



Client Consent for Sharing of Your Information

By signing this form, you allow COHMIS partner agencies to share your personal information to coordinate housing and homelessness resources and related services on your behalf. Please read this form carefully and ask any questions you may have.

What is COHMIS?

COHMIS stands for the Colorado Homeless Management Information System. COHMIS is a system shared by partner agencies to store information about people who use homelessness services for purposes of providing better support for them. COHMIS is managed by the four Continuum of Care groups in the State of Colorado. They are Metro Denver (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson Counties), Pikes Peak (El Paso County) Northern Colorado (Larimer and Weld Counties), and Balance of State (Remaining 54 Colorado Counties).

Who may share my information?

The partner agencies who are allowed to share your information include county human and social services agencies, non-profit community groups, and other care coordination groups that you are receiving, or may receive, services from. A current list of partner agencies is available at <https://cohmis.zendesk.com>

How will my information be used?

The partner agencies may use your personal information for coordinating housing and homelessness resources and related services on your behalf. The Continuum of Care groups and partner agencies may use anonymous information (information that does not identify you) to do research, evaluate service programs, get funding, and for any other legal purposes related to the needs of the homeless community and people at risk of homelessness. The Continuum of Care groups and all partner agencies must keep your personal information confidential and follow all federal and state laws that apply to your information.

What information may be shared?

- Name, date of birth, gender, race, ethnicity, social security number, phone number, address
- Basic medical, mental health, substance use and daily living information
- Housing and program eligibility information
- Use of crisis services, veteran services, hospitals and jail
- Employment, income, insurance and benefits information
- Services provided by partner agencies
- Results from assessments
- Photograph or other likeness

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I have the right to know who has seen my information.
- I may see my information at any time and change it if it is wrong.
- I may cancel this consent at any time by filling out a revocation of consent form, which I can get from any partner agency.
- I may file a complaint if I think my information has been misused by filling out a grievance form, which I can get from any partner agency.
- I may refuse to share information with other agencies while retaining rights of access to this agency's services.
- If I refuse to share information, I may not be eligible to participate or receive services from some programs.
- I may have a copy of this form.
- This consent will expire seven years after this ROI is signed.

Printed Name of Participant or Guardian of Dependent:

Printed Name of Dependent Participants (if applicable):

Signature of Participant or Guardian:

Date: _____

Agency Name: _____

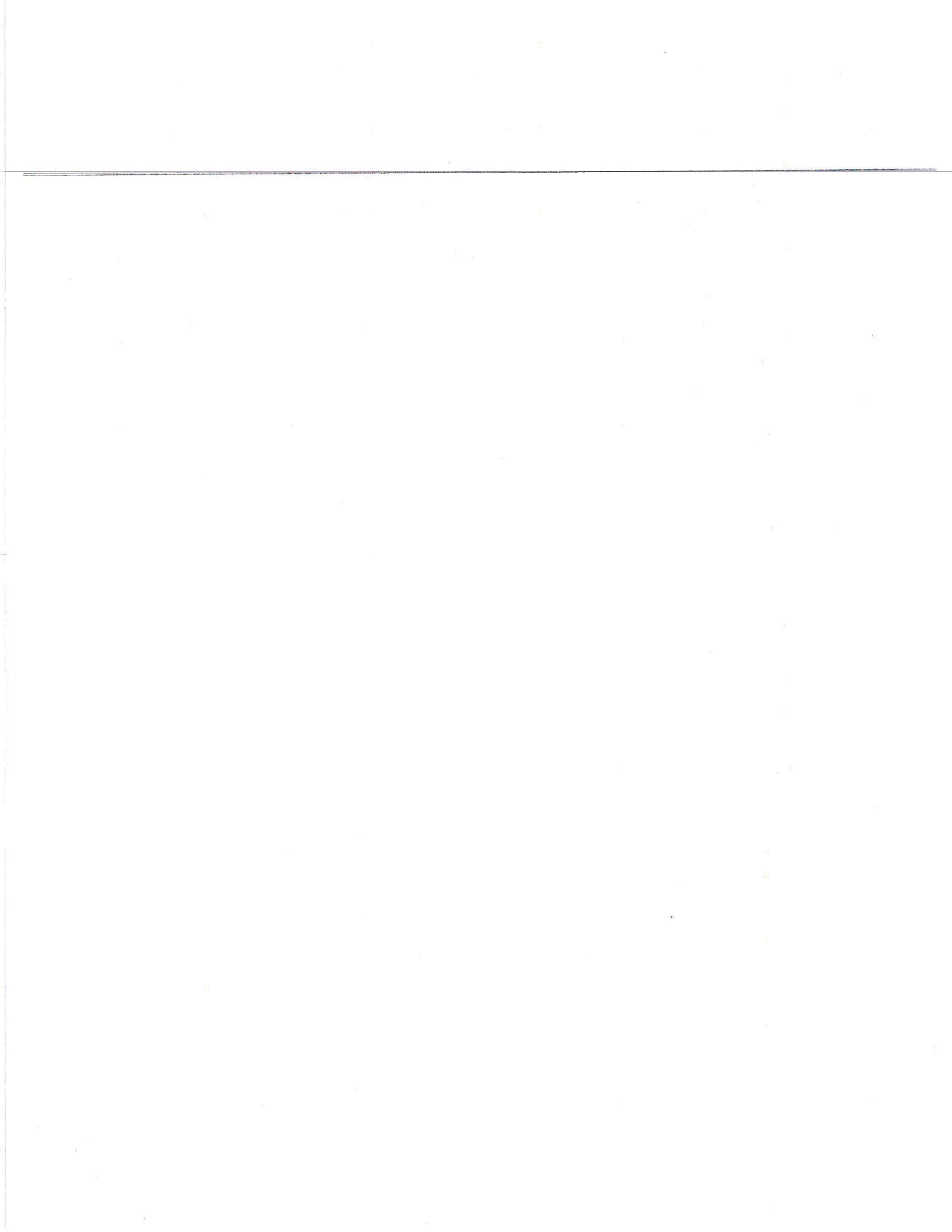
Agency Representative Name: _____

Agency Representative Signature: _____

Date: _____

Staff initials if Verbal consent was obtained: _____

Client initials if client is declining consent: _____



COHMIS Intake

CoC/ESG Intake Form for Project Types:

