



DBHDS Housing Resource Referral Form
Housing Initiatives for Individuals in Settlement Agreement Population



Please type or print clearly and answer all questions completely. Incomplete forms will not be processed. Referral form must be signed by the individual being referred for assistance or their authorized representative and the staff person making the referral. Referrals must be submitted by the person's Support Coordinator or CIM. All forms must be faxed to: 804-692-0077. Please include a cover page addressed to DBHDS-Housing Resource Referral. If you have a question please email Ashley Cooper, DBHDS Program Coordinator at ashley.cooper@dbhds.virginia.gov.

APPLICANT INFORMATION

NAME	Date of Birth (MM/DD/YYYY)	TELEPHONE NUMBER (Area Code-###-####)
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MAILING ADDRESS (Street or PO Box)	CITY	STATE	ZIP CODE
		Virginia	

Which county or city in Virginia does the applicant wish to reside in? If you plan to include more than one locality, please list in order of priority.

Please list all people expected to reside with the applicant:

Name (First Name and Last Name)	Age	Relationship to Applicant (e.g., live-in aide, sibling, friend, etc.) <i>Please indicate if person is also in Settlement Agreement Population</i>

REFERRING STAFF PERSON INFORMATION

NAME	DATE REFERRAL MADE	DEVELOPMENTAL SERVICES REGION
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AGENCY/COMMUNITY SERVICES BOARD <i>(If you contract with a CSB to provide Support Coordination, please list your organization name and the name CSB that you contract with)</i>	REFERRING INDIVIDUAL/ENTITY TYPE				
	<table border="0"> <tr> <td>CSB Support Coordinator</td> <td>Private Case Manager</td> </tr> <tr> <td>Community Integration Manager</td> <td>Center for Independent Living</td> </tr> </table>	CSB Support Coordinator	Private Case Manager	Community Integration Manager	Center for Independent Living
CSB Support Coordinator	Private Case Manager				
Community Integration Manager	Center for Independent Living				

MAILING ADDRESS (Street or PO Box)	CITY	STATE	ZIP CODE
		Virginia	

TELEPHONE NUMBER (Area Code-###-####) Ext.	FAX NUMBER	EMAIL ADDRESS
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APPLICANT NAME: _____



QUALIFYING INFORMATION

Where is the applicant currently living?

- | | | |
|-------------------|--|--|
| Training Center | Sponsored Residential | Homeless (Please list where person is staying at night): _____ |
| Non-state ICF-IID | Dwelling Owned/Leased by Family Dwelling | |
| Nursing Home | Owned/Leased by Applicant | |
| Group Home | Date current lease ends? _____ | Other: _____ |

Does the applicant have a developmental disability? Yes No

Please check the eligibility criteria that the individual meets and attach supporting documentation that verifies eligibility for individuals in nursing homes or ICF-IDD's (e.g., PASRR level 1 and level 2 screening).

- Currently resides at a training center
- Currently resides in an ICF-IID or nursing home and meets the LOF for Development Services Waiver
- Currently receives BI, FIS or CL waiver services
- Currently on the wait list to receive BI, FIS or CL waiver services

Does the individual currently receive tenant or project-based rent assistance? Yes No

If applicant currently lives in their own home or has tenant or project-based rental assistance, please attach an explanation detailing why housing assistance is needed. Please be sure to include the date that their current lease ends.

Assuming that the person referred is approved for a housing program and finds housing, will they have all of the support services and/or natural supports that he or she will need to be safe, healthy and to sustain their tenancy? Yes No

If you answered no to the question above, we strongly suggest that you submit an RST referral prior to making this referral. Please contact the Community Resource Consultant in your region for more information relating to how to submit a RST referral.

If approved for a housing resource, how long will it take the applicant to prepare to move? 60 days 120 days 120+ days

If the applicant will need longer than 120 days to prepare if approved, please attach a detailed explanation as to why they are being referred at this time.

What type of housing assistance is the individual interested in? Please select one or more of the resources listed below.

Project-based rental assistance (Landlord has agreed to participate in a rental assistance program and the rental assistance is linked to units at a specific property. If the person moves, the rental assistance stays with the unit at the property.)

