Georgia Department of Human Services
Division of Family & Children Services

Housing Choice Voucher Referral Program

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

Applicant Information

Application Date: mm/dd/yyyy Requested Housing Authority Jurisdiction: Select

If "Other" or "DCA," list specific housing jurisdiction area:

Head of Household:

First Name: _____ MI: ____ Last Name: _____

Date of Birth: mm/dd/yyyy Mobile Number: _____ Alt. Phone Number: _____

E-mail Address: _____ SSN (last 4 digits): _____

Current Street Address: _____

City: _____ State: ____ Zip Code: _____

Referral Source Information

Referral Contact Name: _____

Mobile Number: _____ Alt. Phone Number: _____

Email Address: _____

Referral Source Type: Select

Community Partner Name (if applicable): _____

Additional Household Members

Household Member Name	DOB	Age	M/F	Relationship to Head of Household (HOH)
	mm/dd/yyyy		-	
	mm/dd/yyyy		-	
	mm/dd/yyyy		-	
	mm/dd/yyyy		-	
	mm/dd/yyyy		-	

Eligibility Criteria (check all that apply)

- ☐ Exiting Out of Foster Care in 90 Days
- ☐ Exited foster care
  Foster Care Exit Date: mm/dd/yyyy
- ☐ Pregnant or Parenting
- ☐ Homeless
- ☐ Family Preservation
- ☐ Imminent Danger of Homelessness
- ☐ Couch Surfing
- ☐ Family Reunification

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 individual with a physical or mental impairment that substantially limits one or more major life activities; an individual with a record of such impairment; or an individual who is regarded as having such an impairment.

Disability Statement? Select

Is the applicant currently employed? Select Is the household a zero-income household? Select

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 your current income? Are you currently in school?)

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: Select

Support Services Provider: _____

Support Services Provider Contact Name: _____

Support Services Provider Email: _____

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) _____ Digital Signature/Date

DFCS Administration Review (print name) _____ Digital Signature/Date