HMIS Permanent Housing (PSH, PH, RRH), Homelessness Prevention, Transitional Housing, Services Only

SOCIAL SECURITY NUMBER (SSN):									
Availability of SSN:		<input type="checkbox"/> Full SSN Reported			<input type="checkbox"/> Client doesn't know				
		<input type="checkbox"/> Approximate or partial SSN reported			<input type="checkbox"/> Client prefers not to answer				
					<input type="checkbox"/> Data not collected				
CLIENT NAME									
Last:									
First:									
Middle:					Suffix:				
AVAILABILITY OF NAME		<input type="checkbox"/> Full name reported			<input type="checkbox"/> Client doesn't know				
		<input type="checkbox"/> Partial, street name or code name reported			<input type="checkbox"/> Client prefers not to answer				
					<input type="checkbox"/> Data not collected				
DATE OF BIRTH (DOB)									
		MONTH		DAY		YEAR			
AVAILABILITY OF DOB		<input type="checkbox"/> Full DOB reported			<input type="checkbox"/> Client doesn't know				
		<input type="checkbox"/> Approximate or partial DOB reported			<input type="checkbox"/> Client prefers not to answer				
					<input type="checkbox"/> Data not collected				
GENDER (select all that apply)									
<input type="checkbox"/> Woman (Girl if child)			<input type="checkbox"/> Non-binary			<input type="checkbox"/> Client doesn't know			
<input type="checkbox"/> Man (Boy if child)			<input type="checkbox"/> Questioning			<input type="checkbox"/> Client prefers not to answer			
<input type="checkbox"/> Culturally Specific Identity (e.g., Two Spirit)			<input type="checkbox"/> Different Identity			<input type="checkbox"/> Data not collected			
<input type="checkbox"/> Transgender									
If different identity, please specify: _____									
CLIENT PRONOUNS									
<input type="checkbox"/> She/Her/Hers		<input type="checkbox"/> They/Them/Theirs		<input type="checkbox"/> Client prefers not to answer		<input type="checkbox"/> Other pronouns: _____			
<input type="checkbox"/> He/Him/His		<input type="checkbox"/> Client doesn't know		<input type="checkbox"/> Data not collected					
RACE/ETHNICITY (select all that apply)									
<input type="checkbox"/> American Indian, Alaska Native, or Indigenous		<input type="checkbox"/> Hispanic/Latina/e/o		<input type="checkbox"/> Client doesn't know					
		<input type="checkbox"/> Middle Eastern or North African		<input type="checkbox"/> Client prefers not to answer					
<input type="checkbox"/> Asian or Asian American		<input type="checkbox"/> Native Hawaiian or Pacific Islander		<input type="checkbox"/> Data not collected					
<input type="checkbox"/> Black, African American, or African		<input type="checkbox"/> White							
Additional Race and Ethnicity Detail (optional): _____									
VETERAN STATUS									
<input type="checkbox"/> Yes*		<input type="checkbox"/> Client doesn't know							
<input type="checkbox"/> No		<input type="checkbox"/> Client prefers not to answer							
<input type="checkbox"/> YES, complete the Veteran Supplemental Questions		<input type="checkbox"/> Data not collected							
RELATIONSHIP TO HEAD OF HOUSEHOLD									
<input type="checkbox"/> Self (Head of Household)		<input type="checkbox"/> Head of household's other relation member							
<input type="checkbox"/> Head of Household's Child		<input type="checkbox"/> Other: nonrelation member							
<input type="checkbox"/> Head of Household's spouse or partner									

Disabling Condition		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes	<input type="checkbox"/> Data not collected	
Physical Disability		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes*	<input type="checkbox"/> Data not collected	
*If YES for Physical Disability <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected
Developmental Disability		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes	<input type="checkbox"/> Data not collected	
Chronic Health Condition		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes*	<input type="checkbox"/> Data not collected	
*If YES for Chronic Health Condition <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected
HIV/AIDS		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes	<input type="checkbox"/> Data not collected	
Mental Health Disorder		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes*	<input type="checkbox"/> Data not collected	
*If YES for Mental Health Disorder <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected
Substance Use Disorder		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Alcohol Use Disorder*	<input type="checkbox"/> Data not collected	
<input type="checkbox"/> Drug Use Disorder*		
<input type="checkbox"/> Both Alcohol and Drug Use Disorder*		
*If YES for Substance Use Disorder <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected

SURVIVOR OF DOMESTIC VIOLENCE

- No
- Yes*

- Client doesn't know
- Client prefers not to answer
- Data not collected

***If YES to Survivor Domestic Violence**

When did this experience occur?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

CASH INCOME FOR INDIVIDUAL

Income from Any Source?	<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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***If YES to Income from Any Source – Indicate all sources that apply**

Income Source (Check all that apply)	Monthly Amount
<input type="checkbox"/> Earned Income (i.e. employment income)	
<input type="checkbox"/> Unemployment Insurance	
<input type="checkbox"/> Supplemental Security Income (SSI)	
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	
<input type="checkbox"/> VA Service-Connected Disability Compensation	
<input type="checkbox"/> VA Non-Service Connected Disability Pension	
<input type="checkbox"/> Private disability insurance	
<input type="checkbox"/> Worker's Compensation	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
<input type="checkbox"/> General Assistance (GA)	
<input type="checkbox"/> Retirement Income from Social Security	
<input type="checkbox"/> Pension or retirement income from a former job	
<input type="checkbox"/> Child support	
<input type="checkbox"/> Alimony and other spousal support	
<input type="checkbox"/> Other Cash Income (Specify: _____)	
Total Monthly Amount	

NON-CASH BENEFITS**Receiving Non-Cash Benefits?**

-
- No
-
-
- Yes*

-
- Client doesn't know
-
-
- Client prefers not to answer
-
-
- Data not collected

***If YES to Receiving Non-Cash Benefits – Indicate all sources that apply**

- | | |
|--|--|
| <input type="checkbox"/> Supplemental Nutrition Assistance Program | <input type="checkbox"/> TANF Transportation Services |
| <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | <input type="checkbox"/> Other TANF-Funded Services |
| <input type="checkbox"/> TANF Childcare Services | <input type="checkbox"/> Other Non-Cash Benefit
(Specify source: _____) |

