DBHDS Housing Resource Referral

Referral Submission Instructions:
The Referral and Assessment Form must be submitted by the person's CSB Support Coordinator/CSB Contracted Case Manager or DBHDS-funded tenancy support staff person (the "Referral Facilitator").

Please download and save this form to your local drive. Type all responses. Provide the current address where the referred individual resides (e.g., not the provider's corporate address). The form must be signed by the individual being referred or their legal decision maker and the Support Coordinator/CSB Contracted Case Manager or DBHDS-funded tenancy support. staff All initials and signatures must be wet signed or electronically signed. Attach digital signature verification for electronic signatures. Incomplete forms will not be processed.

Email this completed form to: housingreferrals@dbhds.virginia.gov. If you do not have an email encryption system, first send an email requesting an encrypted response. Then, reply to the encrypted email and attach the form.

If you have a housing related question or need technical assistance, **please email** housingreferrals@dbhds.virginia.gov

DBHDS Housing Resource Referral

A. REFERRED INDIVIDUAL'S CONTACT INFORMATION

LEGAL NAME (First, Middle, Last Name)	BIRTH DATE (MM/DD/YYYY)	PHONE NO. including area code	SOCIAL SECURITY NUMBER
CURRENT PHYSICAL ADDRESS (Street Address, City, State, Zip)		RACE (Optional) ☐ White ☐ Black/African American	☐ Asian ☐ Two or More Races ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
MAILING ADDRESS if different (Street Address, City, State, Zip)		ETHNICITY (Optional) ◯ Hispanic or Latino ◯ Not Hispanic or Latino	EMAIL ADDRESS

B. SUBSTITUTE DECISION MAKER'S CONTACT INFORMATION (attach guardianship order or Power of Attorney)

NAME (First and Last Name)	PHONE NO. including area code	EMAIL ADDRESS
MAILING ADDRESS (Street Address, City, State, Zip)		
RELATIONSHIP (guardian, conservator, power of attorney, etc.)		

C. EMERGENCY CONTACT'S INFORMATION (if same as the substitute decision maker, write "same as above" in NAME)

NAME (First and Last Name)	PHONE NO. including area code	EMAIL ADDRESS
MAILING ADDRESS (Street Address, City, State, Zip)		
RELATIONSHIP (guardian, conservator, power of attorney, authorized representative, parent, grandparent, sibling, friend, etc.)		

D. REFERRAL FACILITATOR* CONTACT INFORMATION

NAME (First, Last Name)	DATE REFERRAL SUBMITTED TO DBHDS	DBHDS REGION (1-5)
AGENCY NAME/COMMUNITY SERVICES BOARD *(if your agency contracts with a CSB to provide support coordination or tenancy supports, list your organization's Name and the name of the CSB that holds the contract)*		ORGANIZATIONAL ROLE ◯ Support Coordinator ◯ Tenancy Support Staff
MAILING ADDRESS (Street Address, City, State, Zip)		
OFFICE PHONE NUMBER (incl. area code)	MOBILE PHONE NUMBER (incl. area code)	EMAIL ADDRESS

E. HOUSING LOCATION

What county or city in Virginia does the individual prefer to reside in? Please list in order of priority. **Do NOT list towns or neighborhoods.** For a list of counties and cities, copy & paste this website in your browser: https://en.wikipedia.org/wiki/List_of_cities_and_counties_in_Virginia

1)	2)	3)

* DBHDS only accepts housing resource referrals from the following sources: CSB or CSB-contracted DD support coordinators or DBHDS-funded tenancy support staff. Referrals submitted by other sources will be rejected.

F. HOUSEHOLD COMPOSITION

List the referred individual and all persons who will reside with the individual and be on his/her lease. The household cannot include the individual's parents, grandparents or guardians. Do NOT list persons who will live with the individual but have their own leases. Include birth dates, relationship, & student status. Identify household members in the Settlement Agreement population. List each person's gross monthly income and source of income (excluding live-in aides).

First and Last Name	Date of Birth	Relationship (self, spouse, sibling, child, unrelated friend, live-in aide)	In Settlement Agreement population? (Yes or No)	Full-Time Student? (Yes or No)	Gross Monthly Income (include wages, benefits, pensions, etc.)	Source of Income (SSI, SSDI, employment, etc.)
		Referred Individual				

Have all persons above been asked and agreed to become members of the individual's household? YES NO

Have all persons above (excluding live-in aides) agreed to make their income available to the household? YES NO

G. RESOURCE PREFERENCES

What type of housing assistance is the referred individual requesting? Select one or more resources listed below.

1) **Project-based Rental Assistance (PBRA)** – this rent assistance is linked to a specific unit at a specific property. If the person moves, the rent assistance typically stays with the unit at the property.

2) **Tenant-based Rental Assistance (TBRA)** – this rent assistance is linked to a specific person, so if the person moves, the rent assistance goes with him/her. The applicant is responsible for locating a unit with a rent that is within the rent assistance program's maximum subsidy limit.

