Housing Resource Center of Benton and Franklin Counties
Screening Times:
Tuesday, Wednesday and Thursday
8am -11:30am & 1pm - 4:30pm

Phone: 509.737.3946
7102 W. Okanogan Place Suite 201
Kennewick, WA 99336
(In the Benton Franklin Health District Building Second Floor)

Please provide your own copies of documents!

Documents Requested:

- Homeless Status (Letter from the shelter/service provider)
  Or
- Current Eviction Notice/30-day notice/14-day notice/legal court papers/sheriff's notice
- Picture ID for all adults in household
- Social Security Cards for all household members
- Birth certificates for the children in the house
- Copy of current lease/rental agreement
- Ledger from landlord (this is print out of the total amount of back rent owed and for what months)
- Verification of income for everyone in the household
- Application packet with everything in **yellow filled out by the client** and **everything in pink filled out by the landlord**

FOR OFFICE USE ONLY	
HMIS ID: ______	Referred to: ______
Contacted FCS? ☐Yes ☐No (if yes, who?) ______	

Client Information

Household Information Please enter each household member below.

How many people are in your household? Adults: _____ Children: ______

Last Known Permanent City ____________________ **ZIP** ____________

Relation to Head of Household (if applicable) spouse/ child/etc.	**First Name**	**Last Name**	**Birth Date**	**Gender**	**Race** (enter all that apply)	**Ethnicity Hispanic** (H) or **Non-Hispanic** (N)	**Veteran** (served in Armed Forces) Yes or No	**Social Security Number**
1. Self								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

Client Phone Number: ______________________________ **Message Phone:** __________________________

Client email address : ____

Current Living Situation: Please check the best one that fits your current living situation.

☐Place not meant for habitation
☐Emergency Shelter, including motel paid for with voucher
☐Safe Haven
☐Interim Housing/Couch Surfing
☐Foster Care/Group Home
☐Hospital or other residential non-psychiatric medical facility
☐Jail, prison or juvenile detention
☐Long term care facility or nursing home
☐Psychiatric hospital or other psychiatric facility
☐Substance abuse treatment facility
☐Hotel or motel paid for without voucher
☐Living in house/apartment you own **with no** other housing subsidy
☐Living in house/apartment you own **with** housing subsidy____________ (what type of subsidy)
☐Renting **with** housing subsidy
______________ (what type of subsidy)
☐Renting **without** housing subsidy
☐Staying or living in a family member's home
☐Staying or living in a friend's home
☐Transitional housing for homeless persons
☐Fleeing Violence or Sex-Trafficking

Homeless:

Approximate Date Homelessness started: ______________________________
How many times have you been on the streets or in shelters in the past three years? ______________
Total number of months homeless on the streets or shelters: ______________________

OR

At Risk of Homelessness:

When will you lose your primary nighttime residence? ______________________________

Length of Prior Living Situations:

☐1 night or less
☐2-6 nights
☐1 week or more, but less than 1 month
☐1 month or more, but less than 90 days
☐90 days or more, but less than 1 year
☐1 year or longer

Length of Stay Less Than 7 Nights?

☐Yes
☐No

Have you been released from a Psychiatric facility in the last 12 months ☐ Yes ☐ No

Have you been released from an in-patient SUD treatment facility in the last 12 months ☐ Yes ☐ No

Have you ever received rental assistance from HRC? ☐ Yes ☐ No

Household Wellbeing Questions:

Self (1)

Yes	No		
☐	☐	Do you have a physical disability?	Is this long-term? **YES NO**
☐	☐	Do you have a developmental disability?	Does this impair daily living? **YES NO**
☐	☐	Do you have a chronic health condition?	Is this long-term? **YES NO**
☐	☐	Do you have a mental health problem?	Is this long-term? **YES NO**
☐	☐	Do you have a mental health provider?	If yes, please list provider here: ____________
☐	☐	Do you have a drug or alcohol problem? ****Please circle: Alcohol, Drug, Both** Is this being treated? **YES NO**	
☐	☐	Have you been a victim of violence or sex trafficking?	When was the last time? __________
☐	☐	Have you ever been arrested? **YES NO** If yes, please list date and charge: ______________________________	

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unsure ☐ Other ☐ Doesn't know ☐ Refused ☐ Data not collected