HEALTH INSURANCE**Covered by health insurance?**

-
- No
-
-
- Yes*

-
- Client doesn't know
-
-
- Client prefers not to answer
-
-
- Data not collected

***If YES to Covered by Health Insurance – Indicate all sources that apply**

- | | |
|--|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Health Insurance Obtained Through COBRA |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Private Pay Health Insurance |
| <input type="checkbox"/> State Children's Health Insurance Program | <input type="checkbox"/> State Health Insurance for Adults |
| <input type="checkbox"/> Veteran's Health Administration (VHA) | <input type="checkbox"/> Indian Health Services Program |
| <input type="checkbox"/> Employer-Provided Health Insurance | <input type="checkbox"/> Other Health Insurance
(Specify source: _____) |

Would you like to share the reasons or factors you feel contributed to your homelessness?

-
- No
-
- Yes*

***If YES please indicate all reasons that apply**

- | | |
|--|---|
| <input type="checkbox"/> Abuse or violence in my home | <input type="checkbox"/> Lost a job, could not find work |
| <input type="checkbox"/> Alcohol or substance use problems | <input type="checkbox"/> Medical Expenses |
| <input type="checkbox"/> Asked to leave or evicted | <input type="checkbox"/> Mental health condition |
| <input type="checkbox"/> Bad credit | <input type="checkbox"/> Moved to find work |
| <input type="checkbox"/> Client Choice | <input type="checkbox"/> Problems with public benefits |
| <input type="checkbox"/> COVID-19 | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Disabling conditions | <input type="checkbox"/> Reasons related to my race or ethnicity |
| <input type="checkbox"/> Discharged from foster care | <input type="checkbox"/> Reasons related to my sexual orientation or gender |
| <input type="checkbox"/> Discharged from jail | <input type="checkbox"/> Relationship problems or family breakup |
| <input type="checkbox"/> Discharged from prison | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Family member or personal illness | <input type="checkbox"/> Unable to pay rent or mortgage |
| <input type="checkbox"/> Language barrier | <input type="checkbox"/> Unable to pay utilities |
| <input type="checkbox"/> Legal problems | <input type="checkbox"/> Other |

SEXUAL ORIENTATION (REQUIRED FOR PSH, OPTIONAL FOR OTHER PROJECT TYPES)

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Bisexual | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Questioning/Unsure | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Other | <input type="checkbox"/> Data not collected |

If other, please specify: _____

CONTACT INFORMATION (Optional — entered on the **Contacts** tab) Personal Work Message

Phone Number

Email

ADDRESS (Optional — entered on the **Locations** tab) Current Address Last Permanent Address
 Mailing Address

Street

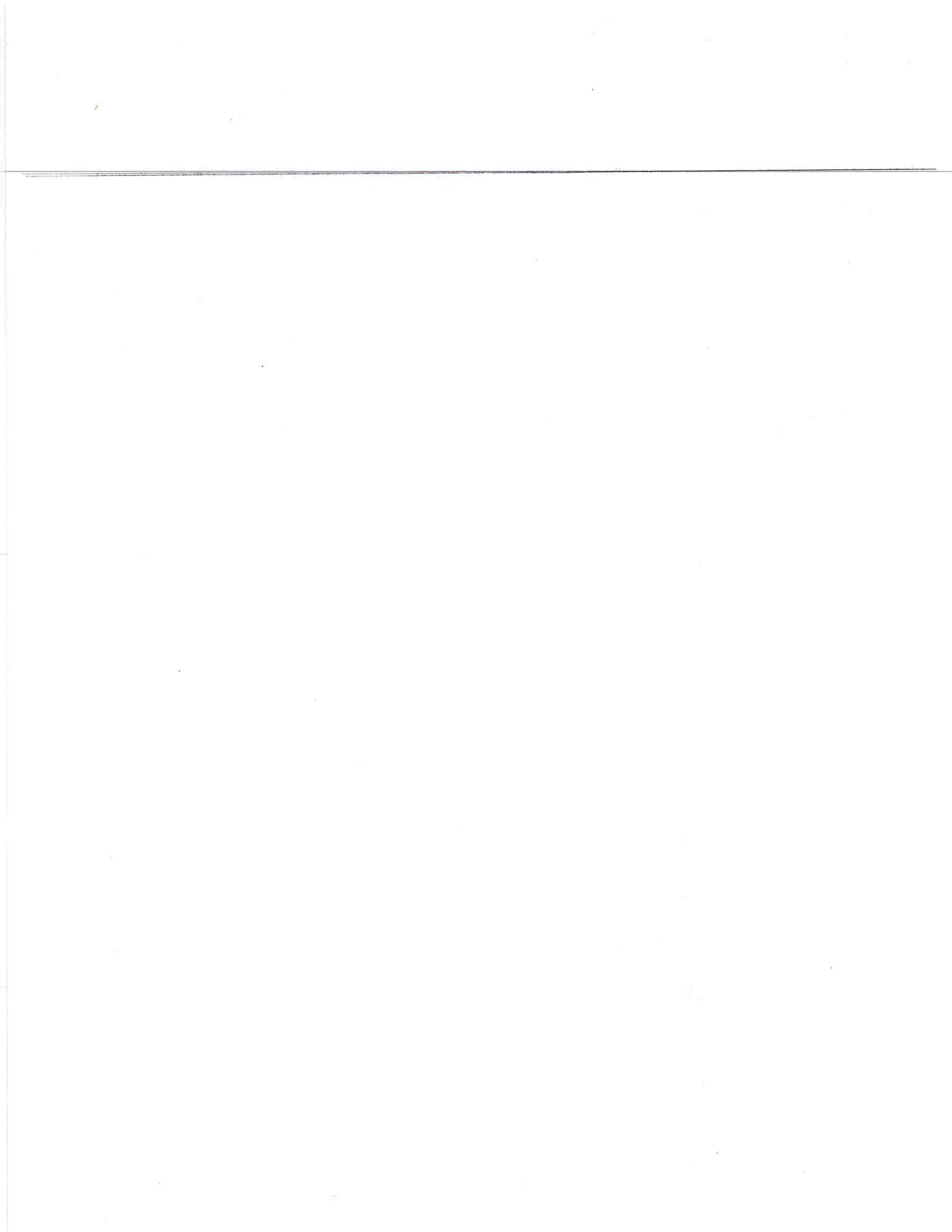
City

State

Zip Code

Signature of applicant stating all information is true and correct

Date





Family Reporting Form

Part 1: Household Members

List all individuals living in your unit:

