☐ Lee ☐ Scott ☐ Dickenson

List Other State: ______________ **Email Address**: ____

Housing Status: ☐ Homeless ☐ Fleeing Domestic Violence ☐ At Risk of losing housing

Household Type: ☐ Single Adult ☐ Couple ☐ Single Parent ☐ Two-parent family ☐ Other

Reason for Call: (Explain)

____

____

____

____

Domestic Violence Victim/Survivor? ☐Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data not collected

Extent of Domestic violence: Check only one

☐ Within past 3 months ☐ 3 to 6 months ☐ Client Doesn't Know
☐ From 6 to 12 months ☐ More than a year ago ☐ Client Refused
☐ Data not collected

If yes, are you currently fleeing? ☐Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Not collected

Gender: ☐ Female ☐ Male ☐Transgender male to female ☐Transgender female to male ☐Client Doesn't Know
☐ Client Refused ☐ Data not collected ☐ Other ______________________

Primary Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Client Doesn't Know

☐ Client Refused ☐ Data not collected

Secondary Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Client Doesn't Know
☐ Client Refused ☐ Data not collected

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Client Doesn't Know
☐ Client Refused ☐ Data not collected

Military Veteran? ☐Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data not collected

Pick only 1 option that applies appropriately to client's entry

(Client is entering form 1. Homelessness 2. Institutional 3. Transitional/Permanent Housing)

Option 1 – Entering Program from Homeless Situation

Residence Prior to Entry: **Check Only One**

☐ Emergency Shelter
☐ Safe Haven
☐ Place not Meant for Habitation

Length of Stay in Previous Place: **Check Only One**

☐ 1 Night or Less
☐ 2 Nights to 6 nights
☐ 1 Week or more, but less than 1 month
☐ 1 Month or more, but less than 90 days
☐ Data Not Collected
☐ 90 Days or more, but less than 1 year
☐ 1 year or longer
☐ Client Doesn't Know
☐ Client Refused

Approximate Date Homelessness Started: __________________________ **(mm/dd/yyyy)**

Regardless of where they stayed last night, number of times the client has been on streets, ES, or SH past 3 years: Check Only One

☐ 1 time
☐ 2 times
☐ 3 times
☐ 4 or more times
☐ Client Doesn't Know
☐ Client Refused
☐ Data Not Collected

Total number of months client has been on street, ES, or SH past 3 years: Check Only One

☐ 1 month, this is the first month
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10
☐ 11
☐ 12
☐ more than 12 months
☐ Client Doesn't Know
☐ Client Refused
☐ Data Not Collected

Option 2 – Entering Program from Institutional Situation

Residence Prior to Entry: **Check Only One**

☐ Foster Care/Group Home
☐ Jail/Prison or Juvenile Facility
☐ Psychiatric Hospital
☐ Hospital or Non-Psychiatric Facility
☐ Long Term Care Facility/Nursing Home
☐ Substance Abuse Treatment Facility/Detox

Length of Stay in Previous Place: **Check Only One**

☐ 1 Night or Less
☐ 90 Days or more, but less than 1 year

- ☐ 2 Nights to 6 nights
- ☐ 1 Week or more, but less than 1 month
- ☐ 1 Month or more, but less than 90 days
- ☐ Data Not Collected
- ☐ 1 year or longer
- ☐ Client Doesn't Know
- ☐ Client Refused

Option 3 – Residence Prior to Entry: Transitional & Permanent Situation

Residence Prior to Entry: **Check Only One**

- ☐ Hotel/Motel paid without ES Voucher
- ☐ Rental with No Subsidy
- ☐ Rental with GPD TIP Subsidy
- ☐ Residential/Halfway House w/no Homeless Criteria
- ☐ Living with Friends
- ☐ Client Doesn't Know
- ☐ Rental with RRH or Equivalent
- ☐ Rental in a Public Housing Unit
- ☐ rental HCV Voucher (tenant/project based)
- ☐ Owned with no Subsidy
- ☐ Perm. Housing Other than RRH for Formerly Homeless
- ☐ Rental with VASH Subsidy
- ☐ Rental with Other Subsidy
- ☐ Living with Family
- ☐ Transitional Housing for Homeless Persons
- ☐ Host Home
- ☐ Client Refused
- ☐ Owned with Subsidy

Length of Stay in Previous Place: **Check Only One**

- ☐ 1 Night or Less
- ☐ 2 Nights to 6 nights
- ☐ 1 Week or more, but less than 1 month
- ☐ 1 Month or more, but less than 90 days
- ☐ Data Not Collected
- ☐ 90 Days or more, but less than 1 year
- ☐ 1 year or longer
- ☐ Client Doesn't Know
- ☐ Client Refused

Relationship to Head of Household: Check only one

- ☐ Self (Head of household)
- ☐ Head of household's child
- ☐ Head of household's spouse or partner
- ☐ Head of Household's other relation member
- ☐ Other: Non-relation member
- ☐ Data not collected

Client Location (this is the CoC where the client is staying prior to entry):

☐ VA-521 - Balance of State (Always Check)

Receiving Income from any source? ☐ Yes ☐ No **Must complete all questions**

Income Source (Enter amount next to category)	Yes	No	Data not collected	Incomplete
Alimony or Other Spousal Support $	☐	☐	☐	☐
Child Support $	☐	☐	☐	☐
Earned Income $	☐	☐	☐	☐
General Assistance $	☐	☐	☐	☐
Other $	☐	☐	☐	☐
Pension/retirement from a Former Job $	☐	☐	☐	☐
Private Disability Insurance $	☐	☐	☐	☐
Retirement Income Social Security $	☐	☐	☐	☐
SSDI $	☐	☐	☐	☐
SSI $	☐	☐	☐	☐

TANF $	☐	☐	☐	☐
Unemployment Insurance $	☐	☐	☐	☐
VA Non-Service connected disability pension $	☐	☐	☐	☐
VA Service connected disability compensation $	☐	☐	☐	☐
Workers Compensation $	☐	☐	☐	☐

Receiving any Non-cash benefits: ☐ Yes ☐ No **Must complete all questions**

Non-Cash source (Enter amount next to category)	Yes	No	Data no collected	Incomplete
Other Source	☐	☐	☐	☐
Other TANF-funded service	☐	☐	☐	☐
WIC	☐	☐	☐	☐
SNAP – Food Stamps	☐	☐	☐	☐
TANF child care services	☐	☐	☐	☐
TANF transportation services	☐	☐	☐	☐
Temporary rental assistance	☐	☐	☐	☐
Sec. 8, Public housing/other ongoing rental assistance.	☐	☐	☐	☐

Health Insurance: ☐ Yes ☐ No **Must complete all questions**

Health Insurance Type	Yes	No	Data not collected	Incomplete
Medicaid	☐	☐	☐	☐
Medicare	☐	☐	☐	☐
Vet. Admin. Medical service	☐	☐	☐	☐
Employer provided Health Insurance	☐	☐	☐	☐
SCHIP	☐	☐	☐	☐
COBRA	☐	☐	☐	☐
Private Pay Health Insurance	☐	☐	☐	☐
State Health Insurance for Adults	☐	☐	☐	☐

Disabling Condition**?** ☐Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused ☐ Data not collected

<u>Type of Disability</u>

Must complete all questions

Disability Type	Yes	No	**Determined with Proof**	
			Yes	No
Alcohol Abuse	☐	☐	☐	☐
If YES" expected to be of long duration and Impairs ability to live independently?				
Chronic Health Condition	☐	☐	☐	☐
If YES" expected to be of long duration and Impairs ability to live independently?				
Developmental	☐	☐	☐	☐
If YES" expected to be of long duration and Impairs ability to live independently?				
Drug Abuse	☐	☐	☐	☐
If YES" expected to be of long duration and Impairs ability to live independently?				
HIV/AIDS	☐	☐	☐	☐

If YES" expected to be of long duration and Impairs ability to live independently?				
Mental Health Problem	☐	☐	☐	☐
If YES" expected to be of long duration and Impairs ability to live independently?				
Physical	☐	☐	☐	☐
If YES" expected to be of long duration and Impairs ability to live independently?				
Physical/Medical	☐	☐	☐	☐
If YES" expected to be of long duration and Impairs ability to live independently?				
Both Alcohol & Drug Abuse	☐	☐	☐	☐
If YES" expected to be of long duration and Impairs ability to live independently?				

Emergency Contact

Contact Name:	Relationship to client:
Contacts Address:	
Phone Number:	

Arrest/Conviction Record

Are there currently any warrants issued for your arrest? ☐Yes ☐ No

Have you previously been convicted of a felony or misdemeanor? ☐Yes ☐ No
If YES" what? ______________________________County and State of Conviction ____________________

Are you currently on probation or parole? ☐Yes ☐ No Probation Officer: ______________________________

Have you been convicted of a domestic violence or sexual related charges? ☐Yes ☐ No

I certify that the information provided for FCSS Intake is true and correct to the best of my knowledge. I give permission to include this information in the Homeward Community Information System (HCIS), a computerized database utilized by FCSS and local partner agencies to identify other services and resources that may be of interest to me and to improve service coordination between these agencies. I understand that some partner agencies may require participation in HCIS to be eligible for services. I also give permission to include this information in other reporting databases utilized by FCSS and its partner agencies. We will use the following information that you have provided to determine if you are eligible to receive financial and counseling assistance. Eligibility does not guarantee assistance. Providing false or misleading information will result in the denial of this application.