Household Wellbeing Questions:

Adult (2)

Yes **No**

☐ ☐ Do you have a physical disability? Is this long-term? **YES** **NO**
☐ ☐ Do you have a developmental disability? Does this impair daily living? **YES** **NO**
☐ ☐ Do you have a chronic health condition? Is this long-term? **YES** **NO**
☐ ☐ Do you have a mental health problem? Is this long-term? **YES** **NO**
☐ ☐ Do you have a mental health provider? If yes, please list provider here: ________________
☐ ☐ Do you have a drug or alcohol problem?
<u>Please circle:</u> Alcohol, Drug, Both** Is this being treated? **YES** **NO**

☐ ☐ Have you been a victim of violence or sex trafficking? When was the last time? ___________
☐ ☐ Have you ever been arrested? **YES** **NO** If yes, please list date and charge:
____

<u>Sexual Orientation:</u> ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unsure
☐ Other ☐ Doesn't know ☐ Refused ☐ Data not collected

Household Member Child (1):

Yes **No**

☐ ☐ Do you have a physical disability? Is this long-term? **YES** **NO**
☐ ☐ Do you have a developmental disability? Is this long-term? **YES** **NO**
☐ ☐ Do you have a chronic health problem? Is this long-term? **YES** **NO**
☐ ☐ Do you have a mental health problem? Is this long-term? **YES** **NO**
☐ ☐ Do you have a mental health provider? If yes, please list provider here:
____

Household Member Child (2):

Yes **No**

☐ ☐ Do you have a physical disability? Is this long-term? **YES** **NO**
☐ ☐ Do you have a developmental disability? Is this long-term? **YES** **NO**
☐ ☐ Do you have a chronic health problem? Is this long-term? **YES** **NO**
☐ ☐ Do you have a mental health problem? Is this long-term? **YES** **NO**
☐ ☐ Do you have a mental health provider? If yes, please list provider here: ____

Household Member Child (3):

Yes **No**

☐ ☐ Do you have a physical disability? Is this long-term? **YES** **NO**
☐ ☐ Do you have a developmental disability? Is this long-term? **YES** **NO**
☐ ☐ Do you have a chronic health problem? Is this long-term? **YES** **NO**
☐ ☐ Do you have a chronic health problem? Is this long-term? **YES** **NO**
☐ ☐ Do you have a mental health provider? If yes, please list provider here:
____

Household Member Child (4):

Yes	No		
☐	☐	Do you have a physical disability?	Is this long-term? **YES NO**
☐	☐	Do you have a developmental disability?	Is this long-term? **YES NO**
☐	☐	Do you have a chronic health problem?	Is this long-term? **YES NO**
☐	☐	Do you have a mental health problem?	Is this long-term? **YES NO**
☐	☐	Do you have a mental health provider?	If yes, please list provider

here: ____________________________________

Household Member Child (5):

Yes	No		
☐	☐	Do you have a physical disability?	Is this long-term? **YES NO**
☐	☐	Do you have a developmental disability?	Is this long-term? **YES NO**
☐	☐	Do you have a chronic health problem?	Is this long-term? **YES NO**
☐	☐	Do you have a mental health problem?	Is this long-term? **YES NO**
☐	☐	Do you have a mental health provider?	If yes, please list provider

here: ____________________________________

Household Member Child (6):

Yes	No		
☐	☐	Do you have a physical disability?	Is this long-term? **YES NO**
☐	☐	Do you have a developmental disability?	Is this long-term? **YES NO**
☐	☐	Do you have a chronic health problem?	Is this long-term? **YES NO**
☐	☐	Do you have a mental health problem?	Is this long-term? **YES NO**
☐	☐	Do you have a mental health provider?	If yes, please list provider

here: ____________________________________

Non-Cash Benefits: Check all that apply

☐ Food Stamps $__________	☐ Medicaid	☐ Medicare
☐ State Children's Health Insurance	☐ VA Medical Services	☐ WIC
☐ TANF Child Care	☐ TANF Transportation	☐ Other TANF
☐ Temporary Rental Assistance__________	☐ Section 8 or Rental Assistance	☐ Private health insurance
☐ Employer provided health insurance	☐ COBRA health insurance	☐ State Adult health insurance

Household Income:

Total Monthly Gross (before taxes) Income: ______________ Income Source: ______________

I do hereby swear and attest that all the information in this application is true and correct.

