



Georgia Department of Human Services

Division of Family & Children Services

Housing Choice Voucher Referral Program for Foster Youth

Georgia Division of Family & Children Services in Collaboration with Georgia Public Housing Authorities

Applicant Information

Application Date: _____
Requested Housing Authority Jurisdiction: _____
If "Other" or "DCA", list specific housing jurisdiction area: _____
Applicant Full Name: (Head of Household)
First Name: _____ MI: _____ Last Name: _____
Date of Birth: _____ Cellphone Number: _____ ALT. Phone Number: _____
E-mail Address: _____ Last four of social security number: _____
Current Street Address: _____
City: _____ State: _____ Zip Code: _____

Referral Source Information

Referral Contact Name: _____
Cell Phone Number: _____ Alternate Contact Number: _____
E-mail Address: _____
Referral Source Type: _____
Community Partner Name (If Applicable): _____

Additional Household Members

Household Member Name	DOB	Age	M/F	Relationship to Head of Household (HOH)

Eligibility Criteria (Check all that Apply)

- ☐ Exiting Out of Foster Care in 90 Days Foster Care Exit Date: _____
☐ Exited Foster Care Foster Care Exit Date: _____
☐ Pregnant or Parenting ☐ Homeless ☐ Imminent Danger of Homelessness ☐ Couch Surfing

Prioritization Details (Check all That Apply)

☐ Domestic
Violence

☐ Overcrowded
Housing

☐ CSEC

☐ Mental Illness
History

Does the applicant have any disabilities as defined below: *Federal nondiscrimination laws define a person with a disability to include any (1) individual with a physical or mental impairment that substantially limits one or more major life activities; (2) individual with a record of such impairment; or (3) individual who is regarded as having such an impairment.* Disability Statement? _____

Is the applicant currently employed? _____ Is the household a zero-income household? _____
What other sources of income do you have? (SSI, Child Support, TANF, family donations, retirement, etc.) _____

Additional Living Conditions Comments (For example, are you facing eviction, when does your current lease end, are you living in a shelter, how long can you stay in the shelter, can you access housing with current income, are you currently in school?):

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Please complete this form and save the form using the "Save As Feature" (do NOT use the Print as PDF feature) and submit a copy to FYI.housing@dhs.ga.gov

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☐ Applicant Meets Criteria ☐ Applicant Does NOT Meet Criteria

Housing Choice Voucher Program: _____

Support Services Provider: _____

Support Services Provider Contact Name: _____

Support Services Provider E-mail: _____

I certify the information presented in this referral is accurate to the best of my knowledge and has been verified by the Georgia Division of Family & Children Services in accordance with the housing choice voucher referral criteria and guidelines.

Reviewed by DFCS Designee (Print Name) _____ Signature _____ Date _____

DFCS Administration Review (Print Name) _____ Signature _____ Date _____