RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING ANNUAL PACKET	Date:

Client Name: _____ **Grant:** _____

Annual Document Checklist:

- ☐ Release of Information
- ☐ Data Collection Consent
- ☐ Annual Assessment
- ☐ Service Plan
- ☐ HUD Lease Addendum
- ☐ Lease*
- ☐ Inspection*
- ☐ Rent Reasonableness* – FP, PSL, MC, IRC
- ☐ Rent Calculation Worksheet*
- ☐ Verification of Income*
- ☐ Utility Allowance*

County → / Housing Type ↓	SLC	MC	IRC	IRC – IN	IRC - OUT
Apartment	FPL/FPUA	FPL	Vero Beach Utilities FPL	Vero Beach Utilities	Vero Beach Utilities
Single Family	FPL/FPUA	FPL	Vero Beach Utilities FPL	Vero Beach Utilities	Vero Beach Utilities
Mobile Home	FPL/FPUA	N/A	N/A	N/A	N/A

***Case Mangers responsibility (not included in packet).**

RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING RELEASE OF INFORMATION	Date:

Client Name: _____ **SSN:** _____ **DOB:** _____

In accordance with Federal Regulation Code 42, Part 2, I hereby authorize the following entity(ies) to release/disclose any and all past, present and future information and records to facilitate my request and receipt of services and assistance:

- ☐ New Horizons of the Treasure Coast
- ☐ Treasure Coast Homeless Services Council
- ☐ Martin County Health & Human Services
- ☐ St. Lucie County Community Services
- ☐ Ryan White Services
- ☐ Legacy Behavioral Health
- ☐ Department of Children and Families
- ☐ Social Security
- ☐ Other: _____
- ☐ Other: _____

Including the following information: patient records related to any attempted suicide, emotional illness, psychological services records, if any; social services records, if any; communications made by me to a social worker, counselor, psychologist, physician, or other health care provider; and information regulated by Federal Public Law 93-282 (confidentiality of alcohol and drug abuse patients and records documenting the diagnosis and/or treatment of communicable diseases and/or serious disease and infections as defined by the US Department of Health and Human Services rules which include venereal disease, tuberculosis, AIDS, ARC, HIV status and other related diseases, if any).

- ☑ Financial Information
- ☑ Housing Requirements
- ☑ Physical/Mental Health Diagnoses and related limitations, including mobility, employment, etc.
- ☐ Other: _____

for services covering the dates from _____ to _____ for the specific purpose of obtaining stable housing, ensuring my ongoing eligibility and accessing other programs.

I release the above cited individuals or facilities of any legal liability that may arise from the release of the information requested. I understand that the agency cannot release information obtained from other sources. I understand that the individual/institution/agency receiving this information may not re-release it to any other individual, institution, or agency. I also understand that this authorization for release of information will expire on _____ unless indicated below:
(Not to exceed 1 year)

Condition date or event of earlier expiration _____

I also understand that this release can be revoked, by me at any time and that the revocation must be signed and dated by me, and that the revoking of the release will not affect information released prior to the revoking of the release.

_____	_____	_____
Head of Household Signature	Date	Relationship (if minor)
_____	_____	
Spouse/Significant other	Date	
_____	_____	_____
Witness Name (print)	Witness Signature	Date

**** I hereby revoke my consent for the release of the previously stated information****

_____	_____	_____
Signature	Date	Relationship (if minor)

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RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING CLIENT CONSENT FOR DATA COLLECTION	Date:

Participation in data collection is a required component of the community's ability to provide the most effective services and housing possible. Please understand that access to shelter and housing services is available without participation in data collection.

This client notice and consent describes how information about you may be used and disclosed and how you get access to this information. Please review it carefully. If you have any questions or desire any further information regarding this form. Please contact your case manager _____ at _____.