Client Signature: ____ **Date:** ______/______/________

Co-Client Signature: ____

Staff Signature: ____ **Date:** ______/______/________

Additional Household Information

Relation to Head of Household: ___________________________
First Name: ______________________________ Middle: ___________________Last: ____________________
Social Security Number: ____
DOB: __________________________________ Age: _________________ Primary Race: ______________
Disabilities Type if any: ___________________________
Income: _____________________ Medicare: ____________ Medicaid: ______________
Other (veteran, criminal history, level of education, health status):
____
____

Relation to Head of Household: ___________________________
First Name: ______________________________ Middle: ___________________Last: ____________________
Social Security Number: ____
DOB: __________________________________ Age: _________________ Primary Race:
____
Disabilities Type if any: ___________________________
Income: _____________________ Medicare: ____________ Medicaid: ______________
Other (veteran, criminal history, level of education, health status):
____
____

Relation to Head of Household: ___________________________
First Name: ______________________________ Middle: ___________________Last_____________________
Social Security Number: ____
DOB: __________________________________ Age: _________________ Primary Race__________________
Disabilities Type if any: ___________________________
Income: _____________________ Medicare: ____________ Medicaid: ______________
Other (veteran, criminal history, level of education, health status):
____
____

Relation to Head of Household: ___________________________
First Name: ______________________________ Middle: ___________________Last_____________________
Social Security Number: ____
DOB: __________________________________ Age: _________________ Primary Race__________________
Disabilities Type if any: ___________________________
Income: _____________________ Medicare: ____________ Medicaid: ______________Other
(Veteran, criminal history, level of education, health status):____
____

BLANK

To be Complete after Intake

Homeless Only

Client Name: ____ HMIS#: ____________

<table>
<tr><th>Housing Barrier</th><th>Triage Score</th></tr>
<tr><td>History of Homelessness
- n/a - prevention
1 First time homeless
2 Homeless one time in the past
3 Multiple episodes of homelessness in the past but does not meet chronic definition
4 Current episode of homelessness has lasted for at least one consecutive year
5 Chronically Homeless: Has been homeless at least 4 separate times in the past 3 years</td><td></td></tr>
<tr><td>Rental History
1 No rental history
1 Prior rental history with no evictions
2 Rental history is limited or out of state; 1-2 explainable evictions
3 Up to 3 evictions for non-payment; some damage to unit; landlord references fair or poor
4 Up to 5 evictions for non-payment or lease violations; poor landlord references; damage to unit
5 More than 5 evictions; serious damage to unit; criminal activity in unit; complaints</td><td></td></tr>
<tr><td>Criminal Justice History
1 No criminal history
2 One or more household members have a few minor offenses such as moving violations, DUI
3 One or more household members have a misdemeanor and/or felony conviction not related to drugs or serious crimes against persons/property
4 One or more household members have convictions that include drug offenses (possession) and/or crime against persons/property; currently on parole
5 One or more household members have convictions for violent crime and/or serious drug offenses; long periods of incarceration; currently on parole</td><td></td></tr>
<tr><td>Credit History
1 Good credit history; no more than two 30-day late payments in the past 12 months
1 No credit history; has non-traditional credit lines
2 Credit history shows pattern of late payments, no collections
2 No credit history; does not have non-traditional credit lines
3 Credit history includes late payments, collections, charge offs, and court judgments for debt not related to unpaid rent
4 Credit history includes late payments, charge offs, with at least 1 court judgment for unpaid rent
5 Multiple judgments for unpaid rent; charge offs;</td><td></td></tr>
<tr><td>Income/Employment
1 Currently employed full-time (working 30 or more hours per week) or has other consistent income source; very low income below 50% AMI; some budgeting skills; insufficient emergency savings
2 Currently employed part-time (less than 30 hours per week or temporary job) or has other inconsistent income source; very low income below 50% AMI; poor budgeting skills; no emergency savings
3 Recent unemployment; has worked within the past 12 months; below 50% AMI; no emergency savings; no budgeting skills
4 Long-term unemployment with no work history within the past 12 months; extremely low Income below 30% AMI; no emergency savings; no budgeting skills
5 No reported work history or disabled and not receiving benefits; zero income; no emergency savings; no budgeting skills</td><td></td></tr>
<tr><td>Transportation
1 Transportation is readily available & affordable; car is adequately insured.
2 Transportation is generally accessible to meet basic travel needs.
3 Transportation is available & reliable but limited and/or inconvenient; household drivers are licensed and insured.
4 Transportation is available but unreliable or unaffordable; household may have car but no insurance, license, etc.
5 No access to transportation, public or private, may have car that is inoperable</td><td></td></tr>
</table>

Factors that Threaten Housing Stability	Triage Score
Mental Health History 1 Symptoms are absent/rare; good or superior functioning in wide range of activities 2 Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning. 3 Mild symptoms may be present but are transient; moderate difficulty in functioning due to mental health problems. 4 Recurrent mental health symptoms but not a danger to self or others; persistent problems with functioning due to mental illness. 5 Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life.	
Substance Abuse History 1 No drug use or alcohol abuse in the last 6 months. 2 Client has used during the last 6 months but no evidence of persistent or recurrent social, occupational, emotional or physical problems related to use; no evidence of recurrent dangerous use. 3 Use within the last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use; problems have persisted for at least one month. 4 Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities. 5 Severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	
Domestic Violence 1 Domestic Violence Survivor/Victim 2 More than a year ago 3 Six to twelve months ago 4 Three to six months but still at risk 5 Currently fleeing	
Tenancy Issues 1 Able to meet basic household care/cleaning requirements; understands landlord-tenant rights/responsibilities; able to communicate effectively with landlord and/or other tenants 2 May have minor problems meeting basic household care/cleaning; lacks awareness of landlord-tenant rights/responsibilities; able to communicate effectively with landlord and/or other tenants 3 May have deficits in meeting basic care/cleaning of apartment; no knowledge of landlord-tenant rights/responsibilities; difficulty communicating with landlord and/or other tenants 4 Lacks skills and/or ability to care for apartment; unable to communicate appropriately with landlord and/or other tenants 5 Cannot meet basic household care/cleaning requirements; unable to interact positively with landlord and/or other Tenants	
Educational Level 1 Has completed education/training needed to become employable; no literacy problems. 2 Needs additional education/training to improve skills or resolve literacy problems to be able to function effectively. 3 Has a high school diploma/GED. 4 Enrolled in literacy and/or GED program & language is not a barrier to employment. 5 Literacy problems, no high school diploma/GED, and/or language are serious barriers to employment	
Child care 1 Able to select quality childcare of choice. 2 Reliable, affordable childcare is available, no need for subsidies. 3 Affordable, subsidized childcare is available but limited. 4 Childcare is unreliable or unaffordable; inadequate supervision is a problem for childcare that is available. 5 Needs childcare but none is available or it is not accessible and/or child is not eligible.	

Notes:

Family Crisis Support Services, Inc.

630 Park Ave NW
Suite 4
Norton, VA 24273
Phone: (276) 325-0471 E-Mail: fcssinc@comcast.net Fax: (276) 3325-0578nj

SELF-DECLARATION OF INCOME

Applicant Name: ____

This is to certify the income status for the above named individual. Income includes but is not limited to:

- 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 and dividend income credited to an applicant's bank account and 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.

Check only one box and complete only that section

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

Source: _______________________________________ Amount: _____________ Frequency: _____________
Source: _______________________________________ Amount: _____________ Frequency: _____________
Source: _______________________________________ Amount: _____________ Frequency: _____________

Client Signature: _______________________________ Date: ______________________

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

Applicant Signature: _______________________________ Date: ______________________

Staff Verification

I understand that third-party verification is the preferred method of certifying income for VHSP 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: ______________________________

VERIFICATION OF INCOME

Applicant 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 program. This information will be used only to determine the eligibility status and level of benefit of the household. **Complete only the selected section below that includes an authorization to release information.**

Please return this form to:
Name & Title: ____ Phone: _____________________
Address: ____ Fax: _______________________
Email: ____

****This section to be completed by employer only****

☐ Employment Income

Applicant Release: I hereby authorize the release of the following employment information.
Applicant Signature: ____ Date: _______________

Employer representative to complete this section:
The person named above is employed by ______________________________________since _______________. He/she is paid $______________ on a _____________basis and is currently working an average of _____________hours per ____________.

Additional compensation please specify (if any):____
Probability of continued employment: ____

Authorized Employer Representative Signature: ____________________________________ Date:_________________
Name, Title: ____
Address and Phone: ____

****This section must be completed by authorized persons only ****

☐ Payments and/or Benefit Income (complete one form for each distinct source of income for person named above)

CIRCLE ONE:

Social Security/SSI	Pension /Retirement	TANF
Public Assistance	Unemployment Compensation	Workers Compensation
Alimony Payments	Foster Care Payments	Child Support Payments
Armed Forces Income		

Other (pls. specify): ____

Applicant Release: I hereby authorize the release of the following payment and/or benefit information.
Applicant Signature: __________________________________ Date: ________________________

Payment source representative to complete this section:
Payments or benefits in the amount of $_______________________ are paid on a ______________________ basis. The expected duration of the payments or benefits is _____________________________.

Authorized Payment Source Representative Signature: _______________________________ Date: _________________

Name, Title: ____

Address and Phone: ____

Mainstream Resources Checklist

About this tool: Families and individuals experiencing homelessness may require a wide range of services that no single agency has the resources or expertise to provide. Consequently, homeless providers should encourage their clients to participate in all of the mainstream benefit and service programs for which they are eligible. Mainstream programs are typically funded at higher levels than homeless-specific programs. By encouraging their clientele to participate in mainstream programs, homeless service providers will be able to focus their efforts on housing and stretch their dollars further to serve more individuals.

User Tips: Case managers can use this checklist to assess which mainstream benefits and services a client receives, to identify which benefits and services he/she may be eligible for, and to track where the client is in the application process. (To learn more about different mainstream programs, and to determine whether a client is eligible for a particular program, visit the Department of Health and Human Services' FirstStep website at http://www.mrsh.net/Firststep/FirstStep%20%28D%29/index.html.) Note: Your continuum may want to assemble a list of the points of contact for each mainstream program to share with case managers and/or clients.

Client Name: ____

Client Case Number: __________________

Intake Date: _________________________

Mainstream Resources	Already Receives? Yes/No	Eligible? Yes/No/ Don't Know	Notes/Comments
TANF			
SSI			
SSDI			
SNAP			
Job Training/ Employment			
Medicaid			
Medicare			
Veterans Health Care			
SCHIP			
Mental Health Care			
Substance Abuse Treatment			
Heating / Cooling Assistance			
Food Pantry			
Clothing Voucher			
Public Housing / Section 8			

Family Crisis Support Services, Inc.
630 Park Ave NW
Suite 4
Norton, VA 24273

Phone: (276)325-4181 E-Mail: fcssinc@comcast.net Fax: (276) 325-4182

Bank Verification Form

☐ I, ______________________________ verify that I have a checking, saving, and/or

(Client Name)

other bank account. Family Crisis Support Services, Inc. will also need a statement from your bank to verify the information you provide.

Client Bank: ______________________________

Account Type: ______________________________

Balance: ______________________________

Client Signature: ______________________________

Co-Client Signature: ______________________________

Date: ______________________________

☐ I, ______________________________ verify that I **DO NOT** have a checking, saving,

(Client Name)

and/or any other bank account.