Full Name	Relationship	Disability (check one)	Date of Birth	Age	Gender (check one)	Veteran (check one)
	Head of Household	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part 2: Contact Information:

Please provide your current contact information:

Home: () _____ Cell: () _____ Email Address: _____

Current Mailing Address: _____

(If Applicable)
 Representative Payee Name: _____ Representative Payee Phone Number: () _____



Part 3: Criminal Activity

Have you or any member of your household been convicted of the following crimes in the last 12 months?

Sexual offense Yes or No Violent criminal act Yes or No
 Methamphetamine production Yes or No Any felony crime Yes or No

Is any member of your household required to register as a sex offender? Yes No If yes, who? _____

Part 4: Income

Check all types of income your household receives:

<input type="checkbox"/> SSI	<input type="checkbox"/> Wages	<input type="checkbox"/> TANF	<input type="checkbox"/> Child Support
<input type="checkbox"/> SSI	<input type="checkbox"/> Day Labor	<input type="checkbox"/> OAP	<input type="checkbox"/> Income from Assets/Annuity
<input type="checkbox"/> Social Security	<input type="checkbox"/> Commission/Tips	<input type="checkbox"/> School financial aid	<input type="checkbox"/> Alimony/ Maintenance
<input type="checkbox"/> VA Benefits	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Money from family/friends	<input type="checkbox"/> Retirement/ Pension
<input type="checkbox"/> AND	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other

List all types of income each household member receives:

Household Member	Type of Income	Amount
		\$ per hr/wk/mo/yr (circle one)
		\$ per hr/wk/mo/yr (circle one)
		\$ per hr/wk/mo/yr (circle one)
		\$ per hr/wk/mo/yr (circle one)
		\$ per hr/wk/mo/yr (circle one)

1. Does anyone outside of your household assist you with paying your bills (cell phone payment, utility bills, groceries, etc)? Yes No
 If yes, who assists you? _____ How often? _____



2. If a household member receives child support payments and/or maintenance payments, are these payments received through the Family Support Registry? Yes No

If the payments are not received through the Family Support Registry, please provide the following information regarding your payments:

Name of person making payment: _____ Phone Number _____
 Address: _____

3. Do you or any household members work? Yes No (If yes, please provide the following information)

**** Attach copies of four current and consecutive pay stubs for each employer to this form.**

Family Member's name: _____ Name and Address of Employer: _____ Phone/Fax number: _____ Self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Start date: _____ Pay rate: _____ Number of hours: _____ How often are you paid? _____	Family Member's name: _____ Name and Address of Employer: _____ Phone/Fax number: _____ Self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Start date: _____ Pay rate: _____ Number of hours: _____ How often are you paid? _____
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4. Is any member of your household 18 years old or older and a full-time student? Yes No

If yes, name of family member: _____

Name of school attending: _____

Address of school: _____

Does this person receive student financial aid assistance? Yes No



Part 5: Assets

Check all types of assets or accounts your household currently has:

My household does not have any asset accounts

<input type="checkbox"/> Savings Account	<input type="checkbox"/> Stocks	<input type="checkbox"/> Certificates of Deposit	<input type="checkbox"/> Payee/escrow account
<input type="checkbox"/> Checking Account	<input type="checkbox"/> Bonds	<input type="checkbox"/> Own a home or land	<input type="checkbox"/> Other
<input type="checkbox"/> Trust Fund	<input type="checkbox"/> Money Market Funds	<input type="checkbox"/> Cash	<input type="checkbox"/> Other

For each asset account, please provide the following information:

Account Holder Name: _____	Account Holder Name: _____
Bank Name: _____	Bank Name: _____
Account Type: _____ Balance: _____	Account Type: _____ Balance: _____
Last 4 of Account Number _____	Last 4 of Account Number _____

Account Holder Name: _____	Account Holder Name: _____
Bank Name: _____	Bank Name: _____
Account Type: _____ Balance: _____	Account Type: _____ Balance: _____
Last 4 of Account Number _____	Last 4 of Account Number _____

Please provide a current statement for all accounts

1. Please list the address of any real estate (including land) that you own: _____
2. Have you closed any type of asset accounts in the last 12 months? Yes No If Yes: Date account closed: _____ (month and year)
If yes, please provide the name of the bank where the account was closed: _____ Type of account: _____

You must attach documentation verifying that the account has been closed



Part 6: Allowances

• Is anyone in your household paying for childcare for children 12 years of age or younger? Yes No If yes, please provide the following:

Family Member: _____ Amount paid: \$ _____ per month
 Child's Name: _____ Name of Provider: _____
 Provider Address: _____ Phone Number: _____

Please attach copies of receipts showing proof of payments

Disabled or Elderly Families Only (Head, Co-head or Spouse is 62 years or older or is a person with a disability)

If you (the Head of Household), your spouse, or co-head are at least 62 years old, or a person with a disability and the medical expenses you pay out-of-pocket each year is more than 3% of your annual income, Division of Housing (DOH) might be able to lower the amount of rent you pay.

Please attach proof of payments (12-month printout, receipts, etc.) for each of the expenses listed above.