I, _____, understand and acknowledge that _____ (the "Agency") is affiliated with the homeless management information system (HMIS), and I consent to and authorize the collection of information and preparation of records related to the services provided to me by the Agency. The information gathered and prepared by the Agency will be included in a HMIS database and shall be used to:

a) Provide individual case management
b) Produce aggregate-level reports regarding use of services
c) Track individual program-level outcomes
d) Identify unfilled service needs and plan for the provision of new services
e) Allocate resources among agencies engaged in the provision of services

I understand and acknowledge the following collection of information (please initial the following appropriate information):

_____ Identifying information (Name, birth date, gender, race, social security number, residential information, phone number, family information)

_____ Medical records (except HIV/AIDS and alcohol/ drug treatment), Psychological records and evaluations, vocational assessment, care coordinators recommendations and direct observation, employment status, etc.

_____ Financial information (income verification, public assistance payments and allowances, food stamp allotments)

_____ HIV/AIDS diagnosis.

_____ Substance abuse diagnosis, treatment plan, progress in treatment, discharge.

_____ For specific purpose of: ☐ Further Care ☐ Evaluation ☐ Other

Please specify other: _____.

_____ I understand that I have the right to inspect, copy, and request all records maintained by the Agency relating to the provision of services to me and to receive a paper copy of this form.

_____ I understand that this release can be revoked by me at any time and that the revocation must be signed and dated by me. I further understand that this consent is subject to revocation at any time, except to the extent that the Agency has already taken action in reliance on it. If not previously revoked, this consent terminates automatically one year after my last treatment or discharge from the Agency.

_____ I understand that my records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without written consent unless otherwise indicated in regulation.

_____ I understand that participation in data collection is optional, and I may be able to access other shelter and housing options not available under this grant if I choose not to participate.

Head of Household Signature: _____ **Date:** _____

Spouse/ Significant Other: _____ **Date:** _____

RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING ANNUAL ASSESSMENT	Date:

Please note the annual assessment must be completed within 30 days of original enrollment date.

Client Name: _____ **Client Email:** _____

Phone Number: _____ **Alternate Number:** _____

Address: _____

Health Insurance: Please select all that apply.

- ☐ Private
- ☐ Private – Employer
- ☐ Private – Individual
- ☐ Medicare
- ☐ Medicaid
- ☐ State Children's Insurance
- ☐ Military Insurance
- ☐ State Funded
- ☐ Combined Children's Health
- ☐ Indian Health Services
- ☐ Other: _____
- ☐ No insurance

Barriers: Please record a status for every barrier.

Barrier:	Barrier Present:	Receiving Services/ Treatment:	Indefinite Condition:	Documentation provided:
Alcohol Abuse	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Chronic Health Condition	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Developmental Disability	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Drug Abuse	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
HIV/AIDS	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Mental Illness	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Physical Disability	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

History of Domestic Violence: ☐ Yes ☐ No **If yes, when:** _____

Currently fleeing? ☐ Yes ☐ No

Source(s) of Income: Please select all that apply.

- ☐ Earned Income [ ]
- ☐ Unemployment [ ]
- ☐ SSI [ ]
- ☐ SSDI [ ]
- ☐ Veteran's Disability [ ]
- ☐ Veteran's Pension [ ]
- ☐ TANF [ ]
- ☐ Retirement (SSA) [ ]
- ☐ Child Support [ ]
- ☐ Other: _____ [ ]
- ☐ Death Benefit [ ]
- ☐ No Income [ ]

Current Gross Monthly Income: _____

Does the client have a payee? ☐ Yes ☐ No **Payee Name:** _____

Benefits applied for in past year:

- ☐ Retirement (SSA)
- ☐ SSI
- ☐ SSDI
- ☐ Veteran's Pension
- ☐ Veteran's Disability
- ☐ TANF
- ☐ Child Support
- ☐ Employment
- ☐ Food Stamps

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RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING ANNUAL ASSESSMENT	Date:

Total Rent: _____ **Grant Subsidy:** _____ **Client Copay:** _____

Household Expenses: **Food Stamps:** _____

Rent		Child Support		Tuition	
Food		Credit Cards		Personal	
Electric		Car Insurance		Laundry	
Water		Transportation		Cable	
Telephone		Car Payment		Other:_____	
Medical bills		Gasoline		**TOTAL**	$ 0.00