Client Signature: ______________________________

Co-Client Signature: ______________________________

Date: ______________________________

FCSS Agent: ______________________________

By signing this FORM, you are certifying that the information provided above is accurate to the best of your knowledge, furthermore falsifying information will lead to the termination of your assistance application.

Assets Checklist

Do you or any of your household members have any of the following types of assets?

- Checking Account ☐ Yes ☐ No
- Saving Account ☐ Yes ☐ No
- Cash at home or anywhere else ☐ Yes ☐ No
- Certificate of deposit ☐ Yes ☐ No
- Money market Accounts ☐ Yes ☐ No
- Trust Funds ☐ Yes ☐ No
- Stocks/Bonds/Treasury Accounts ☐ Yes ☐ No
- Individual Retirement Accounts (IRA) ☐ Yes ☐ No
- Lump Sum Receipts ☐ Yes ☐ No
- Real Estate ☐ Yes ☐ No
- Whole Life Insurance ☐ Yes ☐ No
- Other Investments ☐ Yes ☐ No

Has any household member disposed of any assets within the past two (2) years? ☐ Yes ☐ No

Are there any full-time students, 18 years of age or older, residing in the household? ☐ Yes ☐ No

Do you file a tax return? ☐ Yes ☐ No

By signing this form, you are certifying that the information provided is accurate to the best of your knowledge, furthermore falsifying information will lead to the termination of your assistance.

Staff Signature: ____ **Date:** _________________

Client Signature: _____________________________________ **Date:** _________________

Co-Client Signature: __________________________________ **Date:** _________________

Client Name:______________ CASE MGR:_________________________________

INCOME			
Income Sources	**Amount**	**Frequency**	**Monthly Income**
Employment Income			0
Housing Subsidy			0
Child Support			0
TANF			0
SSI:			0
SSDI:			0
SS:			0
SS:			0
SNAP			0
Other			0
Total			**$ -**

BUDGET ANALYSIS	
Total Monthly Income	
Total Monthly Expenditures	
Monthly Variance	**$ -**

RENTAL/UTILITY ASSISTANCE			
Rental Expense	**Total**	**Client Amount**	**Assistance Total**
Security/Deposits			$ -
First/Last Deposit			$ -
Rent (Assistance #1)			
Rent (Assistance #2)			$ -
Rent (Assistance #3)			$ -
Other #1			
Other #2			$ -
Other #3			$ -
Total			**$ -**

EXPENSE	
Expenses	**Amount**
Rent	
Groceries	
Clothing	
Childcare	
Car Payment	
Car Insurance	
Car Maintenance & Fees	
Gasoline	
Public Transportation	
Medical/Prescriptions	
Dental	
Vision	
Telephone - Landline	
Telephone - Cell	
Utilities	
Cable	
Laundry & Dry-cleaning	
Toiletries & Household Products	
Credit Card Payment	
Student Loan Payment	
Entertainment/Recreation	
Tuition Fees	
Pocket Money	
Savings	
Other:	
Other:	
Other:	
Other:	
Other:	
Total	

**Client must be reassessed for eligibility and need after three months*

HUD 5 Calculator Worksheet

****go to HUD exchange income calculator ****

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- Lease which shall include proof of monthly rental and deposit (Must state address and phone number of landlord, the physical address of rental property, dated and signed)
- Unlawful detainer or housing lost within 14 days
- Proof of all household income including non-cash benefits such as SNAP or TANF
- Proof of alimony or child support
- Statement of water or electric bill and/or termination notice
- If applicable, proof of medical bills
- Written statement from doctor stating condition and length of treatment
- Proof of identity for all household members i.e. social security cards and photo I.D. for anyone over 18 years of age, social security cards and birth certificates for anyone under 18 years of age.
- Proof of checking/savings account.
- Other____
  ____

❖ Note: ALL BILLS AND PROOF DOCUMENTS MUST BE IN THE APPLICANTS NAME.

❖ Note: These forms are used to determine eligibility and are not a guarantee of assistance. Only after these documents marked above are turned in your application will be processed. Please allow 7-14 days to process the application.

Applicant Signature: ______________________________ **Date:** ________________

Next Appointment: ____

BLANK

FLAP 2

- CONFIDENTIALITY & NON-DISCLOSURE POLICY
- NON-DISCRIMINATION POLICY
- HMIS RELEASE OF INFORMATION
- CONSENT TO EXCHANGE INFORMATION
- VHSP PROGRAM OVERVIEW FORM
- TERMINATION POLICY

Family Crisis Support Services, Inc.

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Confidentiality & Non-Disclosure Policy

Policy: VHSP recognizes the client 'right to privacy and confidentiality. The agencies strive to uphold all applicable state and federal laws governing confidentiality of client information. Clients have the right to understand confidentiality, to give their information written consent for release of information and to know the limits of confidentiality.

Non-Disclosure Policy of Confidential Information: Because of the importance of protection the confidential nature of information contained in agency records, under no circumstances are contents of records divulged by anyone in the agency who is not a member of the professional staff. No information may be given by a volunteer of clerical staff.

Client specific information that is shared between programs will only be done so with the client's written consent.

Participant Rights: As a participant of this program you have the right to:
1. View your own file upon request
2. To be treated with respect and dignity
3. To participate actively in the development of your case plan
4. To receive answers to your questions about services provided
5. To file a grievance regarding this program, this agency or its staff

Client Grievance & Appeals Process

To access the grievance procedure when you, the participant, feel that your rights have been violated:
- First, discuss your concerns with your Housing Counselor/Case Manager. If you do not feel that you can discuss your concerns with them, contact their Program Manager.
- If you feel the supervisor has not addressed your concerns, contact the Executive Director in writing, which should include your complaint and all the steps that you have taken to resolve this concern. At which time a case review will be conducted to review your concerns and assure that all agency and legal guidelines have been followed.
- The Executive Director will review the case and respond to you in writing within (10) business days' receipt of the grievance.

Under critical circumstances, some clients may need to continue to receive treatment of services beyond their ability to pay and/or beyond available, approved funding. In this circumstance, it is the policy of the agency to continue to provide services for a brief period and/or until appropriate referral can be implemented.

____________________________________ **Date:** ________________________

Client Signature

____________________________________ **Date:** ________________________

Co-Client Signature

____ **Date:** ___________________________

Staff Signature

BLANK

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630 Park Ave NW
Suite 4
Norton, VA 24273

Phone: (276) 325-4181 E-Mail: fcssinc@comcast.net Fax: (276) 325-4182

Confidentiality & Non-Disclosure Policy (CLIENT COPY)

Policy: VHSP recognizes the client ‘right to privacy and confidentiality. The agencies strive to uphold all applicable state and federal laws governing confidentiality of client information. Clients have the right to understand confidentiality, to give their information written consent for release of information and to know the limits of confidentiality.

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Date: ___________________________

Client Signature

Date: ____________________________

Co-Client Signature

Date: ____________________________

BLANK

Family Crisis Support Services, Inc.
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Norton, VA 24273
Phone: (276) 325-4181 Mail: fcssinc@comcast.net Fax: (276) 679-4182

Nondiscrimination Policy

Family Crisis Support Services, Inc. is dedicated to serving all individuals and families, regardless of race, gender, ethnicity, religion, sexual orientation, nationality, gender identity or expression, age, and/or disability. In order to provide the highest quality services and work environment, we are working to create a community organization that recognizes the specific and individual differences of individuals and families from different communities. We are a welcoming and inclusive organization, and will not tolerate discrimination, harassment or abusive behavior from staff or clients. Family Crisis' mission is to provide specific services that are individualized to meet the needs of all clients. We are committed to the mission of elimination discrimination, achieving social change, and empowering the individuals and families we serve. We believe this can only be accomplished through the support of each community we serve.

If you feel that your rights have been violated, that you have been discriminated against, or have complaints, there is a grievance policy given out upon intake which outlines the steps to resolve these issues.

I have read, or have had read to me, Family Crisis Support Services, Inc. nondiscrimination policy and have been made aware of the grievance procedure.

____ **Date:** ______________________
Client Signature

____ **Date:** ______________________
Co-Client Signature

____ **Date:** ______________________
Staff Signature

BLANK

Family Crisis Support Services, Inc.
630 Park Ave NW Suite 4
Norton, VA 24273

Phone: 276-325-4181 Fax: 276-325-4182 E-Mail: fcssinc@comcast.net

HMIS Release of Information

When you request or receive services from this agency, we collect information about you and /or your household that has entered it into a computerized database called HMIS. This agency and other area agencies that provide services to people who are at risk of homelessness use this information to identify services and resources that may be of interest to you. This information is also used to improve services coordination and to produce reports.

This release will be used for the following programs: : ☐ Homeless Services : ☐ Rapid Re-housing / Prevention

What information is collected?

Depending on your situation, you may be asked for some or all of the following:

- Basic identifying information (examples: name, SSN, driver's license number, date of birth)
- Demographic information (examples: gender, race, ethnicity, veteran status, disability status, household relationships)
- Housing information (examples: prior housing, homeless status, reasons for homelessness)
- Income & benefit information (examples: sources and amounts of household income, enrollment in benefit programs, employment information)
- Health-related information (examples: mental and physical health conditions, substances abuse history)

How is information protected?

- Partner Agencies must abide by relevant state of federal laws protecting client data;
- HMIS Policies & Procedures to establish additional protections for client data including requirements form hardware, software, security, confidentiality, and training;
- Data is entered into HMIS via a sure and encrypted internet connection; and
- HMIS data is encrypted and stored in a secured facility

Why is information collected?

- To better assess your needs and the needs of others in the community;
- To make it easier for clients to receive services from several agencies;
- To track whether your needs, and the needs of others, and being met;
- To improve the quality of care and services for people who are homeless or at risk of homelessness;
- To better coordinate services among local service providers; and
- To conduct research on issues and programs related to homelessness

How is information shared?
Once you sign the Release of Information, your record is made available to regional Partners Agencies.

Why share my information?

Partner agencies offer a variety of services of interest to our clients. Connecting these agencies through HMIS Make referrals easier, and decrease duplicative intake through many programs. By sharing your information with Partner Agencies, you will help them:

- Identify others services or programs you may be eligible for,
- Better coordinate services for you and your household,
- More accurately count the number of homeless persons, the services available and what other services are needed, and
- Show the people who fund homeless programs that services are needed and help the agencies to obtain other funding for programs that serve homeless persons.