_____________________________________ _______________

Client signature Date

_____________________________________ _______________

Staff signature Date

BENTON AND FRANKLIN COUNTIES
DEPARTMENT OF HUMAN SERVICES

ZERO INCOME AFFIDAVIT: Complete this only if you have **no income**.

I, ____ have applied for housing assistance. Program regulations require verification of all income from participating households.

Income includes but is not limited to:

- Gross wages, salaries, overtime pay, commissions, fees, tips and bonuses
- Net income from operation of a business or from rental or real personal property
- Interest, dividends, and other net income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
- Lump sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609 (b)(5))
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
- Public assistance
- Alimony and child support payments (whether through the court system or not)
- Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)
- Regular monetary gifts from family and/or friends

I have stated during the last 30 days that I have no income at this time. I have not received any income since ______________________. I do not expect to receive any income until _____________.

I applied for ________________________ (other financial assistance) on __________________.

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the program and may be grounds for termination of assistance. WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing to BFDHS/or grantee agency within ten (10) days.

____ ____________________________

Client Signature **Date**

BENTON AND FRANKLIN COUNTIES
DEPARTMENT OF HUMAN SERVICES

HRC RELEASE OF INFORMATION

PLEASE READ THE FOLLOWING CAREFULLY

The Housing Resource Center (HRC) administered by Benton County Department of Human Services, is requesting your permission to share your confidential information and records in order to provide you with outreach and program services that are provided by other programs and agencies.

The sole purpose of revealing this information will be to enable the HRC staff, under the administration of Benton and Franklin Counties Department of Human Services, to provide you with appropriate external and internal services.

You are not required to give your consent to share this confidential and personal information.

Your eligibility to participate in HRC programs does not depend on your agreement to share your confidential information and personal records with outside agencies.

If you choose not to share your confidential information and personal records, including your Social Security Number, you may not be eligible for further services that require inter-agency cooperation.

Information may be shared with any or all of the following agencies: Community Action Connections, Lourdes Counseling Center, Department of Social and Health Services, Domestic Violence Services, Elijah Family Homes, My Friend's Place, Veterans Opportunity Center, Communities in Schools of Benton and Franklin Counties, Salvation Army, Kennewick Housing Authority, and Oxford House.

The information disclosed to the HRC partnering agencies will not be further re-disclosed by those agencies without your specific authorization and further consent.

I agree that a photocopy of this authorization may be used for the purpose stated above.

By signing below, I authorize Benton and Franklin Counties Department of Human Services to obtain information from **initial**__________ and/or disclose information to **initial**__________ share my confidential information and personal records; this information will be shared with partnering agencies in the community and only on a need-to-know basis.

I understand that my records are protected under Washington State Law and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

This consent is good for 365 days unless updated and may be revoked in writing at any time except to the extent that action has already been taken based on this authorization.

______________________________________ ______________________

Client Signature **Date**

BENTON AND FRANKLIN COUNTIES
DEPARTMENT OF HUMAN SERVICES

TERMINATION AND GRIEVANCE POLICY AND PROCEDURE

The BFDHS in their sole discretion can terminate program participants for violations of Family/Client Responsibilities, Program Occupancy Agreement or these policies and procedures. Termination of such services is the decision of BFDHS, respectively. Repeated violation of program rules or obligations undermines the functioning of the program and constitutes abuse of the program by the client. The client's assistance may be terminated after the do not take corrective action after one documented incident of program violation. Prior to termination of the participant, BFDHS will give written notice to the program participant. This notice will include the reason(s) for termination. The client has a right to appeal this decision utilizing the grievance procedure below; a signed copy is provided to client and kept in client file. BFDHS will send a *Notice of Termination of Tenancy* to the participant with the effective date of the termination.

Step 1: If you have a grievance, please bring it to the attention of the staff. An attempt will be made to immediately resolve the issue.

Step 2: If the issue cannot be resolved with the staff directly, please promptly submit your complaint in writing to: **BFDHS Grievance Coordinator, 7102 W. Okanogan Place, Ste. 201, Kennewick, WA 99336**. You will receive a response to your written complaint within 3 (three) business days.

