

811 Project Rental Assistance Referral Form

This referral form must be completed for any individual seeking housing under the 811 Project Rental Assistance (PRA) grant. There will be project-based units and mobile vouchers available to the priority populations. Only staff who have completed training on the 811 PRA Demo project will be permitted to make referrals.

To be found eligible, individuals must meet the program guidelines including:

- Member of grant target population
- Income limits
- Asset limits
- Criminal records
- Citizenship
- Meet screening criteria of the referred property

Additional supporting documentation will be required for eligibility determination. Please note that this form is used to gain access to the waiting list.

For Category 1 individuals, please submit this form to the Regional Housing Coordinator in your region.

For Category 2-4, please submit this form to the Statewide Housing Partnership Coordinator.

For a step-by-step guide on the referral process, please see the attached form entitled “Housing Lease Up Step-By-Step.”

FOR MORE INFORMATION, PLEASE CONTACT THE STATEWIDE HOUSING PARTNERSHIP COORDINATOR AT:

COURTENAY LOISELLE
(617) 204-3727
COURTENAY.LOISELLE@MASSMAIL.STATE.MA.US

811 PRA Unit Referral Form

Pages 2 and 3 of this referral form should be completed and send to the program person identified on the cover sheet when the individual seeking transition to the community is looking for subsidized housing and supportive services. It is a screening application for the 811 PRA funded projects, MRVP and HCVP specific to MFP participants. Depending on unit/voucher availability, full application and supporting documents may be required when this form is submitted.

Consumer Name: [Click here to enter text.](#)_____

Date Referred:_____

Date of Birth of Referred Individual:_____

Is this consumer between the ages of 18-61 (if older, the consumer is not eligible): Yes No

Social Security Number:_____

MassHealth Number:_____

Name of Institution/facility currently residing in (if applicable): _____

Address of institution/facility or current address if not currently in a facility:_____

Name of Guardian (if applicable): _____

Housing Type Requested: (see Housing Subsidy Fact Sheet for more information)

811 Project-Based Rental Assistance/HCVP Project-Based Unit

Massachusetts Rental Voucher Program

HCVP Mobile Voucher

Housing features needed (check all that apply):

Fully wheelchair accessible

Adaptable; identify what adaptations are needed: _____

Bedroom size: [Click here to enter text.](#)

Any other housing features needed? (please list) [Click here to enter text.](#)

Primary Sources of Funding for Ongoing Supportive Services (Check all that apply):

MFP Demonstration (if someone is Category I, this box must be checked)

Home and Community Based Services Waivers:

MFP Community Living Waiver

MFP Residential Supports Waiver *If checked, please list why the consumer applying for other housing options:*[Click here to enter text.](#)

Acquired Brain Injury (ABI) Non-Residential Habitation Waiver

Department of Developmental Services (DDS) Community Living Waiver

DDS Adult Supports Waiver

DDS Intensive Supports Waiver

Frail Elder Waiver

Traumatic Brain Injury (TBI) Waiver

Other Sources of Ongoing Supportive Services:

State-Funded Program (name agency)_____

Other (Specify)_____

Please note: Regional Housing Coordinator should be notified of any change in contact information immediately in order to avoid missed housing opportunities.

Verification of Eligibility for 811 PRA Unit

Consumer Name: _____

Consumer Date of Birth: _____

Individual’s Priority Category (Individual must be eligible for MassHealth Standard or CommonHealth Plans):

- Category I: Enrolled in Money Follows the Person Demonstration and residing in a qualified institution
- Category II: Residing in a long term care facility and eligible for a MassHealth 1915(c) Home and Community Based Services (HCBS) waiver but who are not eligible for the Money Follows the Person Demonstration
- Category III: Residing in a long term care facility and not eligible for either MFP Demonstration or a HCBS waiver
- Category IV: Living in the community and eligible for a HCBS waiver

By submitting this form on behalf of the consumer listed above, I am certifying that the individual (please initial):

- | | |
|----------------------|--|
| _____ (initial here) | 1. Meets the criteria to be eligible for the priority category listed above |
| _____ (initial here) | 2. Is a person with a disability |
| _____ (initial here) | 3. Is in need of ongoing supportive services |
| _____ (initial here) | 4. Is under the age of 62 |
| _____ (initial here) | 5. Is low income |

Name of Certifier: _____

Title of Certifier: _____

Signature of Certifier: _____

Phone Number of Certifier: _____

Email Address of Certifier: _____

If the Certifier is not the Transition Coordinator, please provide the Transition Coordinator name, phone number, and email address: _____

Reviewer (RHC staff person): _____

Demographic Information of Applicant

Please note this information is collected for use in analysis of program utilization. No demographic information will be connected to a specific person in data analysis. This information is voluntary.

Applicant's disability type:

- Elderly (aged 60-62 ONLY)
- Physical Disability
- Intellectual Disability/Developmental Disability
- Psychiatric Disability
- Refuse/Don't Know

Applicant's Gender:

- Male
- Female
- Refuse/Don't Know

Applicant's Race:

- White
- Black or African American
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Refuse/Don't Know

Applicant's Ethnicity:

- Hispanic
- Non-Hispanic
- Refuse/Don't Know

Does this applicant have children under 18 years of age?

- Yes
- No
- Refuse/Don't Know

If yes, does this applicant intend to live with these children upon discharge/moving to a subsidized unit?

- Yes
- No

What language does this applicant prefer to communicate in? Please list:

Did you have any challenges communicating with this applicant? Please list:

To be completed by the Regional Housing Coordinator Only:

Application Received Date/Time:

Notes :

Application Logged: Yes No

Eligible for subsidy? Yes No If no, why not: _____

If not eligible, has the Enrollee, HSE, and TC been informed? Yes No

Date informed:

If the enrollee selected 811 PRA or HCVP Project-based:

Property Referred to: _____

Did the RAA find the enrollee eligible? Yes No

If no, why not:

Date referred to property:

Accepted/Not accepted to property: _____

If not accepted, why not?

Move in date:

If the enrollee selected MRVP or mobile Section 8:

Date referred to RAA:

Did the RAA find the enrollee eligible? Yes No

If no, why not:

Voucher issuance date:

Voucher expiration date:

Any extensions given?

If yes, new expiration date:

Was the voucher utilized at a property? Yes No

If no, why not:

Property address leased with voucher: