



MEMPHIS HOUSING AUTHORITY

700 Adams Avenue Memphis, Tennessee 38105 (901) 544-1100 (Main) (901) 544-1218 (Fax) www.MemphisHA.org

HOUSING CHOICE VOUCHER PROGRAM FAMILY UNIFICATION PROGRAM (FUP) REFERRAL FORM FOR THE MEMPHIS/SHELBY COUNTY CoC

Household Name:				Referral Date:			
Current Address:				Phone #:			
Relation	Last Name	First Name	MI	Sex	Social Security #	DOB	E/D*
HOH				<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Elderly <input type="checkbox"/> Disabled
				<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Elderly <input type="checkbox"/> Disabled
				<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Elderly <input type="checkbox"/> Disabled
				<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Elderly <input type="checkbox"/> Disabled
				<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Elderly <input type="checkbox"/> Disabled

Does youth need reasonable accommodations? Yes No ---- Does youth need: Wheelchair Accessibility Visual Impairment
 Hearing Impairment Separate Sleeping Quarters (HOH must be below 24 yrs old for youth voucher and disability is not necessary for eligibility.)

Relation: HOH – head of household; S – Spouse; Y – Youth under 18; A – Other Adult

I consent to permit the Memphis Housing Authority and the Tennessee Department of Children’s Services/Community Alliance for the Homeless to share information regarding my family composition, household income, assets, and any other information deemed necessary to determine my eligibility for participation in the Family Unification Program.

Signature: _____ **Date:** _____

Service Provider		
Name:	E-Mail:	Phone:
Referring Agency:		
<p>This client is a family/youth <input type="checkbox"/> for whom the lack of adequate housing is a primary factor in the imminent placement of the family’s child, or children, in out-of-home care, or in the delay of discharge of a child, or children, to the family from out-of-home care or <input checked="" type="checkbox"/> who is at least 18 years old, and not more than 24 years of age, and who has left foster care, or will leave foster care within 90 days, in accordance with a transition plan described in Section 475(5)(H) of the Social Security Act, and is homeless or at risk of becoming homeless at age 16 or older.</p>		

For DCS Housing Liaison Use Only: I certify that the above-household has been screened and meets the initial eligibility requirements for the Family Unification Program.

Name: _____ **Signature:** _____ **Date:** _____

- To refer a family or individual youth:
1. Fill out the MHA FUP Voucher Application
 2. Fill out the HUD-form 9886, Authorization for Release of Information (Found on CAFTH.org)
 3. Please email both forms to CAFTH’s CoC Coordinator, Kirsten Hipkins; kirsten@cafth.org
 4. You must include a brief description of how you are certifying that the individual is homeless or at-risk of homelessness in your email.

For HCVP Use Only:

Approved Denied/Reason: _____ Date: _____