Tenant-based rental assistance (SC and applicant are responsible for locating a landlord that is willing to accept rental assistance and participate in a rental assistance program. The assistance is linked to a specific person, so if the person moves the rental assistance goes with them)

By signing this form you agree to allow DBHDS to share the information contained on this form with any housing or service organization for the purpose of determining your eligibility for housing assistance. If the applicant is unable to sign, please complete the information for the authorized representative. This form will not be processed if the following Acknowledgments page is not completed.

Print Name of Authorized Representative _____

Relationship to Applicant (Legal Guardian, Power of Attorney, etc.) _____

John Doe

Applicant/Authorized Individual's Signature _____

Date _____

Billy Coordinator

Referring Staff Person's Signature _____

Date _____

For office use only

Date DBHDS received referral form: _____

PHA Name: _____

Referral entered by: _____

Date PHA notified: _____

Acknowledgements

Instructions: The eligible individual, substitute decision maker (if any) and the support coordinator must each initial every item below, otherwise this referral form will be deemed incomplete and will not be processed. If there is no substitute decision maker, write "N/A" on the first item and mark a line through the remainder of the column(s).

Initials			Acknowledgements and Certifications
Eligible Individual	Substitute Decision Maker (if, applicable)	Support Coordinator	
<i>JD</i>		<i>BC</i>	I have read the Frequently Asked Questions document (available on DBHDS's website via the following link: http://www.dbhds.virginia.gov/library/developmental%20services/dd_s_set_aside_vouchers_faq_1_19_16.pdf) and I understand this referral is for housing assistance and not an invitation to attend an information session to find out more about the housing assistance.
<i>JD</i>		<i>BC</i>	I understand a referral will not be made for individuals who: 1) are not in the target population; 2) are not at least age 18 or older; 3) want to live with a parent, grandparent, or legal guardian; or 4) want to live in a group home, ICF, nursing home, assisted living facility, etc.
<i>JD</i>		<i>BC</i>	I understand the referral for a housing assistance is a two-part process. DBHDS verifies whether an individual is in the Settlement Agreement population and makes a referral to the local housing program partner based on its priority/preference structure outlined in the FAQ document. After DBHDS makes the referral, the housing organization program begins its intake and screening process to determine if the individual/household meets its eligibility requirements for the housing program.
<i>JD</i>		<i>BC</i>	I understand time is of the essence. It is important that all appointments are attended and that all requested forms and documentation (Photo ID, birth certificate, SS card, etc.) are provided to the local housing program by the required deadlines.
<i>JD</i>		<i>BC</i>	I understand that the individual referred must be ready to move into their own rental housing within 60 days of being approved for a housing assistance.
<i>JD</i>		<i>BC</i>	Release of Information: I/We agree DBHDS, VHDA, the local housing agency, and any other organization assisting with my transition to rental housing, can share information about initial and ongoing eligibility for the housing assistance and any other pertinent information needed to help with my transition (e.g., reasonable accommodation and reasonable modification requests, utility assistance, flexible funding requests, etc.).

PLEASE PRINT

Eligible Individual's Name: _____

Substitute Decision Maker's Name & Relationship to Individual: _____

Support Coordinator's Name: _____





Services and Supports Form

Support Coordinator: Please complete the following information for each individual referred to DBHDS.

Individualized Supports needed (These may or not be supports funded by a Medicaid Waiver)	Name/Type of organization to provide support	Have the supports been secured or is provider proposed at this time?
<i>Example, In Home Support Services</i>	<i>ABC Supports of Richmond, Licensed In-home residential provider.</i>	<i>No, SC has reached out to ABC supports awaiting confirmation.</i>
Independent Living Supports		
Shared Living		
In-Home Support Services		
CD Personal Assistance Services		
CD Companion		
Skilled or Private Duty Nursing		
PERS		
Assistive Technology		
Community Guide		
Non-medical Transportation		
Electronic Home-Based Services		
Environmental Mods		
Transition Services		
Other Supports (Please include specific support areas below)	Name of Organization/Individual to Provide Supports (Please be sure to include the type of organization and/or relationship to individual referred)	Has the supports been secured or is it proposed at this time?
<i>Example, Representative Payee</i>	<i>Individual's Parent</i>	<i>Individual's mom and dad have been approved by SSA to serve as the individual's rep payee.</i>
Representative Payee		
Guardianship		
Power of Attorney		
Housing Location		

Eligible Individual's Name: _____

Please attach additional sheets, as needed.