Some Partner Agencies may require participation in HMIS to be eligible for services. Homeward, as operator of HMIS does not make eligibility determinations for any Partner Agency.

Consent

Please review the statement below and provide your signature if you agree. A current list of HMIS Partner Agencies and the requirements for participation is available by request from this agency.

I consent to share my information with HMIS Partner Agencies in the cities of Richmond and Petersburg and counties or towns of Charles City, Chesterfield, Colonial Heights, Danville, Dinwiddie, Emporia, Goochland, Greensville, Hanover, Henrico, Hopewell, Martinsville, New Kent, New River Valley, Powhatan, Prince George, Rocky Mount, Sussex, Surry and Wytheville. This release will be valid for two years from date of entry.

This release is valid for ___**2**_____ years for date of signature below

____ **Date:** ________________________
Signature of Client or Guardian

____
Print name of Client or Guardian

____ **Date:** ________________________
Signature of Co-Client or Guardian

____
Print name of Co-Client or Guardian

____ **Date:** ________________________
Staff Signature

____
Staff Print Name

Virginia Homeless Solutions Program
CONSENT TO EXCHANGE INFORMATION FORM
(FOR THE PURPOSE OF OBTAINING SERVICES)

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

Name of Consenting Person (Please Print):____

Client Address: ____

____

Client Date of Birth:_______________ Client Social Security No.:____________________

Relationship to the client: □ Self □ Parent □ Guardian □ Legal Representative

The information can be shared: □ in person □ by phone □ by fax □ by mail □ by email

□ I understand that electronic mail (email) is not confidential and can be intercepted and read by other people

I WANT THE FOLLOWING CONFIDENTIAL INFORMATION ABOUT THE CLIENT TO BE EXCHANGED:

Yes	No		Yes	No	
□	□	Assessment information	□	□	Medical information
□	□	Financial Information	□	□	Mental Health Information
□	□	Benefits/Services	□	□	Educational Records
□	□	Identification Documents	□	□	Employment records

Other: ______________________ Other: ______________________

I WANT MY ASSIGNED HOUSING COUNSELOR AND THE FOLLOWING AGENCIES TO BE ABLE TO EXCHANGE THIS INFORMATION:

Agency Name: ____________________ Agency Name: ____________________

Agency Name: ____________________ Agency Name: ____________________

I WANT THIS INFORMATION TO BE EXCHANGED ONLY FOR THE FOLLOWING PURPOSE/S:

□ Service Coordination and Treatment Planning □ Eligibility Determination □ Other:

THIS CONSENT FORM IS GOOD UNTIL THE FOLLOWING DATE: ____________________

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agency from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when and with whom it was shared. If I ask, each agency will show me this information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Client Signature: ________________________________**Date:** ____________________

Co-Client Signature: ______________________________ **Date:** ____________________

Staff Signature: _________________________________ **Date:** ____________________

CONSENT TO EXCHANGE INFORMATION RECORD OF CONTACTS

Client Name: ____

Receiving Agency	Ind. Receiving Info. Include Name, Title and Phone #	Type of Information Disclosed	Reason of Purpose of Disclosure	Date Disclosed

VIRGINIA HOMELESS SOLUTIONS PROGRAM
PROGRAM OVERVIEW

VHSP is a short-term rental or homeless assistance program offered to persons or families that are in a current financial crisis**.** In order to be eligible for the VHSP program you must meet the following basic criteria:

- If renting, you must have been served with an **eviction notice given by your landlord**. This means your landlord has given you an **Unlawful Detainer** with his/her name address and phone number with the regular monthly amount of your rent and the amount of any past due rent owed broken down by month. Also, VHSP Program **requires a signed lease agreement**, VHSP Basic Habitability Form signed by both you and your landlord, and a W-9 form from your landlord.
- If you are living in a shelter, doubled up/couch surfing, or dwelling not meant for human habitation, you must have notification from your current place of residency stating the allowable amount of time you may remain and why you are being asked to leave by a third party verification with date, person's name and signature, address, and telephone number.
- **If homeless due to Domestic Violence, you must either be residing in a Domestic Violence shelter (if one is located in your county) or have documentation (i.e.) an active restraining order/police report**.
- **You must have a written letter of referral to our program from a caseworker, doctor, or other person who knows your current situation. It must state the date, person's name, address, and telephone number**.

It is your responsibility to ensure that you understand this program in its entirety. The Housing Counselor will effectively go over all documentation with you and will inform you of anything else that may be required for you to be approved/denied for this program. **If you do not turn in all required documents and/or if you fail to contact the Housing Counselor when/if there are any changes to your living situation you will be subject to immediate termination of assistance through this program and a letter will be sent to both you and your landlord. Your eligibility is based on the information you provide and if you provide incorrect information it will be left to the discretion of the Housing Counselor to determine if you can continue in this program.**

***Please Note: VHSP assistance is limited to those households who will imminently lose their primary nighttime residence and otherwise meet all other requirements for prevention including having household incomes below 30 percent AMI. DHCD Program Participant Eligibility Requirements documentation must be included in each program participant file.**

***Note: Assistance is limited and not guaranteed.**

These forms are to determine eligibility and not a guarantee of assistance. Only after all of the documents are turned in will you be given an appointment with the Housing Counselor who will approve or deny each evaluation. You and your landlord will receive a letter of the decision by the Housing Counselor.

Due to the **limited** availability of program funds it is possible that you may not qualify for the Virginia Homeless Solutions Program.

If you are in critical need of financial assistance to prevent an eviction, or if you are currently homeless, please call 2-1-1 (a free information and referral line) where an information Specialist can provide useful information and resources.

Termination of Services Policy

The services provided at Family Crisis Support Services, Inc. are voluntary, therefore both client and agency are free to terminate such services at any time. However, we will not stop services without reason and whenever possible, without prior notification to the client. We request that clients also notify us, whenever possible, why they wish to stop using Family Crisis Support Services, Inc. services.

The following are some reasons that would cause termination of services:

1. Allowing anyone but those on the lease to live with you.
2. If you or anyone living in the house engages in prostitution, drug use, manufacture or distribution of drugs, the abuse or neglect of children or elders, or other illegal activities.
3. If you discontinue or refuse to work on your case plan with your case manager.
4. If you threaten to, or, perpetrate a crime against any agency staff.
5. Breaking confidentiality by giving the Names, phone number, and address of program participants to anyone without the participant's permission.
6. Missing three consecutive appointments without prior notification to your case manager as well as monthly check-ins with your case manager.
7. May be terminated due to change of income.
8. We are no longer able to help if you get approval for HUD.

Warning Policy

1. First and second warnings will be given verbally in writing.
2. At second warning you will be placed on a 30-day probation and given a written outline of what you are to accomplish during the next 30 days.

Program Termination

- Termination from the program will result if a third incident occurs.

Agency staff are here to work with you and recognize that change is a process. For that reason, the warning process gives chances. We believe you can be fruitful in your search to better your life and we offer your support to successfully complete the program. All decisions are with the discretion of the program coordinator.

By signing below, I agree that I have fully read and understood the expectations required from being a VHSP participant.

_________________________________ **Date: ______________________**

Client

__________________________________ **Date: _______________________**

Co-Client

__________________________________ **Date: ________________________**

Staff Signature

FLAP 3 PAGES

- o VHSP HOMELESS CERTIFICATION FORM
- o VHSP RE-CERTIFICATION (IF APPLICABLE)
- o VHSP RAPID RE-HOUSING ELIGIBILITY FORM
- o VHSP PREVENTION ELIGIBILITY FORM
- o UNLAWFUL DETAINER
- o THIRD PARTY VERIFICATION OF HOMELESSNESS

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Self-Declaration of Homelessness

Staff Member Name: ____

☐ Household without dependent children (complete one form for each adult in the household)

☐ Household with dependent children (complete one form for household)

Applicant Name and Unique Identifier: ____

Number of persons in the household: _________

This is to certify that the above named individual or household is currently either literally or imminently homeless based on the check mark, other indicated information, and signature indicating their current living situation. Check the appropriate type of documentation used to verify homelessness and attach it to this worksheet.

CHRONIC HOMELESS CERTIFICATION

***Agency must select "Yes" if household meets the following criteria**

Individual or family is literally homeless and has third-party, intake worker, or household documentation of the following:

☐ Has been homeless for at least one year continuously or on at least four separate occasions in the last three years, **where the cumulative total of the four occasions is at least one year (Stays in institutions of 90 days or less will not constitute a break in homelessness, but such stays are included in the cumulative total)** in a place not meant for human habitation, a safe haven, or an emergency shelter**; and**

☐ Has an adult head of household (or a minor head of household if no adult is present in the household) with a diagnosable substance use disorder, serious mental illness, developmental disability post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions.

CHRONICALLY HOMELESS: ☐Yes***** ☐No

GENERAL HOMELESS CERTIFICATION

Complete with information on the <u>primary</u> cause of homelessness

	Homeless Status	Type of Eligible Documentation	Documentation/Eligibility
	LITERAL HOMELESSNESS (RAPID RE-HOUSING ELIGIBLE)		
☐	**Persons living on the street or sleeping in a place not designed for or ordinarily used as a regular sleeping accommodation**	• Signed and dated written certification by person seeking services • Signed and dated written certification by an outreach worker	☐Yes ☐No
☐	**Persons living in a shelter designed to provide temporary living arrangements** - congregate/scattered site emergency shelters - transitional housing-hotels/motels paid for by a charitable organization or government program	• HMIS shelter record • Written referral from previous shelter staff • Written referral from charitable organization or government program	☐Yes ☐No

☐	Persons exiting an institution where they resided for 90 days or less and resided in a place not meant for human habitation immediately before entering institution	• HMIS shelter record • Written referral from previous shelter staff • Written referral from institution	☐Yes ☐No
☐	Persons fleeing domestic violence.***Must meet one of the homeless status categories listed above***	• Written, signed and dated verification from the participant • Written, signed and dated verification from the domestic violence service provider.	☐Yes ☐No
	IMMINENT RISK OF HOMELESSNESS (PREVENTION/DIVERSION ELIGIBLE)		
☐	Person will imminently lose primary nighttime residence within 14 days and meets both of the following circumstances - No appropriate subsequent housing options have been identified - Household lacks the financial resources and support networks needed to obtain immediate housing or remain in its existing housing	• Documentation of efforts to divert from homelessness (contact with prevention provider)—**Notate in case file** • Eviction letter from tenant/homeowner (If living with another, i.e. doubled up) • Letter from hotel/motel manager and cancelled checks to verify costs covered by the participant • Court order/eviction notice	☐Yes ☐No ☐ N/A
☐	Persons fleeing domestic violence ***Must also be imminently homeless***	• Written, signed and dated verification from the participant • Written, signed and dated verification from the domestic violence service provider.	☐Yes ☐No

Documentation of attempts to obtain third party verification (required): *Third party verification is the preferred method of certifying homelessness or risk for homelessness for an individual who is applying for homeless assistance.*

Self Declaration of Homelessness: *Self declaration is only permitted when third party verification cannot be obtained.*

Client Signature: ____ Date: ______________________

Form Completed By: ____________________________________

Staff Signature: ____ Date: ______________________

RE-CERTIFICATION FORM

Households receiving VHSP Prevention and Rapid Re-Housing Rental Assistance must be recertified at least every 90 days. At the end of each recertification, the case manager must attach the new evidence to this form documenting the household is still eligible for the program. Housing Stabilization services, such as case management, can be provided after the term of a program participant's rental assistance expires. The client must be re-certified for case management services after 12 months.