   ***Does the individual plan to share a dwelling unit with other tenants who each have their own leases*?** YES NO

3) **Leasing Preference at Low-Income Housing Tax Credit (LIHTC) Property** - Rental housing that has units with rents set at levels affordable to households within certain income ranges. Rents do not change based on household income changes. Individuals with very low incomes (e.g., SSI/DI) may also require Tenant-based Rent Assistance. Some LIHTC properties have Project-based Rent Assistance. A leasing preference gives an applicant priority over other applicants to lease an available unit. *If the individual is interested in a specific LIHTC property, insert the name here:*

H. QUALIFYING INFORMATION

1. Does the referred individual have a developmental disability as defined by the Code of Virginia § 37.2-100? YES NO

2. Please check the eligibility criteria that the referred individual meets and attach supporting documentation that verifies eligibility for individuals residing in nursing facilities or ICF-IDDs (e.g., PASRR level 1 and level 2 screening).
   - Currently resides at a DBHDS Training Center
   - Currently resides in an ICF-IDD or nursing facility and meets the functional requirements for a Developmental Disability Waiver (please attach documentation)
   - Currently receives Building Independence, Family and Individual Support or Community Living Waiver services
   - Currently on the waitlist to receive Building Independence, Family and Individual Support or Community Living Waiver services

3. Where does the referred individual currently live?

Training Center	Living with Family in Rented Unit	Homeless (describe where person stays at night)
Non-state ICF-IDD	Living with Family in Family-Owned Unit	
Nursing Facility	Dwelling Owned by Applicant	
Group Home	Dwelling Leased by Applicant	Other (describe):
Sponsored Residential	Dwelling Leased to Applicant by Licensed Provider	

I. HOUSING HISTORY

Describe the referred individual's current living situation in terms of the type of residence, rent, subsidy and leasing arrangements.

1. Type of Residence (e.g., training center; ICF/DD; group home; family home; commercial rental property; public housing; or unit owned by service provider, private owner, relative, etc.) ____
2. Does the individual have a lease in his/her name? YES NO
   If YES, what date does the lease end? _______________
3. If there is no lease, has individual been given a date he/she must leave this housing? YES NO
   If YES, what date must individual leave this housing? _______________
4. Does the individual pay rent? YES NO
   If YES, how much is the rent (e.g., $X/month)? ____________________
5. Does the individual or any household member listed in the household composition currently receive tenant- or project-based rent assistance? YES NO
6. If approved for rent assistance, will the referred individual continue to live in the same rental unit or house? YES NO

If the individual currently leases his/her own home or has tenant or project-based rent assistance, attach a detailed explanation of why housing assistance is needed. Please complete and attach the Financial Need Verification Form and a copy of the current lease.

J. READINESS

Individuals referred for participation in a rental assistance program typically pay 30%, but not more than 40%, of GROSS monthly income towards rent and required utilities, NOT including phone, internet, and cable, in their first year of occupancy. Individuals are referred to housing resources in the locality in which they wish to live, based on availability.

This section examines barriers to applying for rent assistance and/or rental housing and affording independent living, such as (1) required documentation to submit an application, (2) outstanding debts, (3) criminal charges or convictions that would disqualify him/her, and (4) insufficient resources to cover initial housing costs and routine living expenses.

1. Does the referred individual have the following items *(indicate Yes or No)*? Note that DBHDS does not require submission of these items for this referral. However, individuals must have these items to apply for rent assistance and rental housing.

	Social Security card
	Government issued photo ID (e.g., passport, state issued ID, military ID)
	Birth certificate or proof of citizenship/permanent legal residency in the U.S.
	Proof of income letter from Social Security
	Current bank statement(s)
	Other income and asset documentation

2. Does the referred individual currently owe money to (indicate Yes or No):
   You can determine this by obtaining a free credit report from www.annualcreditreport.com.

	a previous landlord (e.g., for unpaid rent, fees or damages)?
	a public housing agency (e.g., for rent or other amounts)?
	a utility company (e.g., for unpaid utility bills or fees)?
	other debts (describe and indicate which debts are in collections):

3. Has the referred individual (indicate Yes or No):

	been convicted of manufacturing or producing methamphetamine on the premises of an assisted housing project?
	been subject to a lifetime registration requirement under a state sex offender registration program?
	engaged in the use of illegal drugs (within the last 12 months)?
	had any other criminal charges or convictions?

4. Does the referred individual need an accessible unit for physical disability needs? YES NO
5. Does the referred individual need an accessible unit for sensory disability needs (e.g., hearing or vision)? YES NO

6. Flexible Funding is available to offset the upfront costs associated with moving into housing. There is up to $5000 available to cover one-time expenses for individuals making an initial transition to housing, such as security deposits, utility connection fees and deposits, rent arrearages, moving expenses, essential furniture and household supplies, community housing guide assistance, and environmental modifications and assistive technology not funded by other sources. See Flexible Funding FAQ for more information: https://dbhds.virginia.gov/assets/doc/DS/housing/flexible-funding-faq_01.22.pdf

Check each up-front cost the referred individual needs assistance to pay to make the transition to housing:

holding fee
security deposit
utility deposits/connection fees
moving expenses (vehicle, movers, boxes, etc.)
furniture
household supplies