Step 3: If you are still not satisfied with the results, please submit a written request for a hearing to: **BFDHS Administrator, 7102 W. Okanogan Place, Ste. 201, Kennewick, WA 99336**.

A hearing will be scheduled within 10 (ten) business days upon receipt of your written request. After your hearing, you will be notified in writing within 5 (five) business days of the hearing results.

By signing below, I acknowledge that I have been informed of the Benton and Franklin Counties Department of Human Services Grievance Policy and Procedure; a signed copy will be provided to me for my records.

Client Signature **Date** **Staff Initials**

NON-COMPLIANCE

EACH OF THE FOLLOWING CONSTITUTES ONE PROGRAM NON-COMPLIANCE

1. Missing scheduled appointments without showing good cause
2. Not following housing stability plan and/or goals and objectives
3. Not providing information concerning changes in household and/or income within 10 (ten) days of the change
4. Violation of rental agreement/lease/contract
5. Non-payment of tenant's portion of rent
6. Lack of contact with staff within a 30-day period
7. Unauthorized person (s) living in the subsidized unit
8. Not reporting increased income

THE FOLLOWING CONSTITUTES AUTOMATIC PROGRAM TERMINATION

1. Eviction from rental unit with "cause"
2. Fraud
3. Abandonment of rental unit
4. Damage to rental or motel unit
5. Refusing housekeeping services at the motel/hotel

This list is a guideline only and may not include all non-compliance issues. Each case will be dealt with on an individual basis and may result in a written warning(s), probationary status or up to and including immediate termination. Please sign below that you understand the contents of this form.

Client Signature **Date** **Staff Initials**

BENTON AND FRANKLIN COUNTIES
DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION TO RELEASE INFORMATION

Applicant's Last Name (please print)	First Name	M.I.	Date of Birth

I hereby authorize the Benton and Franklin Counties Dept. of Human Services to provide information to the following agencies for the purposes such as the verification of rent, residential placement, property management issues, or housing stability goals directly related to participation in the BFDHS Housing Program.

Agency Name	*Contact Person*	*Address*	*Phone Number*	*Fax Number*
Kennewick Housing Authority	**Amanda * anyone at KHA**	**1915 W 4th Place Kennewick, Wa 99336**	**509.586.8576**	**509.582.7544**
Pasco Housing Authority	**Dawn *anyone at PHA**	**2505 W Lewis St Pasco, Wa 99301**	**509.547.3581**	**509.547.4997**

This request and authorization applies to (check items)

_____Face sheet
_____Treatment Plans
_____Progress notes
_____Discharge Summary
__X__Other (Specify): Housing

_____Physicians
_____Psychiatric evaluation
_____Initial Intake
_____Medication use and related information

I understand that my records are protected under Washington State Law and cannot be disclosed without my written consent unless otherwise provided for in the regulations. **This release is good for 365 days unless updated and may be revoked in writing at any time except to the extent that action has already been taken based on this authorization.**

____ ______________

Client signature/Authorized Representative (Relation to client) Date

____ ______________

Staff signature Date

2nd adult

Client Release of Information and Informed Consent

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation; 3) are being served in a program that requires disclosure of HIV/AIDS status (i.e.; HOPWA); or 4) under 13 with no parent or guardian available to consent to enter the minor's information in HMIS.
If this applies to you, ***STOP- Do not sign this form****.*

This agency participates in the Washington State Homeless Management Information System (HMIS) by collecting information, over time, about the characteristics and service needs of people facing homelessness. **RCW 43.185C.180 and RCW 43.185C.030**

- To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Washington State. In order to insure that clients are not counted twice, we need to collect four pieces of personally identifying information. Specifically, we collect: **name, birth date, and race/ethnicity.** You may also choose to provide your social security number. However, signing this form does not require you to do so. Your information will be stored in our database for 7 years after the last date of service. If you have questions about collection of data or your rights regarding your personally identifying information, contact the HMIS System Administrator at: (360) 688-4534 or HMIS@commerce.wa.gov

- We use strict security policies designed to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and two-factor authentication required for each system user. There is a small risk of a security breach, and someone might obtain and use your information inappropriately. If you ever suspect the data in HMIS has been misused, immediately contact the HMIS System Administrator at: (360) 688-4534 or HMIS@commerce.wa.gov

- The data you provide may be combined with data from the Washington State Department of Social and Health Services (DSHS) and Education Research and Data Center for the purpose of further analysis. Your name and other identifying information will not be included in any reports or publications. Only a limited number of staff members, who have signed confidentiality agreements, will be able to see this information. Your information will not be used to determine eligibility for DSHS programs. Washington State HMIS system administrators have full access to all information in HMIS. This includes the Department of Commerce staff, designated HMIS system administrators, and the software vendor.

