GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Division of Residential Services
Pre-Lease Package – Checklist

Consumer _____

Address _____ **Unit** _____

Date ____/____/____

☐ ***Pre-Lease Unit Approval Form***
- Signed by the Landlord
- Income information matches income documentation
- Property address and unit ID on form

☐ ***Income & Household Certification Form***

☐ ***Income Documentation***
- Documentation for <u>all</u> household members eighteen (18) years and older; Signed Zero-Income form if no income.

☐ ***Pre-Inspection Checklist***
- Signed by the CSW/Housing Liaison

☐ ***Housing Program Agreement***
- Signed by the Consumer/Tenant
- Community Support Worker/Housing Liaison

Upon completion, please e-mail scanned documents to:
kimberly.jones@dc.gov Subject Line: Consumers initials – Pre-Lease Packet.
Please ensure all documents are legible.
Contact Kimberly Jones at 202-671-2900 with any questions.
<u>Note: Failure to submit all the items listed above will delay in your Packet being processed.</u>

DBH Received Date: ___/___/_____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Division of Residential Services
Pre-Lease Unit Approval Form

PLEASE COMPLETE & SIGN FORM. ATTACH PRE-INSPECTION CHECKLIST, INCOME & HOUSEHOLD CERTIFICATION FORM, PROGRAM AGREEMENT, HOUSEHOLD INCOME DOCUMENTATION.

☐ **NEW Voucher Awardee** ☐ **Home First Program Relocation**

CONSUMER INFORMATION **Date of Submission** ___/___/_____

Name of Consumer _____

SS # _____ DOB ___/___/_____ Ecura # _____

Core Service Agency (CSA) _____

Housing Liaison Name _____ Phone _____

Housing Liaison E-Mail _____ CSW Name_____

PROPERTY INFORMATION

Property Address _____ Unit _____

Zip Code _____ Ward _____ Expected Move-In Date ___/___/___

Utilities Included
☐ **YES** ☐ **NO** ☐ **Partial**

Unit Size (Number of Bedrooms)
☐ **SRO** ☐ **EFF** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **House** ☐ **Condo**

No. Adults _____ **No. Children** _____ **Security Deposit $** _____

Consumer's Household Monthly Income	Consumer's Rental Payment (30% of Income)	Total Monthly Rent	Housing Subsidy
$ _____	$ _____	$ _____	$ _____

***LANDLORD INFORMATION*/Property Name**_____

Landlord/Property Manager_____

Contact Name _____ Phone _____

E-mail _____ Fax_____

The landlord will not charge the consumer rental payments in excess of the dollar amount contained in this Subsidy Approval Form. The landlord further agrees to comply with DC Municipal Regulations, Title 22A, Chapter 23, Section 2313, *Landlord Participation*, and has been provided with a copy of this section, which is also available on the DBH website at www.DBH.dc.gov.

_____
Landlord/Property Manager Signature **Date**

_____ _____
DBH Approving Director **Date** **DBH Housing Staff** **Date**

DBH Office Use Only **Inspection Date** ___/___/____ **Lease Up Date** ___/___/____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Division of Residential Services
Income & Household Certification Form

Name _____

SS # _____ **DOB** ____/____/_____ **Ecura #** _____

Phone – Cell/Home _____ **E-mail** _____

☐ **Pre-Lease** ☐ **Income Adjustment** ☐ **Relocation Request** ☐ **Subsidy CANDIDATE**

Income Change Date: _____

Note: Decreases in income will be effective on Income Change Date or no more than sixty (60) days prior to receipt of this form.

Core Service Agency (CSA) _____

CSW Name _____ Phone _____

HL Name _____ HL E-mail _____

Household Members (continue on a separate sheet if necessary)

	Name	M/F	Date of Birth	Social Security Number	Relationship
1	**SELF**				
2					
3					

Representative Payee (Check One) (provide information on a separate sheet if necessary)

☐ Self ☐ Bread For The City ☐ CSA ☐ Friend/Relative* ☐ Other (describe) _____

** Provide Name & Contact Information*

Household Income (continue on a separate sheet if necessary) **Include Income Documentation*

	Name	Total Monthly Income Amount	Income Source (Check all that apply)						
			Empl.	SSI	SSDI	VA	TANF	IDA	Other
1	**SELF**								
2									
3									

_____ _____

Consumer Signature & Date Housing Liaison Signature & Date

Consumer MUST sign this form. Read the following carefully before signing.

A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonable by expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties.