Check all types of out of pocket medical expenses your family pays for and include the estimated amount paid each month:

<input type="checkbox"/> Prescription co-pays \$ _____ /month	<input type="checkbox"/> Doctor visit co-pays \$ _____ /month	<input type="checkbox"/> Insurance premiums \$ _____ /month	<input type="checkbox"/> Eyeglasses/ eye care payments \$ _____ /month	<input type="checkbox"/> Other _____ \$ _____ /month
<input type="checkbox"/> Dental payments \$ _____ /month	<input type="checkbox"/> Hearing Aid payments \$ _____ /month	<input type="checkbox"/> Hospital payment(s) \$ _____ /month	<input type="checkbox"/> Prescribed OTC medications \$ _____ /month	<input type="checkbox"/> Other _____ \$ _____ /month
<input type="checkbox"/> Transportation to treatment (cab fare, mileage, etc) \$ _____ /month	<input type="checkbox"/> Service Animal Costs \$ _____ /month	<input type="checkbox"/> Other _____ \$ _____ /month	<input type="checkbox"/> Other _____ \$ _____ /month	<input type="checkbox"/> Other _____ \$ _____ /month



Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

Applicant Name:	
Mailing Address:	
Telephone No:	Cell Phone No:
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	Cell Phone No:
E-Mail Address (if applicable):	
Relationship to Applicant:	
Reason for Contact: (Check all that apply)	
<input type="checkbox"/> Emergency	<input type="checkbox"/> Assist with Recertification Process
<input type="checkbox"/> Unable to contact you	<input type="checkbox"/> Change in lease terms
<input type="checkbox"/> Termination of rental assistance	<input type="checkbox"/> Change in house rules
<input type="checkbox"/> Eviction from unit	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Late payment of rent	
Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.	
Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.	
Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.	

Check this box if you choose not to provide the contact information.

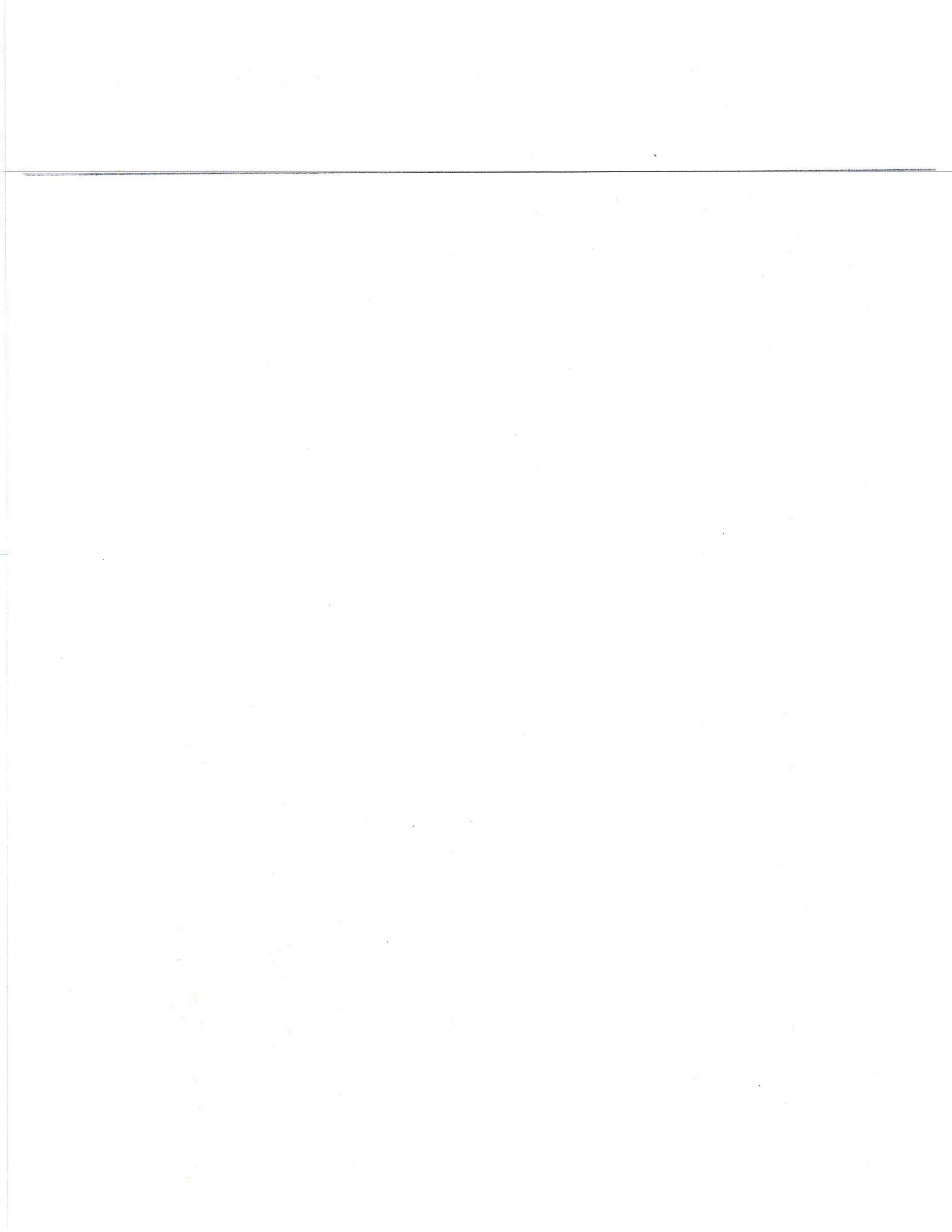
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Signature of Applicant

Date

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

Privacy Statement: Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.



**Authorization for the Release of Information/Privacy Act Notice to the U.S. Department of Housing and Urban
Development and the Housing Agency/Authority (HA)**
U.S. Department of Housing and Urban Development, Office of Public and Indian Housing

PHA or IHA requesting release of information (full address, name of contact person, and date):

Authority: Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544. This law requires you to sign a consent form authorizing: (1) HUD, and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; and (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service.

Section 104 of the Housing Opportunity and Modernization Act of 2016. The relevant provisions are found at 42 U.S.C. 1437n. This law requires you to sign a consent form authorizing the HA to request verification of any financial record from any financial institutions as defined in the Right to Financial Privacy Act (12 U.S.C. 3401)), whenever the HA determines the record is needed to determine an applicant's or participant's eligibility for assistance or level of benefits.

Purpose: In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form.
Private owners may not request or receive information authorized by this form.

Who Must Sign the Consent Form: Each member of your family who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the family or whenever members of the family become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

- Public Housing
- Housing Choice Voucher
- Section 8 Moderate Rehabilitation

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

Revocation of consent: If you revoke consent, the PHA will be unable to verify your information, although the data matches between HUD and other agencies will continue to automatically occur in the Enterprise Income Verification (EIV) System if the family is not terminated from the program.

