**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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