DBH Received Date: ____/____/____

DBH Received Date:

___/___/____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Division of Residential Services
Pre-Inspection Checklist

Date of Inspection ____/____/____ **Date of Submission** ____/____/____

Name of Consumer _____

SS # _____ DOB ____/____/____ Ecura # _____

Core Service Agency (**CSA**) _____

CSW Name _____ Phone _____
E-mail _____ Fax _____

Unit Size □ **SRO** □ **EFF** □ **1** □ **2** □ **3** □ **4** □ **5** □ **House** □ **Condo**

Utilities Included: □ **Yes** □ **No** □ **Partial** **Monthly Rent** $_____ **Security Deposit** $ _____

Landlord/Property Manager _____

Phone _____ **Fax** _____ **Other** _____

Property Address & Unit _____

Zip Code _____ **Ward** _____

YES / PASS	NO / FAIL	Item
		Neighborhood
		On or near MetroBus or MetroRail
		Grocery/convenience store within five (5) miles
		Building
		Secure Entry Door
		Lobby and corridors well-lit
		No signs of rodent or insect infestation
		Fire extinguishers in hallway
		Mailboxes with locks available
		Building well-maintained overall
		Kitchen
		Working stove and oven
		Working refrigerator with freezer
		No signs of pipe or ceiling leakage
		Running hot and cold water

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Division of Residential Services
Pre-Inspection Checklist

YES / PASS	NO / FAIL	Item
		Food storage available
		At least one (1) working outlet and one (1) affixed light fixture
		Bathroom
		Toilet flushes properly
		Tub/shower has running hot and cold water and drains properly
		Sink has running hot and cold water and drains properly
		At least one (1) working outlet and one (1) affixed light fixture
		No signs of pipe or ceiling leakage
		Living Room
		At least two (2) working outlets and one (1) affixed light fixture
		At least one (1) window and window(s) are free from breakage/damage
		Bedroom
		At least two (2) working outlets and one (1) affixed light fixture
		At least one (1) window for egress and window(s) are free from breakage/damage
		Clothes storage (closet)
		General
		Working smoke detectors
		Unit free from electrical hazard (*e.g.* hanging wires)
		Working heating and cooling systems

Comments

_____

_____

_____

_____

_____

CSW / Housing Liaison Date

DBH Residential Services Use Only

Comments: _____

_____

_____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Division of Residential Services
Housing Program Agreement

THIS AGREEMENT IS MADE BETWEEN _____ (CONSUMER/TENANT)

AND _____ (COMMUNITY SUPPORT WORKER) ON _____

(DATE), WHO WILL RESIDE AT _____ (ADDRESS), BEGINNING

ON _____ (DATE). CONSUMER/TENANT HEREBY AGREES TO THE FOLLOWING HOUSING AGREEMENT.

1. RENT SHALL BE PAID BY THE FIRST DAY OF EACH MONTH TO THE LANDLORD/PROPERTY MANAGER, IN THE AMOUNT OF $_____, WHICH IS TENANT'S PORTION OF THE RENT.

2. RENT SHALL BE PAID EACH MONTH TO _____.
(LANDLORD/PROPERTY MANAGER)

3. REIMBURSEMENT WILL BE PAID TO THE APPROPRIATE AGENCIES, IF TENANT SHOULD BECOME EMPLOYED OR RECEIVE ANY TYPE OF BENEFIT.

4. ALL UTILITIES NOT INCLUDED IN RENT, (WATER, GAS, ELECTRIC, TELEPHONE) ARE THE RESPONSIBILITY OF THE TENANT.

5. A TELEPHONE IS REQUIRED IN ORDER TO ASSURE THAT YOU HAVE A MEANS OF CONTACT IN AN EMERGENCY.

6. THE HOUSING UNIT AND IMMEDIATE PREMISES, INCLUDING FURNISHINGS, WILL BE KEPT IN GOOD CONDITION. TENANT WILL BE RESPONSIBLE FOR ANY DAMAGES TO THE PROPERTY, WHICH IS A RESULT OF TENANT OR GUEST(S) NEGLECT. THE DMH AND HOUSING PROVIDER WILL BE NOTIFIED PROMPTLY OF ANY DEFECTS OR BREAKAGE IN THE STRUCTURE, FIXTURES, FURNISHINGS, OR EQUIPMENT OF THE HOUSING UNIT.

7. DMH AND HOUSING PROVIDER STAFF SHALL HAVE ACCESS TO THE PREMISES FOR PURPOSES OF INSPECTION AND MONTHLY HOME VISITS.

8. TENANT WILL NOT USE OR PERMIT THE PREMISES TO BE USED FOR ANY DISORDERLY OR UNLAWFUL (**ILLEGAL**) PURPOSE. THIS INCLUDES ABUSE OF ALCOHOL, DRUGS OR WEAPON.

Division of Residential Services
Housing Program Agreement

9. NO OTHER INDIVIDUALS WILL BE PERMITTED TO RESIDE ON PROPERTY, OTHER THAN THOSE SIGNING THIS AGREEMNT.

10. ALL PERSONAL PROPERTY ON THE PREMISES SHALL BE THE SOLE RESPONSIBILITY OF THE TENANT. ALL BELONGINGS MUST BE MOVED WHEN THE PROPERTY IS VACATED.

11. TENANT SHALL GIVE LANDLORD AND CLINICAL MANAGER, THIRTY-DAY (30) NOTICE **IN WRITING** OF INTENT TO VACATE THE PROPERTY. THE TENANT IS REQUIRED TO BROOM SWEEP THE UNIT, DISCARD TRASH AND REFRIGERATED ITEMS.