Sources of Information to be Obtained

State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only) (This consent is limited to the wage and self-employment information and payments of retirement income as referenced at Section 6103(l)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages; and (b) financial institutions as defined in the Right to Financial Privacy Act (12 U.S.C. 3401), whenever the HA determines the record is needed to determine an applicant's or participant's eligibility for assistance or level of benefits. I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information.

Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.

This consent form remains effective until the earliest of (i) the rendering of a final adverse decision for an assistance applicant; (ii) the cessation of a participant's eligibility for assistance from HUD and the PHA; or (iii) The express revocation by the assistance applicant or recipient (or applicable family member) of the authorization, in a written notification to HUD or the PHA.

Signatures:

Head of Household	Date		
Social Security Number (if any) of Head of Household		Other Family Member over age 18	Date
Spouse	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date

Privacy Advisory. Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). Purpose: This form authorizes HUD and the above-named HA to request income information to verify your household's income in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent: HUD and the HA (or any employee of HUD or the HA) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD or the HA for the unauthorized disclosure or improper use.

OMB Burden Statement. The public reporting burden for this information collection is estimated to be 0.16 hours for new admissions and .08 hours for household members turning 19, including the time for reviewing, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Collection of information income and assets is required for program eligibility determination purposes. The submission of the consent form is necessary (form-HUD 9886) so that PHAs can carry out the requirements of Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 3544) and Section 104 of HOTMA to ensure that HUD and PHAs can verify eligibility and income information for applicants and participants. This information collection is protected from disclosure by the Privacy Act. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions to reduce this burden, to the Office of Public and Indian Housing, US. Department of Housing and Urban Development, Washington, DC 20410. When providing comments, please refer to OMB Approval No. 2577-0295. HUD may not conduct and sponsor, and a person is not required to respond to, a collection of information unless the collection displays a valid control number.



**AUTHORIZATION FOR THE RELEASE OF INFORMATION
 AND PRIVACY NOTICE**

Rental Assistance Programs

ORGANIZATION(S) REQUESTING RELEASE OF INFORMATION:

Colorado Division of Housing
 1313 Sherman St. Room 320
 Denver, CO 80203
 Phone (303) 864-7852 Fax (303) 864-7857

PURPOSE: The Colorado Department of Local Affairs, Division of Housing (DOH) may use this authorization and the information obtained within it to administer and enforce program rules and policies.

AUTHORIZATION: I authorize the release of any information (including documentation and other materials) pertaining to my eligibility for participation in, and/or the enforcement of DOH's housing programs. I authorize the above named organization to obtain information about me or my family that is pertinent to eligibility for, or participation in, assisted housing programs and to obtain information on wages or unemployment compensation from State Employment Agencies.

<p>Information Inquiries may be made about:</p> <ul style="list-style-type: none"> Child Care Expenses Credit History Criminal Activity Family Composition Employment, Income, Pensions, Assets Federal, State, County, or Local Benefits Handicapped Assistance Expenses Identity and Marital Status Medical Expenses Social Security Numbers Residences and Rental History 	<p>Individuals or Organizations That May Release Information:</p> <p>Any individual or organization including any governmental organization may be asked to release the following types of information:</p> <ul style="list-style-type: none"> Departments of Social Services Banks and Other Financial Institutions Courts, Credit Bureaus Law Enforcement Agencies Employers (Past and Present) Landlords (Past and Present) <p>Providers of:</p> <ul style="list-style-type: none"> Alimony, Child Care, Child Support, Credit, Handicapped Assistance, Medical Care, Pharmacies, Pensions/Annuities <ul style="list-style-type: none"> Schools and Colleges Dept. of Labor and Employment U.S. Social Security Administration U.S. Postal Service U.S. Department of Veterans Affairs Utility Companies
<p>Release to speak with a specific individual:</p> <p>Individual to be contacted:</p> <p>_____ <u>Desra McDonald</u> _____</p> <p>Agency:</p> <p>_____ <u>MHP</u> _____</p>	

COMPUTER MATCHING NOTICE AND CONSENT: I agree that DOH or the Department of Housing and Urban Development (HUD) may conduct computer-matching programs with other governmental agencies including Federal, State, Tribal or local agencies.

CONDITIONS:

- I agree that photocopies of this authorization may be used for the purposes stated above.
- I understand that each member of the household who is 18 years of age or older must sign the authorization.
- I understand that if I do not sign this authorization, my housing assistance may be denied or terminated.
- I understand that this authorization will expire 15 months from the date it is signed.

PRIVACY NOTICE: DOH uses your family income and other information to assist in managing and monitoring assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information will not be otherwise disclosed or released outside of DOH, except as permitted or required by law.

Warning: Section 1001 of Title 18, United States Code makes it a criminal offense to make willful, false statements of misrepresentation to any Department or Agency of the United States as to any matter within its jurisdiction.

SIGNATURES:

Head of Household (Print)	Signature	Date	Last 4 of SS Number
Co-Head / Spouse (Print)	Signature	Date	Last 4 of SS Number
Adult Family Member (Print)	Signature	Date	Last 4 of SS Number
Adult Family Member (Print)	Signature	Date	Last 4 of SS Number
Adult Family Member (Print)	Signature	Date	Last 4 of SS Number
Live-in-Aide (Print)	Signature	Date	Last 4 of SS Number



Your housing contact: NAME _____ EMAIL _____ PHONE _____

Statement of Understanding - DOH Federal Voucher Programs

You and your household members are responsible to know all of the information listed on this form. Division of Housing (DOH) may terminate assistance for violations of one or more of the following obligations:

1. Participants must supply all information requested by DOH and/or their housing coordinator.
 - a. You must report honestly, accurately and timely report changes in income,
 - b. changes in household members (members moving in or out),
 - c. all household member social security numbers; and,
 - d. all household members' evidence of citizenship or legal status.

