RECERTIFICATION for RRH

|  |  |  |
| --- | --- | --- |
| HMIS #: | Date Completed | Staff Initials |
| Release Form -Universal: updates annually-DV Release: updates every 6mths |  |  |
| Self Sufficiency Action Plan |  |  |
| Recertification Form (HMIS print out must be used) |  |  |
| Budget Worksheet |  |  |
| Self-Declaration of Income (Each Adult) |  |  |
| Third Party Verification of Income (if applicable) |  |  |
| Paystubs, Social Security Statement, Print Outs, etc. (12 weeks) |  |  |
| Checking/Savings/IRA/Tax Documents/etc. Print Outs |  |  |
| Copies of recent Utilities |  |  |
| Staff Recertification Form  |  |  |
| Recertification Denial (if applicable) |  |  |

Region 16 Universal Release Form
Consent to Release Confidential Information

|  |  |  |
| --- | --- | --- |
| Issuing Agency: |  | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   |  |  |
|  |  |  |
| Participant Name: |  DOB: | SS#: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please indicate, “All of the following”, or initial the individual agencies with whom you wish to share information.I, hereby authorize: |
| \_\_\_ All of the following |
| \_\_\_O.S.U. Extension | \_\_\_ Mental Health | \_\_\_ One-Stop |
| \_\_\_ Early Start | \_\_\_Probate Juvenile Court | \_\_\_ Red Cross |
| \_\_\_ School Districts | \_\_\_Physicians | \_\_\_ Sheriff |
| \_\_\_ Board of MRDD | \_\_\_Community Action | \_\_\_ Police Department |
| \_\_\_ Head Start | \_\_\_ Bureau of Support | \_\_\_ Prosecutor |
| \_\_\_ Job & Family Services | \_\_\_ Recovery Programs | \_\_\_ Victim/Witness |
| \_\_\_ Children’s Services | \_\_\_ Hospital | \_\_\_Adult Probation |
| \_\_\_ Health Department | \_\_\_Domestic Violence Programs | \_\_\_Adult Parole |
| \_\_\_Rehabilitation Services Commission | \_\_\_ Veteran’s Services | \_\_\_VA Chillicothe |
| \_\_\_Vocational/Educational Services | \_\_\_Goodwill Industries | \_\_\_ Commission on Aging |
| \_\_\_ Early Intervention | \_\_\_ Employment Services Program | \_\_\_Alternative School |
| \_\_\_Service Plan Coordinator | \_\_\_ Metropolitan Housing Authority | \_\_\_Nursing Home |
| \_\_\_Legal Services | \_\_\_ Transportation | \_\_\_Employer |
| \_\_\_Family & Children First | \_\_\_ Pregnancy Center | \_\_\_Landlord |
| \_\_\_Continuum of Care | \_\_\_ Food Pantry  | \_\_\_CLUSTER |
| \_\_\_Potential Housing Providers | \_\_\_ Region 16 Coordinated |  |
| \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intake Partners |   |
| There may be a need to share documents, as necessary to develop an effective service plan, avoid duplication of services to, or better assess the needs of the household. Such documents may include: |
| \_\_\_All of the following | \_\_\_Housing Information | \_\_\_Medical Records |
| \_\_\_Psychotherapy Reports | \_\_\_Psychological Reports | \_\_\_Service Records |
| \_\_\_Scholastic/Attendance Reports | \_\_\_Court Records | \_\_\_Employment Information |
| \_\_\_Arrearages | \_\_\_Individual/Family Service Plans | \_\_\_Individual/Family Case or Goal Plans |
| \_\_\_Individual/Family Referrals | \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_Only\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Specify where required by confidentiality laws and regulations. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| By signing this form, I understand that papers may contain private information about me and my children and that I am allowing this information to be shared by those indicated above. I also understand that the information released is protected by State and Federal confidentiality regulations and cannot be disclosed without my written consent. I further understand that I may revoke this consent at any time. This consent automatically expires one year after the day of the signature. |
| Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ | Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Please Indicate: |  \_\_\_Father |  \_\_\_Mother |  \_\_\_Legal Guardian | \_\_\_Self |  \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| Revoked date: \_\_\_\_ -\_\_\_\_ -\_\_\_\_\_ | Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Please Indicate: |  \_\_\_Father |  \_\_\_Mother |  \_\_\_Legal Guardian | \_\_\_Self |  \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Renewal Date: \_\_\_\_ - \_\_\_\_ -\_\_\_\_\_ | Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Please Indicate: |  \_\_Father |  \_\_Mother  |  \_\_\_Legal Guardian | \_\_\_Self |  \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Self Sufficiency Action Plan

Participant Name: Date: \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Matrix | Participant Responsibilities | Case Manager Responsibilities | Outcome |
| Income: |  | Update file as necessary |  |
| Employment: |  | Update file as necessary |  |
| Housing Situation: | Currently Housed | Provide Landlord List | Participant is housed through housing program |
| Food: |  | Provide Community Resource List |  |
| Childcare: |  | Refer to JFS Childcare if applicable |  |
| Children’s Education: |  | Refer to Head Start if applicable |  |
| Adult Education: |  | Provide if requested |  |
| Legal: |  | Refer to Legal Aid if applicable |  |
| Health Care: |  | Refer to JFS for Medicaid if applicable |  |
| Life Skills: | Refer to Housing History Assessment in Tab 2 | Update as needed |  |
| Mental Health: |  | Refer to Local Mental Health Agency if applicable |  |
| Substance Abuse: |  | Refer to Local Recovery Agency if applicable |  |
| Family Relations: |  | Update file as necessary |  |
| Transportation: |  | Refer to transportation services if applicable |  |