- By signing this form, you acknowledge and allow Department of Commerce staff to obtain additional records of information from other state agencies with which there is a data sharing agreement (DSA) on file between Commerce and the other agency. Our DSA guides data transfer and storage security protocols. If DSAs are in place, Commerce is authorized by you to obtain, add to HMIS, and use for evaluation purposes any other data you have provided to other Washington state agencies.

- Your decision to participate in the HMIS will not affect the quality or quantity of services you are eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter or housing. However, if you do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders MAY require that you consent to provide your personally identifying information in HMIS in order for you to receive services from that funding source.

I understand the above statements and consent to the inclusion of personally identifying information in HMIS about me and any dependents listed below, and authorize information collected to be shared with partner agencies. I understand that my personally identifying information will not be made public and will only be used with strict confidentiality. I also understand that I may withdraw my consent at any time by filing a 'Client Revocation of Consent' form with this agency. I understand that I may obtain a copy of my signed consent form from this Agency (including forms signed electronically).

Dependent children under 18 in household, if any (Please print first and last names):

____________________ ____________________

____________________ ____________________

Client Signature (Parent/Guardian) — Date

Client Name (Print clearly) — Agency Staff Name (Print clearly) Initials

Client refused consent ________ (Agency Staff Initials) **HMIS Unique Identifier (optional) __________**

This form may not be amended except by approval of the Washington State Department of Commerce
Approved as to form by Sandra Adix, Assistant Attorney General, 6/5/2018

Client Release of Information and Informed Consent

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation; 3) are being served in a program that requires disclosure of HIV/AIDS status (i.e.; HOPWA); or 4) under 13 with no parent or guardian available to consent to enter the minor's information in HMIS.
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- To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Washington State. In order to insure that clients are not counted twice, we need to collect four pieces of personally identifying information. Specifically, we collect: **name, birth date, and race/ethnicity.** You may also choose to provide your social security number. However, signing this form does not require you to do so. Your information will be stored in our database for 7 years after the last date of service. If you have questions about collection of data or your rights regarding your personally identifying information, contact the HMIS System Administrator at: (360) 688-4534 or HMIS@commerce.wa.gov

- We use strict security policies designed to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and two-factor authentication required for each system user. There is a small risk of a security breach, and someone might obtain and use your information inappropriately. If you ever suspect the data in HMIS has been misused, immediately contact the HMIS System Administrator at: (360) 688-4534 or HMIS@commerce.wa.gov

- The data you provide may be combined with data from the Washington State Department of Social and Health Services (DSHS) and Education Research and Data Center for the purpose of further analysis. Your name and other identifying information will not be included in any reports or publications. Only a limited number of staff members, who have signed confidentiality agreements, will be able to see this information. Your information will not be used to determine eligibility for DSHS programs. Washington State HMIS system administrators have full access to all information in HMIS. This includes the Department of Commerce staff, designated HMIS system administrators, and the software vendor.

- By signing this form, you acknowledge and allow Department of Commerce staff to obtain additional records of information from other state agencies with which there is a data sharing agreement (DSA) on file between Commerce and the other agency. Our DSA guides data transfer and storage security protocols. If DSAs are in place, Commerce is authorized by you to obtain, add to HMIS, and use for evaluation purposes any other data you have provided to other Washington state agencies.

- Your decision to participate in the HMIS will not affect the quality or quantity of services you are eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter or housing. However, if you do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders MAY require that you consent to provide your personally identifying information in HMIS in order for you to receive services from that funding source.