Program Participant Name (s): ____

Client is enrolled in: ☐ Prevention Program (must have income below 30% AMI)
☐ Rapid Re-Housing Program (must have income below 30% AMI)
☐ Housing Stabilization Services/Case Management

Date of Entry into Program: _________________ Case Manager: ____________________

Number of Months (Including Arrears) Household has received rental assistance: _____________

Date of this Re-Certification: ______________________

Household Size: _____

30% of Area Median Income for Household Size: $___________________

Total Household Annual Gross Income: $___________________

INCOME

☐ Household income, based on Section 8 income eligibility standards, is **below** 30 percent Area Median Income (AMI). *Include a copy of income eligibility determination completed worksheet found at:* http://www.hud.gov/offices/cpd/affordablehousing/library/modelguides/2005/1780.pdf (see page 25). *This must be signed by a program participant. The Area Median Income Limits are found at* *http://www.huduser.org/DATASETS/il.html*

☐ Household income, based on Section 8 income eligibility standards, is **at or above** 30 percent Area Median Income (AMI)—**Households with an income that is at 30% AMI or higher are no longer eligible to receive VHSP financial assistance**

RESOURCES: Staff must document the lack of resources, BUT FOR VHSP financial assistance (example, bank savings/statements, medical bills, etc.) for the clients who are receiving on-going VHSP assistance.

☐ No appropriate subsequent housing options have been identified and the household lacks the financial resources and support networks needed to prevent them from becoming literally homeless-- **Households with more than $500 in assets are no longer eligible to receive VHSP rental assistance**

☐ Subsequent housing options have been identified and the household has the financial resources and support networks needed to prevent them from becoming literally homeless—**Households with more than $500 in assets are no longer eligible to receive VHSP rental assistance**

HOUSING STABILITY GOALS
Household agrees to work on the following goals to ensure a stable housing outcome:

1. ____

2. ____

3. ____

STAFF CERTIFICATION: (please check one)

☐ Household Eligible for additional rental assistance
☐ Household Ineligible for additional rental assistance

☐ Household Eligible for additional case management services
☐ Household Ineligible for additional case management services

If ineligible for financial and/or case management services, please list community based agencies that the household can access for further support.

1. ____

2. ____

3. ____

Staff Signature: ____ Date: _______________

Program Participant Signature: _________________________________ Date: ________________

Documentation proving the statements on this form MUST be attached. The lack of support networks should be notated within the client file. Subsequent recertification forms and evidence should be kept in the client file.

VHSP Rapid Re-Housing Program Participant Eligibility Requirements

This form is required for all VHSP rapid re-housing assistance.

Head of Household Full Name: ____

Date Completed: ____________________________________

Program participants must identify all subsidy or assistance received within the past six months. VHSP assistance must not be provided in the same cost category when subsidies by any other source (e.g., Section 8) are being provided.
☐ Participant is receiving tenant or project-based rental assistance, excluding rental arrearages, through other public sources for the same time period and/or cost type **(document in client file--ineligible for VHSP assistance)**
☐ Participant is **NOT** receiving tenant or project-based rental assistance through other public sources for the same time period and/or cost type **(document in client file)**

Comments/Notes:

Overall Minimum Requirements

In order to receive rapid re-housing financial assistance or services funded by VHSP, individuals and families must meet the following minimum requirements. Please check if applicable:

☐ Completed Initial Evaluation/Intake

☐ The household meets both of the following circumstances:

☐ No appropriate subsequent housing options have been identified; **AND**

☐ The household lacks the financial resources and support networks needed to obtain immediate housing or remain in its existing housing; **AND**

Meets at least one of the following risk factors:

☐ Living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels/motels paid for by charitable organizations or by federal, state, and local government programs); **OR**

☐ Sleeping in a place not meant for human habitation, such as cars, parks, abandoned buildings, streets/sidewalks; **OR**

☐ Exiting an institution for 90 days or less and was sleeping in an emergency shelter or other place not meant for human habitation (cars, parks, streets, etc.) immediately prior to entry before entering that institution; **OR**

☐ Fleeing or attempting to flee domestic violence (must meet one of the above mentioned risk factors as well)

All supporting documentation for project participant eligibility must be readily available in client records and case notes. Third-party verification must be provided and is the preferred method of certifying homelessness for an individual who is applying for VHSP assistance.

Determination of Program Eligibility Completed By (name of staff):

____

PRINT NAME OF STAFF PERSON

____

STAFF PERSON SIGNATURE

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

____

PRINT NAME OF PROGRAM PARTICIPANT

____

PROGRAM PARTICIPANT SIGNATURE

Date: __________________

VHSP Prevention Participant Eligibility Requirements
This form is required for all VHSP prevention assistance.

Head of Household Full Name: ______________________________________

Date Completed: __________________________________

An individual or family: (must have income **below** 30% percent AMI, lacks sufficient resources & meets one of the following risk factors)

Prioritization: Individuals or families that were formerly homeless who also meet the risk factors for imminent homelessness.

☐ Completed Initial Evaluation/Intake

☐ Household income, based on Section 8 income eligibility standards, is **below** 30 percent Area Median Income (AMI). *Include a copy of income eligibility determination completed worksheet found at:* http://www.hud.gov/offices/cpd/affordablehousing/library/modelguides/2005/1780.pdf (see page 25). *This must be signed by program participant. The Area Median Income Limits are found at* http://www.huduser.org/DATASETS/il.html **(Please note $500 limit on assets –documentation required**)
; **AND**

Household Size (all adults/children): _______

30% of Area Median Income for Household Size: $____________________

Total Household Annual Gross Income: $_____________________

☐ The household lacks the financial resources and support networks needed to prevent them from becoming literally homeless; **AND**

Meets one of the following risk factors of imminent homelessness with acceptable documentation:

☐ Housing loss within 14 days – has been notified of their right to occupy their current housing or living situation will be terminated within 14 days after the date of application for assistance: notification to leave within 14 days *must be written and only third party source/written is appropriate* **(must document 1 of the following criteria)**:

- ☐ If tenant: eviction notice, court order to leave within 14 days; ***or***
- ☐ If living with another (doubled up): eviction letter from tenant/homeowner; ***or***
- ☐ If living in a hotel/motel: letter from hotel/motel manager and cancelled checks to verify costs covered by the participant

Household may also receive assistance if imminently homeless and meets one of the following factors with acceptable documentation:

☐ Persistent housing instability - has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance **(must document the following 2 criteria)**:

☐ Housing history must demonstrate 2 or more moves within 60 days: documentation may include HMIS records, referral from housing/service provider, letter from tenant/owner (***intake observation not appropriate***); **and**

☐ Economic reasons may include termination from employment, unexpected medical costs, inability to maintain housing including utilities, etc.: documentation may include notice of termination, healthcare bills indicating arrears, utility bills indicating arrears (***intake observation not appropriate***).

☐ Living in the home of another person/individual because of economic hardship **(must document the following 2 criteria)**:

☐ Housing must be in the home of another (i.e., doubled up): documentation may include letter from tenant/homeowner (***intake observation may be appropriate***); **and**

☐ Economic reasons may include termination from employment, excessive medical costs, inability to maintain housing including utilities, etc: documentation may include notice of termination, healthcare bills indicating arrears, utility bills indicating arrears (***intake observation not appropriate***).

☐ Discharge from a public institution or system of care (including prisons, mental health institutions, and hospitals) **(must document 1 of the following criteria):**

☐ Source documentation (i.e., discharge paperwork); ***or***
☐ Referral letter

☐ Residency in housing that has been condemned by housing officials and is no longer meant for human habitation **(must document 1 of the following criteria):**

☐ Source documentation (i.e., letter); ***or***
☐ Intake Observation

☐ Living in a rented hotel or motel and cost is not paid for by charitable organization or by Federal, State, or local government programs for low-income individuals **(must document the following 2 criteria)**:

☐ Housing must be in a hotel/motel: documentation may include either letter from hotel/motel manager or intake observation; **and**

☐ Costs have not been covered by charitable organization or government program: documentation – cancelled check.

I certify that the program participant has received no other rental subsidy or assistance for the same time period and cost type, excluding rental arrangements, within the past six months.

Determination of Project Eligibility Completed By (name of staff):

____

PRINT NAME OF STAFF PERSON

____

STAFF PERSON SIGNATURE

I certify that no other rental subsidy or assistance has been received for the same time period and cost type, excluding rental arrangements, within the past six months. I also certify that any other information I have provided in applying for VHSP assistance is true, accurate and complete.

____

PRINT NAME OF PROGRAM PARTICIPANT

____

PROGRAM PARTICIPANT PERSON SIGNATURE

Family Crisis Support Services, In
630 Park Avenue Suite 4
Norton, Va 24273
Phone: (276) 325-4181 e-Mail: fcssinc@comcast.net Fax: (276) 325-4182

THIRD PARTY VERIFICATION OF HOMELESSNESS

I, ____, certify that ____
Print First and Last Name of HomeOwner/ Primary Renter Print Applicant's First and Last Name

Has been living with me at: ____
Street Address, City and Zip Code

due to the following reasons: ____
____
____

Since: _______________.

He/She must vacate the residence by: ____

McKinney- Vento Act Definition of Homelessness

Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; living in motels, hotels, trailer parks, or camping grounds due to lack of alternative accommodations; living in an emergency shelter or transitional shelters; abandoned in hospitals; or awaiting foster care placement.