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Budget Worksheet

PARTICIPANT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_

Complete in:

 Tab 5

|  |  |
| --- | --- |
| MONTHLY EXPENSES | ActualAmt |
| Rent |  |
| Utilities: Electric PIPP: Y N  |  |
|  Gas PIPP: Y N  |  |
|  Water |  |
|   |  |
| Cell phone  |  |
| Food expenses covered by SNAP benefit  |  ( ) |
| Food expenses (include *ONLY* if HH need exceeds SNAP benefit) \*Calculates @ $50/person weekly (ex: 2 person HH; 50x2=100wkly. 100 x4= 400 monthly) |  |
| Baby Formula and/or Diapers  |  |
| Transportation: (car payment, gasoline or transportation fare) |  |
| Child Care |  |
| Medical (prescriptions, co-pays, medicine needs) |  |
| Insurance (Automobile, Renters) |  |
| Household Supplies |  |
| Personal Needs (clothing, shoes, haircut, etc.) |  |
| Tobacco Use |  |
| School Expenses (school lunch, fees, tuition, books, etc.) |  |
| Installment loans & other Debt Payments |  |
| Child Support Payments |  |
| Savings (please specify) |  |
| Other (please specify) |  |
|  |  |
|  |  |
| A: *TOTAL MONTHLY COSTS* Exclude Food expenses covered by SNAP benefit |  |
| B: *TOTAL NET MONTLY INCOME*Include: Wages, child support, SSI, OWF (any eligible income) *Do NOT include SNAP benefit*. |  |
| C: ADJUSTED MONTHLY INCOME(Total NET Monthly Income – Total Monthly Costs) |  |
| Participant’s Monthly Rent Contribution |  |

 Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

 Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Self-Declaration of Income

Participant 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: \_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  I certify, under penalty of perjury, that I do not have any income from any source at this time and I do not have any support networks that could help me with my housing.

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff Verification
I understand that third-party verification is the preferred method of certifying income for HCRP 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RRH: Must be under 50% AMI at entry and under 30% AMI at 90-day recertification.

PSH: Must be under 35% AMI at entry & annual recertification.

## Third Party Verification of Income

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructions for Employer/Payment Source Representative: This is to certify the income received by the above named individual for purposes of participating in the HCRP 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Employment Income
Participant Release: I hereby authorize the release of the following employment information.
Participant 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Release: I hereby authorize the release of the following payment and/or benefit information.

Participant 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 STAFF RECERTIFICATION OF ELIGIBILITY- RRH ASSISTANCE

Purpose: This form serves as documentation that: (1) the program participant named below meets all eligibility criteria for continued housing assistance; (2) this eligibility determination is based on true and complete information; (3) neither the staff member making this determination nor his/her supervisor are related to the program participant through family, business or other personal ties; and (4) this eligibility determination has not resulted from, nor will result in, any financial benefit to the staff member making this determination, his/her supervisor, or anyone related to them.

Instructions: This form must be completed for each program participant upon the determination of his/her continued eligibility for housing assistance. This form must be signed and dated by the housing staff person and housing supervisor that determine a household’s eligibility for recertification. This form must be kept in the housing program participant’s case file. This form will remain valid, unless different housing staff re‐determines the household’s eligibility, in which, case a new form will be required.

|  |
| --- |
| Participant Name:  |
| Recertification Date: |
| \*List all members of household: |
|  |
|  |
|  |
|  |
|  |

*\*All members in household that will benefit from housing assistance must be listed here.*

Required certifications: Each person signing below certifies to the following: (1) To the best of my knowledge, the program participant named above meets all requirements to receive continued assistance under this program. (2) To the best of my knowledge and ability, all of the information used in making this eligibility recertification is true and complete. (3) I am not related to the program participant through family, business or other personal ties. (4) To the best of my knowledge, neither I, nor anyone related to me, has received or will continue receive any financial benefit for this eligibility recertification. (5) I understand that fraud is investigated by the Department of Housing and Urban Development, Office of Inspector General, and may be punished under Federal laws to include, but not limited to, 18 U.S.C. 1001 and 18 U.S.C. 641. (6) I understand that if any of these certifications is found to be false, I will be subject to criminal, civil and administrative penalties and sanctions.

Staff Signature: Date:

Supervisor Signature: Date:

Recertification Denial

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RE: Housing Stability Program PSH Recertification Determination

Dear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The RRH recertification you applied for has been *denied*. The funds must be utilized by participants with income below 30% of the Area Median Income (AMI); have barriers to maintaining their housing; and meet other program criteria.

This letter is regarding the recent recertification submitted to the RRH housing program. You are not eligible to continue receiving RRH assistance. This decision is based on the following information:

[ ]  Participant does not meet eligibility requirements:

 [ ]  Income at or above 30% of the Area Median Income (AMI)

 [ ]  Housing barriers were not met,

 [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Recertification was not completed:

[ ]  Required documentation to complete recertification process was never received

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should you have any questions or concerns, please call \_\_\_\_\_\_\_\_\_\_\_ at (\_\_\_) \_\_\_\_-\_\_\_\_\_.

Respectfully,

CASE MANAGER (signature)