I understand the above statements and consent to the inclusion of personally identifying information in HMIS about me and any dependents listed below, and authorize information collected to be shared with partner agencies. I understand that my personally identifying information will not be made public and will only be used with strict confidentiality. I also understand that I may withdraw my consent at any time by filing a 'Client Revocation of Consent' form with this agency. I understand that I may obtain a copy of my signed consent form from this Agency (including forms signed electronically).

Dependent children under 18 in household, if any (Please print first and last names):

______________________ ______________________

______________________ ______________________

______________________ ______________________

Client Signature (Parent/Guardian) Date

______________________ ______________________

Client Name (Print clearly) Agency Staff Name (Print clearly) Initials

Client refused consent ________ **(Agency Staff Initials)** **HMIS Unique Identifier (optional)** ____________

This form may not be amended except by approval of the Washington State Department of Commerce
Approved as to form by Sandra Adix, Assistant Attorney General, 6/5/2018

Client Identification				
NAME		DATE OF BIRTH	IDENTIFICATION NUMBER	
ADDRESS		CITY	STATE	ZIP CODE
TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION			

Consent

Notice to Clients: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

Consent

1. I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I also grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or electronically, by mail, or hand delivery.

   Reason for Disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.

   Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

   - ☐ Health care providers: ____________________
   - ☐ Mental health care providers: ____________________
   - ☐ Substance use disorder service providers: ____________________
   - ☐ Other DSHS contracted providers: ____________________
   - ☐ Housing programs: ____________________
   - ☐ School districts or colleges: ____________________
   - ☐ Department of Corrections: ____________________
   - ☐ Employment Security Department and its employment partners: ____________________
   - ☐ Social Security Administration or other federal agency: ____________________
   - ☐ See attached list
   - ☐ Other:

2. Reason for disclosure: ☐ Continuity of care ☐ Legal ☐ Personal ☐ Other:

3. I authorize and consent to sharing the following records and information (check all that apply):
   - ☐ All my client records ☐ Records on attached list
   - ☐ Only the following records
     - ☐ Family, social and employment history
     - ☐ Treatment or care plans
     - ☐ Payment records
     - ☐ Individual assessments
     - ☐ School, education, and training
     - ☐ Mental health care information (specify):
     - ☐ Health care information (specify):
     - ☐ Other (list):

Client Identification		
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER

Please note: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Substance Use Disorder

- **This consent is valid for one-year or ☐ until _______________ (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE		DATE
WITNESS / NOTARY SIGNATURE, IF APPLICABLE	WITNESS / NOTARY PRINTED NAME	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

Notice to Recipients of Information: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to **drug or alcohol abuse** by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Screening Tool

Phone #			
Last Known Permanent Address			
Length of stay at above address	☐1 night ☐ 2-6 nights ☐ 1 week or less ☐ less than month ☐ 30-90 days ☐ 90 days-1 year ☐ 1 year or longer		
# of People in household		**Do you receive:**	☐ Medicaid ☐ State Insurance ☐ Food Stamps
Gross Monthly Income	$	**Source of Income**	

Name	**Date of birth**	**Gender**	**Race**	**Ethnicity Hispanic (H) or Non-Hispanic (N)**	**Social Security Number**

Please check the box that reflects your current housing situation.

(A) **Homeless Situations**	(C) **Institutional Situations**	(E) **Transitional & Permanent Housing**
☐ Place not meant for habitation ☐ Emergency Shelter (including hotel/motel paid for with an emergency voucher) ☐ Staying in a family member's room, apartment or house ☐ Staying in a friend's room, apartment or house **Length of stay in living situation:** ☐ 1 night ☐ 30-90 days ☐ 2-6 nights ☐ 90 days-1 year ☐ 1 week or less ☐ 1 year or longer ☐ less than month **(B)** **Date you became homeless:** **How many times homeless in the last 3 years?** ☐ One time ☐ Two times ☐ Three times ☐ Four times or more **Total number of months homeless**: ☐ One month or less ☐ 2-12 months ➡# of months: ________ ☐ More than 12 months	☐ Foster care home or group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center **(D)** **Do you have an eviction notice?** ☐ 30-day ☐ 20-day ☐ 14-day ☐ 3-day ☐ Court papers/Sherrif's notice	☐ Hotel/motel paid for without emergency voucher ☐ Owned by client, no ongoing subsidy ☐ Owned by client, with ongoing subsidy ☐ Permanent housing (other than Rapid Re-Housing) for formally homeless persons ☐ Rental by client, no ongoing subsidy ☐ Rental by client, with VASH subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Residential project or halfway house with no homeless criteria ☐ Transitional housing for homeless persons (including homeless youth)