Having a primary nighttime residence that is a public or private place not designed or ordinarily used as a regular sleeping accommodation for human beings.

Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or seminal settings.

I understand that providing false information to a federally funded program is against the law. I further understand that I am verifying that at the time of this applicant's application, the above named individual was homeless, as defined by the McKinney-Vento Act stated above.

____ **Date:** ___________________________
Signature

____ **Date:** ___________________________
Staff Signature

FLAP 4

- RENT REASONABLENESS CHECKLIST
- UTILITY ALLOWANCE FORM
- DHCD VHSP BASIC HABITABILITY CHECKLIST
- LEAD BASED PAINT VISUAL ASSESSMENT
- LANDLORD COMMUNICATION AGREEMENT
- W-9 FORM
- LANDLORD LETTER/PROPERTY DESCRIPTION FORM
- RENTAL ASSESSMENT AGREEMENT
- LEASE AGREEMENT

RENT REASONABLE CHECKLIST

To verify that the rent for the unit you have selected is reasonable, find the address of another unit in the neighborhood that is similar to the unit you have chosen. It must be the same type of unit and have the same number of bedrooms. The rent must be the same or less than the rent of the unit you have selected.

Proposed Unit Address: ____

	Selected Unit	**Unit # 1**	**Unit # 2**	**Unit # 3**
Address of Unit				
Type of Construction/Unit Circle applicable type	Apt. 1-4 Floors Apt. 5+ Floors Duplex/Townhouse Manufactured Home Single Family Other____________	Apt. 1-4 Floors Apt. 5+ Floors Duplex/Townhouse Manufactured Home Single Family Other____________	Apt. 1-4 Floors Apt. 5+ Floors Duplex/Townhouse Manufactured Home Single Family Other____________	Apt. 1-4 Floors Apt. 5+ Floors Duplex/Townhouse Manufactured Home Single Family Other____________
Number of Bedrooms				
Approximate Year Built				
Approximate Square Footage				
Handicap Accessible				
Amentias: Circle all that apply	Air Conditioner Garbage Disposal Dishwasher Washer/Dryer Carpet Recreational Facilities Storage Area Parking Maintenance Service Housing Services Other__________	Air Conditioner Garbage Disposal Dishwasher Washer/Dryer Carpet Recreational Facilities Storage Area Parking Maintenance Service Housing Services Other__________	Air Conditioner Garbage Disposal Dishwasher Washer/Dryer Carpet Recreational Facilities Storage Area Parking Maintenance Service Housing Services Other__________	Air Conditioner Garbage Disposal Dishwasher Washer/Dryer Carpet Recreational Facilities Storage Area Parking Maintenance Service Housing Services Other__________
General Housing Condition	Good Fair Poor	Good Fair Poor	Good Fair Poor	Good Fair Poor
Any Utilities included in rent?	Yes /No	Yes /No	Yes /No	Yes /No

Unit Rent	$________________	$________________	$________________	$________________
+Utility Allowance	$________________	$________________	$________________	$________________
=Gross Rent	$________________	$________________	$________________	$________________

Certification:

A. Comparison with Fair Market Rent ☐ Income Based Housing

Proposed Contract Rent: $______________________

Applicable Fair Market Rent (for comparison only) $_____________________

FY 2022 Fair Market Rent Summary

YEAR 2021-2022	**Efficiency**	**1 bedroom**	**2 bedroom**	**3 Bedroom**	**4 Bedroom**
Lee County 2022	**$479**	**$616**	**$702**	**$898**	**$1038**
Scott County 2022	**$524**	**$546**	**$702**	**$920**	**$1012**
Wise Co. & City of Norton 2022	**$479**	**$574**	**$702**	**$941**	**$952**

B. Rent Reasonableness

Based upon a comparison with the rents for comparable units, I have determined that the proposed rent for the unit **[ ] IS [ ] IS NOT** reasonable.

Name: ____

Signature: _______________________________________Date: ______________________

Agency: Family Crisis Support Services, Inc.

Family Crisis Support Services, Inc.

630 Park Ave NW Suite 4
Norton, VA 24273

Phone: (276) 325-4181 E-Mail: fcssinc@comcast.net Fax: (276) 325-4182

Utility Allowance Form

Allowances for
Tenant-Furnished Utilities

Family Name: ____________________________
Unit Address: ____________________________
____

***Voucher Size:** __________ ***Unit Bedroom Size:** _________
**Use smaller size to calculate tenant-supplied utilities and appliances.*

Unit Type: 3 Exposed Walls									
Utility	**Usage**	**Monthly Dollar Amount**							
		0 BR	**1 BR**	**2 BR**	**3 BR**	**4 BR**	**5 BR**	**6 BR**	**7 BR**
Appliance	**Range/ Microwave**	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00
	Refrigerator	$3.00	$3.00	$3.00	$3.00	$3.00	$3.00	$3.00	$3.00
Bottled Gas	**Cooking**	$8.00	$11.00	$14.00	$18.00	$22.00	$26.00	$29.00	$32.00
	Home Heating	$54.00	$75.00	$97.00	$118.00	$151.00	$172.00	$193.00	$215.00
	Water Heating	$20.00	$28.00	$36.00	$44.00	$56.00	$64.00	$72.00	$80.00
Electricity	**Cooking**	$3.00	$4.00	$5.00	$6.00	$7.00	$8.00	$9.00	$10.00
	Cooling (A/C)	$6.00	$8.00	$10.00	$13.00	$17.00	$19.00	$21.00	$23.00
	Home Heating	$21.00	$29.00	$37.00	$45.00	$56.00	$65.00	$73.00	$81.00
	Other Electric	$10.00	$14.00	$18.00	$22.00	$28.00	$32.00	$36.00	$40.00
	Water Heating	$9.00	$13.00	$16.00	$20.00	$25.00	$29.00	$32.00	$36.00
Natural Gas	**Cooking**	$2.00	$2.00	$3.00	$3.00	$4.00	$5.00	$5.00	$6.00
	Home Heating	$42.00	$58.00	$74.00	$90.00	$114.00	$132.00	$147.00	$164.00

	Water Heating	$16.00	$22.00	$28.00	$34.00	$43.00	$50.00	$56.00	$62.00
Sewer	Other	$20.00	$27.00	$35.00	$43.00	$55.00	$62.00	$70.00	$78.00
Trash Collection	Other	$12.00	$12.00	$12.00	$12.00	$12.00	$12.00	$12.00	$12.00
Water	Other	$17.00	$23.00	$30.00	$36.00	$46.00	$53.00	$59.00	$66.00
Utility Allowance Total:		$	$	$	$	$	$	$	$

DHCD VHSP Basic Habitability Checklist

Unit or Shelter Address (include street address, city and zip code)	
Grantee Name (if shelter) or Landlord/ Property-owner Contact Information (include name, company name, mailing address and phone number)	

	YES	NO
State and local codes. Unit is compliant with all applicable state and local housing codes, licensing requirements, and any other requirements in the jurisdiction regarding the condition of the structure and the operation of the housing or services.	☐	☐
***Structure and materials*.** The unit is structurally sound so as not to pose any threat to the health and safety of the occupants and so as to protect the residents from the elements.	☐	☐
1. ***Access***. Where applicable, the shelter is accessible in accordance with: a. Section 504 of the Rehabilitation Act (29 U.S.C. 794) and implementing regulations at 24 CFR part 8; b. The Fair Housing Act (42 U.S.C. 3601 et seq.) and implementing regulations at 24 CFR part 100; and Title II of the Americans with Disabilities Act (42 U.S.C. 12131 et seq.) and 28 CFR part 35.	☐	☐
Space and security. Each resident is afforded adequate space and security for themselves and their belongings. Each resident must be provided an acceptable place to sleep.	☐	☐
***Interior air quality*.** Every room or space has natural or mechanical ventilation. Unit is free of pollutants in the air at levels that threaten 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, may be used in privacy, and are adequate for personal cleanliness and the disposal of human waste.	☐	☐
Thermal environment. The unit has adequate heating and/or cooling facilities in proper operating condition.	☐	☐
Illumination and electricity. The unit has adequate natural or artificial illumination to permit normal indoor activities and to support the health and safety of residents. There are sufficient electrical sources to permit the use of essential electrical appliances while assuring safety from fire.	☐	☐
Food preparation and refuse disposal. All food preparation areas contain suitable space and equipment to store, prepare, and serve food in a sanitary manner.	☐	☐
Sanitary condition. The unit and any equipment are maintained in sanitary condition.	☐	☐
Fire safety. Each 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. 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.	☐	☐
Fire safety. The public areas of all units must be 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, community rooms, day care centers, hallways, stairwells, and other common areas.	☐	☐

Agency - Family Crisis Support Services, Inc.

Agency Name　　　　Agency Staff Name

Signature Date

Tenant (if applicable)

Name Date

Signature

Landlord/ Property-owner (if applicable)

Name Date

Signature

BLANK

Family Crisis Support Services, Inc.
630 Park Ave NW Suite 4
Norton, VA 24273

Phone: (276) 325-4181 E-Mail: fcssinc@comcast.net Fax: (276)325-4182

Lead Based Paint Visual Assessment

All units in which the Family Crisis Support Services, Inc. program participants reside are subject to Lead-Based Paint requirements. This form must be completed and included in each program participant file. Individuals completing this form must complete the online HUD http://www.hud.gov/offices/lead/training/visualassessment/h00101.htm training.

Program Participant Name: ____

Property Address: ____

____

Property Owner Name: ____

Check all that apply:

☐Property was built after 1978 Year Property Built: __________

☐No child under 6 lives with program participant

☐Property is zero bedrooms, SRO housing, elderly housing

☐Property has been tested and determined to not to contain lead-based paint **(attach documentation)**

☐Property has had lead-based paint hazards removed **(attach documentation)**

☐If any items are checked above, no visual assessment is required. Please include appropriate signatures (agency and program participants) and dated.

☐No items are checked above (Visual Assessment required)

Interior: Is there any peeling, chipping, chalking, or cracking paint?
☐YES ☐NO

Interior: Deterioration exceeds the demonism level?
☐YES ☐NO ☐NA

Exterior: Is there any peeling, chipping, chalking, or cracking paint?
☐YES ☐NO

Exterior: Deterioration exceeds the demonism level?

☐YES ☐NO ☐NA

Common Areas: Is there any peeling, chipping, chalking, or cracking paint?

