

Relocation Request Form

This request form should be completed by the service provider on behalf of a participant when requesting to relocate AND, the participant is eligible according to the Relocation Policy.

1. **FHSP Participant Information** Full Name: _____ CID: _____
2. **Current occupancy information** # of Bedrooms: _____ # of Bathrooms: _____ # of Household members _____
3. **Has the participant resided for at least 12 months (1 year) in their current unit?**
 Yes No
4. **Is the FHSP Participant currently in good standing with their housing? Good standing includes:**

<input checked="" type="checkbox"/> Up to date with Rent	<input type="checkbox"/> Yes
<input checked="" type="checkbox"/> No recent lease violations	<input type="checkbox"/> No - If no, please provide an explanation below
<input checked="" type="checkbox"/> No unauthorized guests	
<input checked="" type="checkbox"/> Unit is in good condition	

If you marked “No” the participant is not in good standing with their property provider, please summarize the current issues the household is experiencing including when the issues started, how they are being resolved and participant compliance:

5. **Is the FHSP Participant requesting Move-In Assistance in order to relocate?**
 Yes No

Please mark the reason(s) the participant would like to relocate:

<input checked="" type="checkbox"/>	Reason
<input type="checkbox"/>	Household Size Increase
<input type="checkbox"/>	Personal Preference
<input type="checkbox"/>	Eviction Prevention
<input type="checkbox"/>	Safety Concerns that pose imminent harm or threat to wellbeing
<input type="checkbox"/>	Domestic/Intimate Partner Violence
<input type="checkbox"/>	Landlord Negligence
<input type="checkbox"/>	<i>Reasonable Accommodations:</i> Health Related Issues (Requires letter from clinical provider)
<input type="checkbox"/>	Other:

Please provide a summary of the reason(s) the participant is requesting to relocate and the mitigation plan including but not limited to all attempted interventions, action plans in place, and any other supporting or relevant factors.

Summarize the reason for relocation:

All attempted interventions:

Action plans in place:

By signing this form, the service provider agrees that this information is accurate.

Service Provider Referral:

Name: _____

Signature: _____ Date: _____

Brilliant Corners Only:

Reviewed by: _____

Signature: _____ Date: _____

Funder Only:

Reviewed by: _____ Signature: _____

Approved Date: _____

Denied Date: _____