**Other Agency Certification of Shelter and**

**Give this form to DTA**

* By Mail: DTA Document Processing Center,

P.O. Box 4406, Taunton, MA 02780‐0420

* By Fax: (617) 887‐8765
* Upload to the DTA Connect App
* In person at your local DTA office



**Utility Costs**

**Section A – Client’s Residential Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Last 4 Digits of Client’s SSN or Agency ID

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Residential Address City/Town State Zip Code

**Section B – Licensing Agency (Choose One)**

|  |  |  |
| --- | --- | --- |
| Department of Developmental Services | Department of Mental Health | Department of Public Health |
| Department of Children and Families | Department of Youth Services | MA Rehabilitation Commission |
| MA Commission for the Blind | MA Commission for the Deaf and Hard of Hearing | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section C – Facility Type (Choose One)**

|  |  |  |
| --- | --- | --- |
| State Operated - Group Home | State Operated - Independent Living | Vendor Operated - Group Home |
| Vendor Operated - Independent Living | Residential Drug Treatment Program | Residential Alcohol Treatment Program |
| Residential Teen Living Program | Halfway or Sober House | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section D – Household Information**

Does the client reside with his/her spouse or child(ren) in the Residential Facility?  Yes  No **→** If yes, please provide their names:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section E – Shelter and Utility Information**

1. Is the client responsible to pay for housing through his/her monthly charges for care OR separate billing?  Yes  No
2. If yes, how much is the client charged for housing costs each month? $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Is the client responsible to pay for utilities through his/her monthly charges for care OR separate billing?  Yes  No
4. If yes, which utilities does the client contribute towards? Please check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| Heating (seasonal) | Cooling (seasonal) | Electric | Gas (cooking fuel) |
| Water/Sewerage | Trash Removal | Phone (landline, cellular or prepaid) | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Other Agency Representative Name (Print) Other Agency Representative Signature Date

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