Please provide <u>two</u> emergency contacts/NOK information:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Case Manager Signature: _____ **Date:** _____

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RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING ANNUAL ASSESSMENT (ADDITIONAL HOUSEHOLD MEMBERS)	Date:

ADDITIONAL INFORMATION TO BE COMPLETED FOR EACH HOUSEHOLD MEMBER

Use additional pages as needed

Client Name: _____ **SSN:** _____ **DOB:** _____

Gender: _____ **Relationship to Head of Household**: _____

Race: _____ **Ethnicity:** _____

Chronically Disabled: ☐ Yes ☐ No **Diagnosis:** _____

Is the client a Veteran? ☐ Yes ☐ No **Military Branch:** _____

Discharge Status: _____ **Service Era:** _____

Health Insurance: Please select all that apply.

☐ Private	☐ Medicaid	☐ Combined Children's Health
☐ Private – Employer	☐ State Children's Insurance	☐ Indian Health Services
☐ Private – Individual	☐ Military Insurance	☐ Other: _____
☐ Medicare	☐ State Funded	☐ No insurance

Barriers: Please record a status for every barrier.

Barrier:	Barrier Present:	Receiving Services/ Treatment:	Indefinite Condition:	Documentation provided:
Alcohol Abuse	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Chronic Health Condition	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Developmental Disability	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Drug Abuse	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
HIV/AIDS	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Mental Illness	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Physical Disability	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

History of Domestic Violence: ☐ Yes ☐ No **If yes, when:** _____

Source(s) of Income: Please select all that apply.

☐ Earned Income		☐ Veteran's Disability		☐ Child Support	
☐ Unemployment		☐ Veteran's Pension		☐ Other: _____	
☐ SSI		☐ TANF		☐ Death Benefit	
☐ SSDI		☐ Retirement (SSA)		☐ No Income	$ 0.00

Current Gross Monthly Income: $ 0.00

Case Manager Signature: _____ **Date:** _____

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RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING SERVICE PLAN	Date:

Client Name: _____ **Diagnosis Code:** _____

1.

2.

3.

4.

5.

Has discharge criteria been met? ☐ Yes ☐ No

Changes/Modifications:

New Problems/Needs:	Goal#:	Services/Frequency:	Provider:

My signature below indicates that I am in agreement with this review and any changes and/or additions made to my individual treatment plan.

Client Signature: _____ **Date:** _____

Case Manager Signature: _____ **Date:** _____

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RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING HUD LEASE ADDENDUM	Date:

Tenant Name: _____ **Tenant Number:** _____

Landlord Name: _____ **Landlord Number:** _____

Landlord Email: _____ **Landlord Fax Number:** _____

Property Address: _____

A. Terms of Lease: The term shall begin on _____ and shall continue until: (1) the Lease is terminated by the Landlord in accordance with applicable state and local Tenant/Landlord laws; OR (2) the Lease is terminated by the Tenant in accordance with the Lease or by mutual agreement during the term of the Lease; (3) OR the Lease expires.

B. Base Rent: The following is the base rent for the unit indicated above. _____

C. Utilities and Appliances: Please indicate who provides the following utilities and amenities below.

Utility/Appliance	Landlord	Tenant Paid
Electric	☐	☐
Heating Fuel (specify): _____	☐	☐
Cooking Fuel (specify): _____	☐	☐
Water	☐	☐
Sewer	☐	☐
Trash Collection	☐	☐
Range/Microwave	☐	☐
Refrigerator	☐	☐
Other (specify): _____	☐	☐

Electricity Provider: _____

D. Household Members: Household members authorized to live in this unit are listed below. The Tenant may not permit other persons to join the Household without notifying case manager and obtaining the Landlord's permission.

List Household Members:

E. Number of Bedrooms: Please indicate the number of bedrooms below.

☐ **Studio** ☐ **1 BR** ☐ **2 BR** ☐ **3 BR** ☐ **4 BR** ☐ **5 BR**

Case Manager Signature: _____ **Date:** _____

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