12. THIS AGREEMENT ASSUMES A WORKING RELATIONSHIP BETWEEN THE TENANT AND DMH PROVIDER. IF AT ANY TIME THE TENANT AND DMH HOUSING AND/OR TREATMENT PROVIDER DETERMINE THAT THE HOUSING SITUATION IS NON-THERAPEUTIC OR EVEN DANGEROUS, THIS AGREEMENT SHALL BE AMENDED OR TERMINATED.

13. WHEN A CONSUMER DISCONNECTS FROM THE DMH PROVIDER AND IS NO LONGER RECEIVING TREATMENT, THE SUBSIDY WILL STOP WITHIN 90 DAYS.

_____ _____

Consumer /Tennant Signature Date

_____ _____

Community Support Worker / Housing Liaison Date

D.C. Department of Mental Health - Housing

Housing Waiting List Application

Application Date _____/_____/_____ | **DMH-Received Date** _____/_____/_____

Applicant Last Name | **First Name** | **Middle Name**

Ecura ID | **Date of Birth** | **Social Security Number** | **Gender** □ Male □ Female

Ethnicity *check one block below (Not Requires)*

□ Hispanic or Latino
□ Alaska Native □ Asian □ Black or African American □ White or Caucasian
□ Native Hawaiian or Other Pacific Islander □ Other Race

Marital Status

□ Single □ Married
□ Separated □ Divorced
□ Widowed

□ **English** Primary Language _____ □ **Non-U.S. Citizen**

Consumer's Current Housing Situation *(Check all that apply)*

□ Shelter *(Shelter Name)* _____
□ St Elizabeths □ Other Psychiatric Hospital _____
□ Crisis Bed □ Incarcerated *(Release Date ___/___/___)*
□ Sub-Standard Housing □ Single Residential Occupancy (SRO)
□ Treatment Facility □ Apartment or Rent-Burdened
□ Pension
□ Other (Explain) _____
□ living on the Streets
□ Child Support
□ live with/Family/Friends
□ Boarding/Rooming House
□ Apartment & Eviction Risk

Population Designation(s)

□ St Elizabeths Hospital □ Veteran (Military) □ HIV/AIDS
□ Transition-Age Youth (CFSA) □ DDS (Agency)-Involved □ DC Linkage Plus

Consumer's Phone Number(s):

Cell: _____
Other: _____

DSM IV Diagnosis *(Numbers and Text)*

Axis I _____ Axis III _____ _ Axis V_____
Axis II _____ _ Axis IV_____

Special Housing Requirements

□ Ground-Floor Unit □ Wheelchair Accessibility
□ Service Animal □ Hearing-Impaired Accommodations
□ Pet □ Other (Explain) _____

Income Source(s) *(check all that apply)*

Monthly Household Income: $_____

□ Supplemental Security Income (SSI) $_____
□ Social Security Disability Insurance (SSDI) $_____
□ Interim Disability Assistance (IDA) $_____
□ Veterans Administration Benefits (VA) $_____
□ Social Security $_____
□ Employment $_____
□ Temporary Assistance to Needy Families (TANF) $_____
□ Retirement/Civil Service Annuity $_____
□ No Income *(submit Zero Income Statement and proof of application for benefits)* □ Other $_____

Proof of registered for housing assistance with the D.C. Housing Authority (DCHA) □ Yes □ No

Core Service Agency (CSA) _____
CSA Housing Liaison _____ Phone _____ Fax _____
CSA HL Signature _____ HL E-mail _____

_____ _____
Applicant Signature & Date Applicant Name (Print)

Revised: 01/2013

D.C. Department of Mental Health – Housing
Home First Program
Zero-Income Statement

Name of Program Participant _____

Household Member *write 'SAME', if applicable*) _____

Social Security Number _____ **Date of Birth** _____

Relationship to Participant ☐ **Self** ☐ **Household Member**

This statement is to certify that I am not receiving any income, public benefits, or financial assistance from any source and/or that I am unemployed. Income sources include the following:

- Employment – Full-Time or Part-Time
- Unemployment Compensation Benefits
- Social Security or Annuity Benefits
- Veterans Benefits (VA)
- Pension or Retirement Income
- Public Assistance (PA) or Temporary Assistance to Needy Families (TANF)
- Child Support or Social Security Benefits for Minor Children

As a Home First Program Participant or a household member of a Participant, I understand that:

- **I must apply for all public benefits for which I am eligible.**
- My Home First Program subsidy is affected by my household income.
- I must provide documentation of any changes in my income within thirty (30) days of the change.
- The Department of Mental Health – Housing will send me written notification of verified changes in my household income and changes in my Home First Program subsidy.

The certifying of this statement is made for the purpose of obtaining access to housing assistance from the Department of Mental Health. I understand that false statements or information may exclude me and/or my family from obtaining housing assistance. In addition, it may be grounds for termination from a subsidized housing program.

Participant Signature: _____ Date: _____

Household Member Signature: _____ Date: _____

Community Support Worker Signature: _____ Date: _____

Housing Liaison Signature: _____ Date: _____

Revised: 07/2012