DOH required information is not limited to those listed above.
2. The voucher program is a confidential program. We will not share information with others without your permission; however, your coordinator must be able to obtain and disclose necessary information with your current landlord and, when applicable, with new and former landlords.
3. You must notify your DOH housing coordinator of changes of income or family members moving out within 10 days of the change. If you have a case manager, reporting it only to your case manager is not enough, you must also report this to your DOH housing coordinator. Zero income forms are required for any adults in the household with no income.
4. No one can move into your home or stay for long periods without DOH approval BEFORE the person moves in. Reach out to your coordinator for this approval process. This request may be denied by DOH.
5. Your voucher may be in jeopardy if you damage the home you are renting.
6. Your voucher may be in jeopardy if you allow any of your utilities to be shut off (because you do not pay the bill).
7. Your voucher may be terminated or in jeopardy if you commit any violations of the lease, or get demand notices from your landlord.
8. You cannot enter into a second lease or side agreement with your landlord.
9. Our inspector or your coordinator will schedule an inspection of your unit yearly or once every two years. Once this appointment has been confirmed, you must allow us to enter and inspect the unit. Your voucher can be terminated if you are not home or do not allow us entry on the appointment date.
10. If you want to move once your lease is up, you must provide proper written notice to the landlord and to your DOH coordinator at least 60 days before moving.
11. If you receive an eviction notice or a rent increase notice, you must notify your DOH housing coordinator within 3 days.



12. You are only allowed to have one home in the program, and you must use your subsidized unit as your only residence.
13. You cannot rent out (sublease) the unit to another person/family; you cannot add a roommate without DOH approval first. You are not allowed to own the unit.
14. If you are going to be away from your unit for more than 30 days, you must continue to pay your rent and utilities and you must notify your housing coordinator of your intent to return to your home. If you have a case manager, reporting it only to your case manager is not enough, you must also report this to your DOH housing coordinator.
15. While in the program, you and/or your household members must not commit fraud, bribery or any other criminal act. Also, you and/or your household members must not engage in drug-related criminal activity or violent criminal activity.
16. Be a good neighbor. You and your household members must not abuse alcohol in a way that threatens the health, safety, or right to peaceful enjoyment of others.
17. You are only allowed one voucher assistance at a time and cannot receive other housing assistance for the same or different unit.

Other Causes for Termination or Denial of Assistance:

1. Any member of the household currently owes money to DOH or another public housing authority and/or fails to make payments toward their repayment agreement with DOH.
2. Any member of the household has made threats of violence or has engaged in abusive or violent behavior toward DOH staff, housing coordinator(s) and/or other agency staff.
3. Any member of the household is convicted of drug-related criminal activity for methamphetamine manufacturing.
4. Any member of the household is required to register as a sex offender.

A complete list of obligations may be found on the actual voucher.

Right to a Hearing

If a decision is made to terminate housing assistance, the participant will receive a written notice. The notice will advise the participant of a time limit by which they may request a hearing to appeal the decision.

I have read and understand all the information provided on this statement.

Head of Household Name - Printed

Head of Household Name - Signature

Date

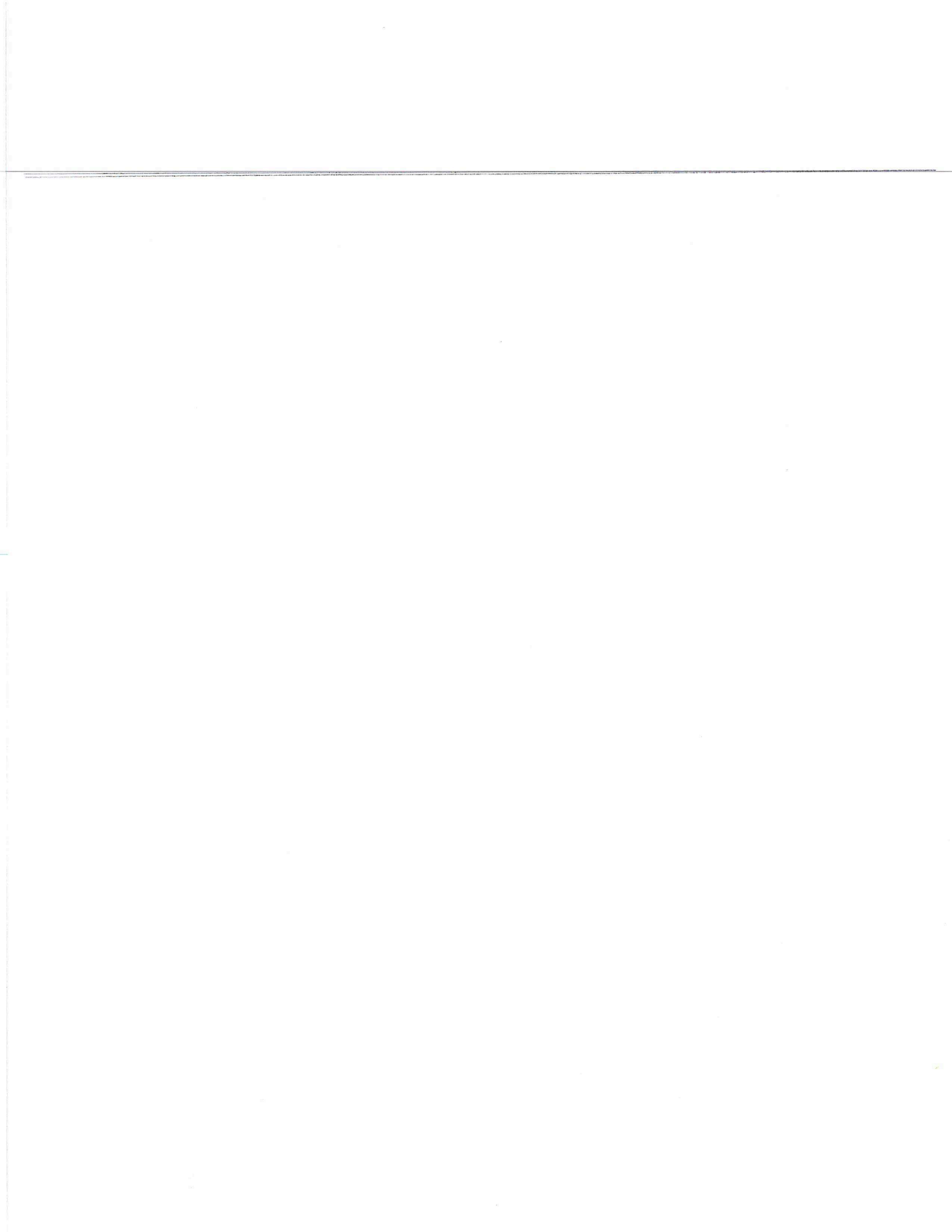
Other Household Member 18 years old or older - Signature

Date

Other Household Member 18 years old or older - Signature

Date





Request for Tenancy Approval
Housing Choice Voucher Program

U.S Department of Housing and
Urban Development
Office of Public and Indian Housing

OMB Approval No. 2577-0169
exp. 04/30/2026

When the participant selects a unit, the owner of the unit completes this form to provide the PHA with information about the unit. The information is used to determine if the unit is eligible for rental assistance.