K. ACKNOWLEDGEMENTS

The referred individual (or guardian/power of attorney as appropriate) and Referral Facilitator must initial these statements. **Initials must be ink or electronically signed (DocuSign or other digital signature with date/time stamp).**

Referred Individual	Referral Facilitator	
		I understand this referral will not be processed if it is not completed in its entirety. This referral begins the process to obtain housing assistance. It is not an invitation to learn more about housing assistance.
		I understand the referral for housing assistance is a two-part process. DBHDS verifies the individual is in the target population and makes a referral to a Partner Agency (PA) using the DBHDS referral priorities outlined in its referral policy. After DBHDS makes the referral, the Partner Agency begins its intake and screening process to determine if the individual and other household members meet the program eligibility requirements.
		I understand that active case management is required for the referred individual to ensure he/she has the support needed to complete the entire housing transition process. Prior to the individual being referred for rental assistance, a plan should be established to determine who will assist the individual through the housing transition process (development of an independent living budget, completion of the eligibility/application process with the housing agency, locating and applying for a rental unit, signing the lease, obtaining furniture and household items, moving in, etc.).
		I understand that it is important that the individual and the referral facilitator (or a family member) attend all housing appointments and that all requested forms and documentation (original copies of birth certificate and Social Security card, photo ID, income documentation, etc.) are provided to the PA or the local housing program by the required deadlines. I understand that the housing application must be completed within 45 days of the date that DBHDS makes a referral to the PA. If the above referenced time-frame is not met; the individual will be deemed non-responsive, and the referral will be closed.
		I understand that it is important that the individual and referral facilitator determine what supports are needed to be healthy and safe in housing and to secure those supports prior to leasing a rental unit.
		I have read and understand the eligibility criteria for inclusion in the target population and hereby certify that all information provided on this referral form is true and accurate to the best of my knowledge. I understand that this referral will not be processed until all information and requested documentation is received by DBHDS.

L. REFERRAL FACILITATOR CERTIFICATION

I certify the information contained in this document is accurate to the best of my knowledge.

Referral Facilitator Signature: Date:

M. CONSENT FOR THE RELEASE AND EXCHANGE OF INFORMATION

If the referred individual is unable to agree and consent, a documented legal representative must complete and provide consent. Failure to provide consent will prohibit processing of the DBHDS Housing Resource Referral.

I,____, am signing this form for

____

(FULL PRINTED NAME OF REFERRED INDIVIDUAL)

My relationship to the client is: Self Power of Attorney Guardian Other

(If other, please describe): ____

I permit the Office of Community Housing in the Department of Behavioral Health and Developmental Services (OCH/DBHDS) to request, obtain, release and share with the following entities any and all information regarding my anticipated housing and services needs and housing history for the purpose of determining initial and on-going eligibility for housing waitlist preferences, housing assistance and any housing resource provided to the Settlement Agreement population:

- the CSB or CSB-contracted support coordination entity and staff identified on page one, Section D.
- any Partner Agency that provides a Housing Choice Voucher Set-aside or preference for individuals in the Settlement Agreement Population
- any Partner Agency that is under contract with DBHDS to administer the State Rental Assistance Program or Flexible Funding
- any owner/developer of a Low-income Housing Tax Credit (LIHTC) financed property that has a leasing preference for individuals with developmental disabilities
- any management agent of a LIHTC financed property that has a leasing preference for people with developmental disabilities (DD)

I acknowledge that, upon request, OCH/DBHDS will provide a list of Partner Agencies and LIHTC owners/developers/management agents that provide a leasing preference for the DD target population.

I also permit OCH/DBHDS to use and exchange the information in this housing referral and assessment with the Approved Parties below for the purpose of assisting me with identifying and applying for housing resources and services for which I may be eligible and coordinating access to housing resources and services.

Information may be shared (check all that apply): in writing in meetings by phone by computerized data by fax

Approved Parties (include emergency contacts, family members, service providers, housing providers):

This authorization is effective on ______________ (start date) and is good until (check one): ________________ (end date) or when my case is closed.

I can withdraw this authorization at any time by notifying any involved agency listed above. The listed agencies must stop sharing information after they know my authorization 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. I want all agencies to accept a copy of this authorization as valid consent to share information. ***If I do not sign below, information will not be shared, and I will have to contact each agency individually to give them information about me that they need.*** However, I understand that housing and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule. This authorization does NOT allow OCH/DBHDS to release or share information about substance abuse diagnoses or treatment. OCH/DBHDS must obtain a separate authorization from me to release or share this information with a specific party on a case-by-case basis.

SIGNATURES

Authorizing Person: Date:

Person Explaining Form: Date:

Name of Person Explaining Form: Email:

Relationship to Authorizing Person: Phone:

FOR AGENCY USE ONLY

CONSENT HAS BEEN: DATE REQUEST RECEIVED: ______________

- ☐ Revoked in entirety
- ☐ Partially revoked as follows:_______________________________________

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

☐ Letter (Attached Copy) ☐ Telephone ☐ In Person

AGENCY REPRESENTATIVE RECEIVING REQUEST:

____

(Agency Representative's Full Name and Title)

____

(Agency Address and Telephone Number)