☐YES ☐NO ☐NA

Common Areas: Deterioration exceeds the de minimis level?

☐YES ☐NO ☐NA

Describe Any Action Taken:

____________________________________ **Date**: _____________________

Client Signature

____________________________________ **Date:** _____________________

Landlord

____________________________________ **Date:** _____________________

Signature

Family Crisis Support Services, Inc.
630 Park Ave NW Suite 4
Norton, VA 24273

Phone: (276) 325-4181 E-Mail: fcssinc@comcast.net Fax:(276)325-4182

LANDLORD-TENANT-CASE MANAGER COMMUNICATION AGREEMENT

Family Crisis Support Services Inc. will be working with the following client to ensure that they follow all rules related to their lease agreement and to make sure rent is paid on time. Our assistance will only continue if they follow their lease agreement and make progress toward goals. If you have any questions please call 679-7240 Monday – Friday, office hours are 9am – 5pm to speak with Adam Thompson, Curt Hileman or Shelia Hileman

Dear: Landlord / Property Owner

My goals are to:
- Fulfill my obligations as outlined in the lease
- Ensure rental payments are received on time
- Maintain the rental unit in good condition
- Help maintain a safe, pleasant and decent housing community

One way to achieve these goals is to help maintain a positive and communicative landlord-tenant-case manager relationship. Therefore, I will immediately inform the signers of this agreement (unless otherwise indicated), both verbally and in writing, if any of the following occurs (initial next to all that applies):

Landlord (Please Initial all that apply)

_____ I have not received full rent by the 3rd day of the month.

_____ I have received a complaint that there is too much noise from the tenant's apartment.

_____ I have significant concerns about the condition of the tenant's unit. (Examples: Landlords have seen damage or received complaints about bad smells that could be related to garbage.)

_____ I think someone is living in the tenant's unit who is not named on the lease.

_____ I think someone in the tenant's unit may be doing something illegal.

_____The behavior of someone living in or visiting the tenant's unit is causing other tenants to complain.

_____I have seen something that is a violation of the lease. Describe:
____

Tenant (Please Initial)

_____A rare, but serious emergency occurs that will impact my ability to pay rent on time

_____I will be away from the unit for an extended time period (Examples 30, 60, 90 days)

_____Inform the landlord of maintenance issues

_____I observe or experience an issue or event that impacts the safety of the community

_____Follow up / Respond quickly to injuries and concerns

Case Manager and/or Housing Coordinator

____Inform the landlord if I become aware of a situation that will impact the tenant's ability to pay the rent on time.

_____Inform the landlord if I become aware of a circumstance that will impact the tenant's occupancy of the unit (Examples: tenant is hospitalized for 30, 60, 90 days)

____I observe a maintenance issue

_____I observe or experience an issue or event that impacts the safety of the community

_____Participate in problem solving / troubleshooting only in the event that the tenant and landlord are unable to resolve an issue without my assistance.

____Follow up / respond quickly to inquiries and concerns

Please contact me using the following information:

	Phone	Phone 2	Email	Address
Landlord Name				
Tenant Name				
Case Manager	276-325-0471	276-325-0578 fax		615 Kentucky Avenue SE Norton, VA 24273

Please list following the following people that will be living in the home:

1. ________________________ 4. ________________________

2 ________________________ 5. ________________________

3.________________________ 6. ________________________

Client Signature: ______________________ Date: ________________

Landlord Signature: ______________________ Date: ________________

Staff Signature: ______________________ Date: ________________

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Cat. No. 10231X

Form **W-9** (Rev. 12-2014)

Family Crisis Support Services, Inc.
630 Park Ave NW Suite 4
Norton, VA 24273

Phone: (276) 325-4181 Email: fcssinc@comcast.net Fax: (276) 325-4182

____
Date

To All Landlords:

The Virginia Homeless Solutions Program (VHSP) is to assist and limited to households who are in threat of or who will imminently lose their nighttime residence and who meet all other requirements for homeless prevention including having household incomes below 30% of the Area Median Income levels in Lee, Wise, Scott, and the City of Norton. It is your Tenant's responsibility to turn in all required documents before your Tenant will be given an appointment to meet with the VHSP Housing Counselor who will determine if the tenant/client is approved or denied on a case by case basis.

Please note: The attached forms are a part of the evaluation process and not a guarantee of assistance. Also if we receive evidence that the Tenant is engaged in any illegal activity while receiving assistance with the VHSP program they will be terminated from the program and you will be notified.

If your Tenant is already renting from you, the Tenant must be served with an eviction notice given by the landlord. This means the Landlord has given the Tenant an Unlawful Detainer with his/her name address and phone number with the regular monthly rent amount and the amount of any past due rent owed broken down by each month separately (i.e.) July. $, and Aug. $. Also, we must have a copy of the lease agreement signed by both the Landlord and the Tenant, also the Landlord must fill out a W-9 form.

If you are looking to rent to a Tenant that is in threat of becoming homeless and will be moving into one of your rental properties and there will be children/child under the age of 6 or under and the property was built prior to 1978 we must have a Lead Based Paint Visual Assessment completed and in the file by our Housing Inspector which must be signed by the Inspector, Landlord and potential Tenant.

These documents are a requirement from our funder, The Department of Housing and Community Development (DHCD) and are part of the VHSP Program. We look forward to working together in assisting families in preventing homelessness in our communities.

Sincerely,

Family Crisis Support, Inc.

Housing Information

Landlord Information:
Landlord /Property Owner Name: ____
Address: ____
Phone Number: ______________________________
E-Mail: ____________________________________

Proposed Property Description:
Address: ____
Number of Bedrooms: ____________
Square Feet: ________________
Type of Construction: ____________________ (single family home, Apt. 1-4 floors, Apt. 5 + floors, Manufactured Home, Town House, Duplex, Other__________)

Age in Years: ___________
Amenities: ____
Type of Utility: _____________________
Are any utilities included: _____________________?
Monthly Rent Amount: $__________________
Deposit Amount: $__________________
Is the unit income based or subsidized? ____________
Will the client receive a utility subsidy? ___________ Amount ________________
Checks are to be made out to: ____
List Occupants:

1. ____
2. ____
3. ____
4. ____
5. ____

Is the tenant behind on rent? __________ Amount Owed: $_______________
Does the tenant receive a section 8 voucher? ____________________
What months are they behind on rent? ____
Has the tenant been served with an unlawful detainer? _________________
Date Served: _______________________
Date client must pay amount owed or be evicted: ___________________
Checks are to be made out to: ____

Landlord Must Complete

Rental amount before subsidy: _________________________________
Utility Subsidy: ____
Final Monthly Amount Due: ___________________________________

Family Crisis Support Services, Inc.
630 Park Ave NW Suite 4
Norton, VA 24273

Phone: (276) 325-4181 E-Mail: fcssinc@comcast.net Fax: (276)325-4182

RENTAL ASSISTANCE AGREEMENT

Instructions: This Agreement covers VHSP "Tenant-Based" Rental Assistance and must be completed by Family Crisis Support Services, Inc. and Landlord when providing rental assistance under both the homelessness prevention and rapid re-housing components of the VHSP Program. **When paying rental arrears *only* a Rental Assistance Agreement is required as arrears are considered rental assistance. The Rental Assistance Agreement does not take the place of the lease between the program participant and landlord.**

Family Crisis Support Services, Inc. Representative: ____
Program Participant: ____

Address of Unit Being Rented: ____

____

Name of Apartment Complex if applicable: ____

Landlord Name: ____

Landlord Address: ___________________________________ **Phone**: __________________

When providing tenant-based rental assistance, the Rental Assistance Agreement with the Landlord must terminate and no further rental assistance payments be made if:

- The program participant moves out of the housing unit;
- The lease terminates and is not renewed;
- The program participant becomes ineligible to receive ESG rental assistance.

During the term of the Rental Assistance Agreement, the Landlord must provide the FCSS a copy of any notice to the program participant to vacate the housing unit, or any complaint used under state or local law to commence an eviction action against the program participant.

Terms of Agreement: (term of the rental assistance agreement should be for the length of time FCSS anticipates providing assistance). All payments must be made directly to the Landlord.

- The term of this Rental Assistance Agreement begins on ______________________ and ends on ______________________.

Security Deposit:
- FCSS will pay a Security Deposit to Landlord in the amount of $_______________________.

Rental Arrears:

- FCSS will pay Rental Arrears to the Landlord in the amount of $__________________________.

- Number of months of arrears paid: _________________List months: ___________________________________

RENTAL ASSISTANCE AGREEMENT

Clients that receive HUD or approved for income based housing can only receive assistance for deposit amounts

Does the client receive HUD or is unit income based housing? ☐Yes ☐ No

1st Month's Rent:
- The monthly rent payable to the Landlord is: $_________________________
- Of the monthly rent amount FCSS portion is: $_________________________
- Of the monthly rent amount the program participant portion is $___________________

2ND Month's Rent: (if participant qualifies or if funds are available)
- The monthly rent amount payable to landlord is: $_______________________
- Of the monthly rent FCSS portion is 70%: $_____________________
- Of the monthly rent amount the program participant portion is 30%: $_____________________

3rd Month's Rent: (if participant qualifies or if funds are available)
- The monthly rent amount payable to landlord is: $_______________________
- Of the monthly rent FCSS portion is 50%: $_____________________
- Of the monthly rent amount the program participant portion is 50%: $_____________________

Payment Due Date: (payment due date, grace period, and late payment penalty requirements must be the same as indicated in the program participant's lease).

- The payment due date is: ___________________________
- The grace period for payment is: _____________________
- Late penalty requirements are: ____ (FCSS cannot use Program funds to pay late payment penalty costs).