(F)	Yes	No	Explanation/notes
Children 16 and under in the home?			How many?
Persons over 60 in the home?			How many?
(G)			
Anyone in the household have a **Developmental Disability**? If yes, explain.			
Anyone in the household have a **Chronic Health Condition.** Are they receiving SSI or ABD? If yes, explain.			
Anyone in the household have a diagnosed **Mental Health Condition** that they are receiving treatment for? Are they engaged in mental health services? If yes, explain.			
Anyone in the household have a ☐ **drug problem?** ☐ **alcohol problem?** ☐ **both alcohol and drug problem**? Are they engaged in treatment?			
Fleeing violence, sexual assault, stalking, etc.			Last occurrence:
Has anyone in your household served in the US armed forces?			**Branch:** **Dates of Service:** **Discharge status/character:**

Notes: Use this space to explain your current hardship and why you cannot pay your rent.

May we look up your benefits with DSHS and enter your information into our database? ☐Yes ☐No

Client signature **Client print name** Date

BENTON COUNTY
DEPARTMENT OF HUMAN SERVICES

Housing Stability and Subsidy Plan **HMIS #______________**

Name:			
Current Address:			
Length Of Time At Current Address:		Household Size:	
Applied to Kennewick Housing Authority	Yes□ No□	Applied to Pasco Housing Authority	Yes□ No□

**If client is eligible, and has not applied to at least one housing authority, this must be a goal.*

Housing Goals and Steps:	***Date to be Completed***
1) Maintain stable housing	
a)	
b)	
c)	
2) Other	
a)	
b)	
c)	

Subsidy

Date: ___________100% subsidy ______________________________________

Date:____________Graduated subsidy ____________________________________

Date:____________ Graduated subsidy ____________________________________

Date:____________ Graduated subsidy ____________________________________

My signature below indicates my agreement with and commitment to this Housing Plan. I recognize that with my consent, my Case Manager may revise this housing plan over time.

Client signature: ___________________________________ **Date**: _______________

BFDHS staff signature: ______________________________ **Date**: _______________

Consolidated Homeless Grant
Self-Declaration Form

Complete this form to document housing status or income, when applicable.

☐ Homelessness – In the narrative include information about household's primary nighttime residence (where they sleep the majority of the time) and if exiting a system of care narrative must also include information on homelessness prior to system of care entry.

If fleeing violence, indicate in the narrative "fleeing violence." No additional information is required.

☐ At Risk of Homelessness – Refer to *Verification of Household Eligibility and Income Recertification Form* for information that needs to be included in narrative based on housing situation.

☐ Chronic Homelessness – Client must attest to chronic homelessness. **In addition, the case manager must provide written documentation of the living situation and duration/frequency, and the steps taken to obtain the standard evidence allowable for chronic homelessness. This additional documentation must be in the client file.*

☐ Income – In the narrative include details on source of income, income amount, and frequency of income. *In addition, case manager must document attempts to obtain written and verbal verification. This additional documentation must be in the client file.*

☐ No Income – Indicate in the narrative "no income."

Client Name	
HMIS Client Identifier	
Date	
Narrative	
Client Signature	

Chronic Homelessness- for Permanent Supportive Housing **(see additional documentation required from case manager above)*

Client Attestation	
I, ______________________________, have experienced being homeless for the last 12 months in which I lived in a place not meant for human habitation or in an emergency shelter, or on at least four separate occasions in the last three years, I was homeless for a total of at least 12 months.	
Client Signature	
Case Manager Signature	

Benton & Franklin Counties
Dept. of Human Services
7102 W. Okanogan Pl., Ste. 201
Kennewick, WA 99336
Phone: (509) 783-5284
Fax: (509) 783-5981

Habitability Complaint Procedure Notification

If you have a compliant regarding the safety or habitability of the house/apartment/unit you are living in, please notify our office right away.

Step One: Notify us in writing the nature of your complaint. Please include dates and a detailed description of your concerns.