1. Name of Public Housing Agency (PHA) <div style="font-size: 1.2em; font-family: cursive;">MHP for DOH</div>			2. Address of Unit (street address, unit #, city, state, zip code)				
3. Requested Lease Start Date	4. Number of Bedrooms	5. Year Constructed	6. Proposed Rent	7. Security Deposit Amt	8. Date Unit Available for Inspection <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
9. Structure Type <input type="checkbox"/> Single Family Detached (one family under one roof) <input type="checkbox"/> Semi-Detached (duplex, attached on one side) <input type="checkbox"/> Rowhouse/Townhouse (attached on two sides) <input type="checkbox"/> Low-rise apartment building (4 stories or fewer) <input type="checkbox"/> High-rise apartment building (5+ stories) <input type="checkbox"/> Manufactured Home (mobile home)			10. If this unit is subsidized, indicate type of subsidy: <input type="checkbox"/> Section 202 <input type="checkbox"/> Section 221(d)(3)(BMIR) <input type="checkbox"/> Tax Credit <input type="checkbox"/> HOME <input type="checkbox"/> Section 236 (insured or uninsured) <input type="checkbox"/> Section 515 Rural Development <input type="checkbox"/> Other (Describe Other Subsidy, including any state or local subsidy) _____				

11. Utilities and Appliances

The owner shall provide or pay for the utilities/appliances indicated below by an "O". The tenant shall provide or pay for the utilities/appliances indicated below by a "T". Unless otherwise specified below, the owner shall pay for all utilities and provide the refrigerator and range/microwave.

Item	Specify fuel type	Paid by
Heating	<input type="checkbox"/> Natural gas <input type="checkbox"/> Bottled gas <input type="checkbox"/> Electric <input type="checkbox"/> Heat Pump <input type="checkbox"/> Oil <input type="checkbox"/> Other	
Cooking	<input type="checkbox"/> Natural gas <input type="checkbox"/> Bottled gas <input type="checkbox"/> Electric <input type="checkbox"/> Other	
Water Heating	<input type="checkbox"/> Natural gas <input type="checkbox"/> Bottled gas <input type="checkbox"/> Electric <input type="checkbox"/> Oil <input type="checkbox"/> Other	
Other Electric	Mandatory Renters Insurance Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, monthly amount of Renters Insurance \$ _____ Are any utilities a flat monthly rate? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, which utilities _____ & monthly flat rate amount \$ _____	
Water		
Sewer		
Trash Collection		
Air Conditioning		
Other (specify)	List any additional required monthly fees: _____	
Refrigerator		
Range/Microwave		

12. Owner's Certifications

- a. The program regulation requires the PHA to certify that the rent charged to the housing choice voucher tenant is not more than the rent charged for other unassisted comparable units. Owners of projects with more than 4 units must complete the following section for most recently leased comparable unassisted units within the premises.

	Address and unit number	Date Rented	Rental Amount
1.			
2.			
3.			

- b. The owner (including a principal or other interested party) is not the parent, child, grandparent, grandchild, sister or brother of any member of the family, unless the PHA has determined (and has notified the owner and the family of such determination) that approving leasing of the unit, notwithstanding such relationship, would provide reasonable accommodation for a family member who is a person with disabilities.

- c. Check one of the following:

- Lead-based paint disclosure requirements do not apply because this property was built on or after January 1, 1978.
- The unit, common areas servicing the unit, and exterior painted surfaces associated with such unit or common areas have been found to be lead-based paint free by a lead-based paint inspector certified under the Federal certification program or under a federally accredited State certification program.
- A completed statement is attached containing disclosure of known information on lead-based paint and/or lead-based paint hazards in the unit, common areas or exterior painted surfaces, including a statement that the owner has provided the lead hazard information pamphlet to the family.

13. The PHA has not screened the family's behavior or suitability for tenancy. Such screening is the owner's responsibility.

14. The owner's lease must include word-for-word all provisions of the HUD tenancy addendum.

15. The PHA will arrange for inspection of the unit and will notify the owner and family if the unit is not approved.

OMB Burden Statement: The public reporting burden for this information collection is estimated to be 0.5 hours, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Collection of information about the unit features, owner name, and tenant name is voluntary. The information sets provides the PHA with information required to approve tenancy. Assurances of confidentiality are not provided under this collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions to reduce this burden, to the Office of Public and Indian Housing, US Department of Housing and Urban Development, Washington, DC 20410. HUD may not conduct and sponsor, and a person is not required to respond to, a collection of information unless the collection displays a valid control number.

Privacy Notice: The Department of Housing and Urban Development (HUD) is authorized to collect the information required on this form by 24 CFR 982.302. The form provides the PHA with information required to approve tenancy. The Personally Identifiable Information (PII) data collected on this form are not stored or retrieved within a system of record.

I/We, the undersigned, certify under penalty of perjury that the information provided above is true and correct. WARNING: Anyone who knowingly submits a false claim or makes a false statement is subject to criminal and/or civil penalties, including confinement for up to 5 years, fines, and civil and administrative penalties. (18 U.S.C. §§ 287, 1001, 1010, 1012; 31 U.S.C. §3729, 3802).

Print or Type Name of Owner/Owner Representative		Print or Type Name of Household Head	
Owner/Owner Representative Signature		Head of Household Signature	
Business Address		Present Address	
Telephone Number	Date (mm/dd/yyyy)	Telephone Number	Date (mm/dd/yyyy)

Landlord E-mail Address: _____