____ **Date:** ___________________

Signature of Client

____ **Date:** ___________________

Signature of Landlord

____ **Date:** ___________________

Staff Signature

FLAP 5 PAGES

- VENDOR FORMS
- PAYMENT LOG
- CREDIT AUTHORIZATION FORM
- COPY OF CHECKS/RECEIPTS

Payment Log

Client: ______________________________________ **HMIS#**______________________________

DATE	**AMOUNT**	**RENT**	**TO WHO**	**CHECK #**	**RECEIPT Y/N**	**DELIVERY METHOD**
		Deposit				
		1st Month				
		2nd Month				
		3rd Month				
Client must be recertified for assistance to continue after the 3rd month						
		4th Month				
		5th Month				
		6th Month				
	TOTAL $					

Water & Deposits

DATE	**AMOUNT**	**WATER**	**TO WHO**	**CHECK #**	**RECEIPT**	**DELIVERY METHOD**
		Deposit				
		Arrears				
		1st Month				
		2nd Month				
		3rd Month				
	TOTAL $					

Electric & Deposit

DATE	**AMOUNT**	**ELECTRIC**	**TO WHO**	**CHECK #**	**RECEIPT Y/N**	**DELIVERY METHOD**
		Deposit				
		Arrears				
		1st Month				
		2nd Month				
		3rd Month				
	TOTAL $					

Family Crisis Support Services, Inc.
630 Park Ave NW Suite 4
Norton, VA 24273

Phone: (276) 325-0471 Fax: (276) 325-0578

VENDOR AUTHORIZATION FOR PAYMENT

This authorization is a promise by the agency that payment described below will be made to the vendor on behalf of the client when this form is signed and returned to the agency.

TO: ______________________

VENDOR: ______________________ **AGENCY:** Family Crisis Support Services
Address: ______________________ **Address:** 701 Kentucky Avenue SE
______________________ Norton, VA 24273
Phone: ______________________ **Phone:** 276-679-7240

FOR: ______________________ **HMIS #** ______________________
Client's Name: ______________________
Address: ______________________
____
Utility Account: ______________________

****
I authorize and will make the following payment when this form is signed by the above vendor and returned to this agency.

Amount of Payment $ ______________ for ☐ Water/Sewer Deposit/Bill ☐ Electrical Deposit/Bill ☐ Rent/Deposit

______________________________ ______________________
Signature & Title of Authorized Agency Representative Date

****

I certify that I am owed the above amount and agree that in return for payment of that amount I will connect/reconnect service for the above customer.

X______________________________ ______________________
Signature & Title of Authorized Agency Representative **Date**

Please sign and return

BLANK

Family Crisis Support Services, Inc.
630 Park Ave NW Suite 4
Norton, VA 24273

Phone: (276) 325-0471 Fax: (276) 325-0578

LANDLORD VENDOR AUTHORIZATION

This authorization is a promise by the agency that payment described below will be made to the vendor on behalf of the client when this form is signed and returned to the agency.

TO: ____________________

LANDLORD: ____________________ **AGENCY:** Family Crisis Support Services

Address: ____________________ **Address:** 615 Kentucky Avenue SE

____________________ Norton, VA 24273

Phone: ____________________ **Phone:** 276-325-0471

FOR:

Client's Name: ____________________ **HMIS #** ____________________

Address of Property: ____________________

I authorize and will make the following payments when this form is signed by the above landlord and returned to this agency. In addition, rental assistance payments may be made to the above landlord by this agency depending on the client's needs, circumstances and/or Program compliance.

Security Deposit Amount $____________________

Back rent/late fees of $__________ **for period from** __________ **to** __________

Current rent of $__________ **for partial/full payment for the month of** __________

Total Payment to be made: $____________________

____________________ ____________________

Signature & Title of Authorized Agency Representative **Date**

****

If this Authorization is for a security deposit, I agree to accept the above client as a tenant and to execute a lease if that is my normal practice. I agree to return the security deposit (less any deductions for damages or unpaid rent) plus any interest to the above agency when the tenant moves out of the property.

If this Authorization is for back rent/late fees and/or current rent, I certify that I am owed the above amount in back rent and late fees. I agree that in return for payment of that amount, I will stop any pending or active eviction action and will not evict the above client for late or non-payment of rent. I further agree I will continue to rent the above property to the above client for the period of time for which payment by the agency is or will be made. If the agency is making partial payments, I understand I may pursue eviction for non-payment of rent if the above client does not make his/her share of the payment in a timely manner. I also understand that in any case, I may pursue eviction if the above client does not comply with any other terms of the rental agreement.

X____________________ ____________________

Signature of Landlord **Date**

Please Sign and return

Credit Authorization

Date: ____________________ Completed by: ____________________________________

Client Name: ____________________________________ HMIS#: _______________________

Source of funding ( ) Prevention ( ) VERP ( ) HTF

Rent: $_____________________
Rent Arrears: $________________ To: _______________________________
Security Deposit: $______________ _______________________________

Electric Deposit: $________________ To: _________________________________
Current Payment: $______________ _________________________________
Arrears: $______________________ _________________________________
Pledge #: ______________________ Account #: __________________________

Water Deposit: $________________ To: _________________________________
Current Payment: $______________ _________________________________
Arrears: $______________________ _________________________________
Pledge #: ______________________ Account #: __________________________

Total: $________________________ ( ) Receipt Attached
Maximum Amount Approved: $___________________________
Approved by: ____ Date: ___________________

FLAP 6

- CLIENT CASE NOTES
- HMIS PROGRAM EXIT/ SURVEY FORM

CLIENT CASE NOTES

Client Name: ____ **HMIS #**: ________________

	Date	Time	Notes	Staff Int.

Program Exit

Name: ______________________________ **Client ID#:** ________________

☐Found Safe and affordable housing in less than 7 days
☐Found Safe and affordable housing in 8-14 days
☐Found Safe and affordable housing in 15-31 days
☐Found Safe and affordable housing in 1 – 3 months
☐Found Safe and affordable housing in 3 – 6 months
☐Found Safe and affordable housing in 6 months to 1 year

Reason for Leaving: **Check only one**

☐ Completed program
☐ Criminal activity/violence
☐ Death
☐ Disagreement with rules/person
☐ Left for housing opp. before completing program
☐ Needs could not be met
☐ Non-compliance with program
☐ Non-payment of rent
☐ Other
☐ Reached maximum time allowed
☐ Unknown/Disappeared

Destination: **Check only one**

☐ Deceased
☐ Emer. Shelter or motel paid w/ shelter voucher
☐ Foster care or group home
☐ Hospital or non-psychiatric medical facility m
☐ Referred to homelessness prevention
☐ Referred to street outreach
☐ Referred to other COC project
☐ Referred to homelessness diversion project
☐ Unable to refer/accept within COC, ineligible
☐ Unable to refer/accept within COC, services unavailable
☐ Referred to other community project – non COC
☐ Applicant declined referral/acceptance
☐ Applicant terminated assessment prior to completion
☐ Other: specify

Receiving Income from any source? ☐ Yes ☐ No **Must complete all questions**

Income Source	Yes	No	Data not collected	Incomplete
Alimony or Other Spousal Support $	☐	☐	☐	☐
Child Support $	☐	☐	☐	☐
Earned Income $	☐	☐	☐	☐
General Assistance $	☐	☐	☐	☐
Other $	☐	☐	☐	☐
Pension/retirement from a Former Job $	☐	☐	☐	☐
Private Disability Insurance $	☐	☐	☐	☐
Retirement Income Social Security $	☐	☐	☐	☐
SSDI $	☐	☐	☐	☐
SSI $	☐	☐	☐	☐
TANF $	☐	☐	☐	☐
Unemployment Insurance $	☐	☐	☐	☐
VA Non-Service connected disability pension $	☐	☐	☐	☐
VA Service connected disability compensation $	☐	☐	☐	☐
Workers Compensation $	☐	☐	☐	☐

Receiving any Non-cash benefits: ☐ Yes ☐ No **Must complete all questions**

Non-Cash source	Yes	No	Data no collected	Incomplete
Other Source	☐	☐	☐	☐
Other TANF-funded service	☐	☐	☐	☐

WIC	☐	☐	☐	☐

SNAP – Food Stamps	☐	☐	☐	☐
TANF child care services	☐	☐	☐	☐
TANF transportation services	☐	☐	☐	☐
Temporary rental assistance	☐	☐	☐	☐
Sec. 8, Public housing or other rental assistance	☐	☐	☐	☐

Health Insurance: ☐ Yes ☐ No **Must complete all questions**

Health Insurance Type	Yes	No	Data not collected	Incomplet e
Medicaid	☐	☐	☐	☐
Medicare	☐	☐	☐	☐
Vet. Admin. Medical service	☐	☐	☐	☐
Employer provided Health Insurance	☐	☐	☐	☐
SCHIP	☐	☐	☐	☐
COBRA	☐	☐	☐	☐
Private Pay Health Insurance	☐	☐	☐	☐
State Health Insurance for Adults	☐	☐	☐	☐
Indian Health Insurance	☐	☐	☐	☐
Other	☐	☐	☐	☐

Disability? ☐Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused **Must complete all questions**

Disability Type	Yes	No	Client DNK	Client Refused	Data not collected
Alcohol Abuse	☐	☐	☐	☐	☐
Chronic Health Condition	☐	☐	☐	☐	☐
Developmental	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐
Mental Health Problem	☐	☐	☐	☐	☐
Physical	☐	☐	☐	☐	☐
Physical/Medical	☐	☐	☐	☐	☐
Both Alcohol & Drug Abuse	☐	☐	☐	☐	☐

Assessment Disposition (For coordinated assessment only): Check only one

☐ Referred to emergency shelter/safe haven
☐ Referred to transitional housing
☐ Referred to rapid re-housing
☐ Referred to permanent supportive housing
☐ Referred to homelessness prevention
☐ Referred to street outreach
☐ Referred to other COC project
☐ Referred to homelessness diversion project
☐ Unable to refer/accept within COC, ineligible
☐ Unable to refer/accept within COC, services unavailable
☐ Referred to other community project – non COC
☐ Applicant declined referral/acceptance
☐ Applicant terminated assessment prior to completion
☐ Other: specify

If other Assessment Disposition, specify: ____

Housing Assessment at Exit (For Prevention only): Check only one

☐ Able to maintain housing had at project entry
☐ Moved to a new housing unit
☐ Moved in w/ family/friends temporary
☐ Moved in w/ family/friends permanent
☐ Moved to transitional or temporary housing facility or program
☐ Client became homeless, shelter or place unfit for habitation
☐ Client went to jail/prison
☐ Client died
☐ Client doesn't know
☐ Client refused
☐ Data not collected

If able to maintain housing at Entry, Subsidy information: Check only one

☐ Without a subsidy
☐ With subsidy they had at Entry
☐ With subsidy acquired since entry
☐ Only With financial assistance other than subsidy
☐ Data not collected

If moved into a new housing unit, subsidy information: Check only one

☐ With ongoing subsidy ☐ Data not collected ☐ Without ongoing subsidy

I certify that the information indicated above is true and accurate.

Client Signature: ______________________________ **Date:** ________________

Staff Signature: ______________________________ **Date:** ________________