Step Two: Our office will contact the landlord within 7 business days regarding your compliant/concern and ask them to schedule a mandatory Housing Habitability Standards inspection or a Housing Quality Standards inspection. We will coordinate the inspection with you and the landlord. If no inspection is needed and a phone call will resolve this matter your case manager will note it in your file.

_________ **please note that this will not affect your housing program eligibility.**
Client Initials

Step Three: You and your landlord will receive a copy of the housing inspection along with a letter determining the results of the inspection. If the landlord fails to comply with our housing standards, we will put you on a new housing search.

If you have any questions, please feel free to ask our staff.

Client Signature: ______________________________ Date: ____________

Staff Signature: ______________________________ Date: ____________

Consolidated Homeless Grant
Certification of Payment Obligation

Washington State Department of Commerce
July 2025

"Landlord" includes property manager/owner or other person authorized to seek rent payment, including friend/family.

Instructions for service provider if tenant is applying: Complete Sections 1, 2, and 3 with head of household. Service provider gathers necessary information to complete Section 4. Head of household certifies Section 5. Landlord certifies Section 6.

Instructions for landlord if landlord is applying on behalf of tenant: Complete Sections 1, 2, 3, and 4. Service provider works with tenant to complete Section 5. Landlord certifies Section 6. The service provider will contact the tenant to determine eligibility. Submitting this form does not guarantee payment.

1. Household Housing Status (check one)

☐ Household currently lives with friend/family and owes rent

☐ Household is moving in with friend/family
Move In Date: _______________

☐ Landlord is applying on behalf of tenant to collect past due rent

2. Household Information			
Name			
Phone		Email	
Address where household is staying or will stay			
Street			
City		State/ZIP Code	
3. Landlord Information			
Name			
Phone		Email	
Address where rent payment should be sent			
Street			
City		State/Zip Code	

4. Rental and Payment Information			
☐ Agreement End Date _______________(enter date) **OR** ☐ Month-to-Month		# Bedrooms	
Monthly Payments			
Monthly Rent Amount			
Monthly Utility Amount		Monthly Utility Amount	
Past Due, including current month			
Rent	Total amount due		
	Months for which payment is due		
Utilities	Total amount due		
	Months for which payment is due		
Complete the following for utility payments			
Utility provider			
Account number			
Utility provider			
Account number			

5. Household Certification	
I certify that the above information is true and accurate to the best of my knowledge.	
Signature	***Date***
6. Landlord Certification	
I certify that I will accept the above payment(s) to provide housing for the household, and I understand the definition of fraud and that committing fraud is a criminal act.	
Signature	***Date***

Rental assistance programs are obligated to report fraud to law enforcement, the Attorney General's Office, and the Department of Commerce. Fraud is a criminal act in which individuals, groups, or businesses steal taxpayers' monies from local State and Federal programs. Tenants and landlords who make false statements regarding their income or family size, alter official documents, or provide otherwise false information in order to collect rent payments, are committing fraud.

Consolidated Homeless Grant
Landlord Habitability Standards Certification Form

Rental Address ____

Client/Tenant Name ____

I, as landlord/owner/lessor/sub lessor or designated representative, of the above address, certify that the above dwelling meets all relevant provisions outlined in Landlord Tenant Act (Title 59 RCW) attached. Failure to comply with state law may result in termination of rental assistance payments.

When was the rental unit built?

☐ Prior to 1978 ☐ Visual Inspection done by Benton County Dept of Human Services

☐ 1978 or later

☐ N/A-Lot Rent Only

I completed a move in/move out condition report.

☐ Yes, initials: _______

☐ No*

Landlord / Owner Signature ______________________________ Date ____________________

Landlord / Owner Name Printed ____________________________

Phone ____________________________

Benton County Department of Human Services reserves the right to visually inspect any unit receiving rental assistance payments to review compliance with this certification and a lead-based paint inspection if the household composition changes and a child 6 or under occupies the home.

(for HRC use only)

Final FY 2026 & Final FY 2025 FMRs By Unit Bedrooms					
Year	Efficiency	One-Bedroom	Two-Bedroom	Three-Bedroom	Four-Bedroom
2026 FMR	$1,122	$1,268	$1,538	$2,071	$2,385
2025 FMR	$1,101	$1,236	$1,503	$2,003	$2,318