

**Delaware State Housing Authority  
State Rental Assistance Program Application Form**

**Eligibility:** Applicants must be 18 years of age (or within 60 days of 18<sup>th</sup> birthday) or older, must have access to continuing home- or community-based supportive services, and must meet household income guidelines of 30% of State Median Income or less (See Attached Eligibility Information for screening and income guidelines). Applications must be referred to DSHA by a representative of DHSS or DSCYF; **DSHA will not accept applications from the general public for the State Rental Assistance Program.** DSHA does not discriminate based upon race, color, creed, national origin, sex, age, handicap, or familial status.

**HEAD OF HOUSEHOLD INFORMATION**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **M.I.** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email (optional):** \_\_\_\_\_

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (mm/dd/yyyy) **Sex:** \_\_\_\_ **SSN:** \_\_\_\_\_

**Race:** \_\_\_ White \_\_\_ Black \_\_\_ American Indian/Alaskan \_\_\_ Asian \_\_\_ Hawaiian/Pacific Islander

**Ethnicity:** \_\_\_ Hispanic \_\_\_ Non-Hispanic

**Head or Co-Head Disabled (Y/N)?** \_\_\_\_\_ **Head or Co-Head Elderly (62 or older) (Y/N)?** \_\_\_\_\_

**Annual Household Income:** \$ \_\_\_\_\_

\*Total annual income of all persons in household. Includes employment, public assistance, social security, SSI, pensions, veterans' benefits, alimony, child support, unemployment, workman's compensation, military pay, and lottery winnings.

**List all other occupants who will be living in the unit (attach additional sheet of paper if needed):**

Name	DOB	Sex	Relationship to Head of Household
1.			
2.			
3.			
4.			
5.			
6.			

**SUPPORTIVE SERVICES AND CASE MANAGEMENT INFORMATION**

**Applicant is:**

(Check all that apply)

- Exiting a state- or privately-run long-term care facility
- Exiting the Delaware Psychiatric Center
- A young person between the ages of 18 and 21 years old who left foster care at age 16 or older, is receiving services from the Division of Family Services, and lacks affordable housing
- The head of a family for whom the lack of adequate housing is a barrier to family reunification
- At-risk of being admitted to, or of requiring supportive services from, a state-supported institution due to a lack of adequate and affordable housing

Name of Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Case Manager Address: \_\_\_\_\_

Case Manager Email: \_\_\_\_\_ Referring Agency: \_\_\_\_\_

Supportive Services Start Date: \_\_\_ / \_\_\_ / \_\_\_ End date (approx.): \_\_\_ / \_\_\_ / \_\_\_ OR: \_\_\_ Indefinite

Name of Service Provider: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Description of Supportive Services: \_\_\_\_\_

\_\_\_\_\_

Current Employment Status: \_\_\_ Not Employed \_\_\_ Part-time \_\_\_ Full-time \_\_\_\_\_ Hours/week

Place of Employment: \_\_\_\_\_

Current Education Status: \_\_\_ Not in School \_\_\_ Part-time \_\_\_ Full-time \_\_\_\_\_ Classroom hours/week

Type of Education (if enrolled): \_\_\_\_\_ Expected completion date: \_\_\_ / \_\_\_ / \_\_\_

### **SPECIAL UNIT REQUIREMENTS QUESTIONNAIRE**

Does the applicant or any members of the household need an accessible unit (Y/N)? \_\_\_\_\_

If Yes, check all that apply:

\_\_\_ Separate Bedroom \_\_\_ Unit for Vision Impaired \_\_\_ Unit for Hearing Impaired \_\_\_ One-Level Unit

\_\_\_ Barrier-Free Apartment \_\_\_ Bedroom/Bath on 1<sup>st</sup> Floor \_\_\_ Physical Modifications to a Typical Apartment

Can the applicant and all members of the household go up and down stairs unassisted (Y/N)? \_\_\_\_\_

Will the applicant or any members of the household require the assistance of a live-in aide (Y/N)? \_\_\_\_\_

By signing this application I acknowledge that I have read and understand this application and all attachments. I verify that the information contained herein is true and correct. I understand that incomplete or false answers may be grounds for ineligibility or lease termination. I hereby consent to Delaware State Housing Authority (DSHA) conducting an investigation of the information stated on this application, inclusive of information regarding my criminal background. I understand that it is my responsibility to contact DSHA if any of the information listed above changes. I UNDERSTAND MY NAME WILL BE TAKEN OFF THE WAITING LIST IF DSHA CANNOT CONTACT ME.

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Case Manager

\_\_\_\_\_  
Signature of Case Manager

\_\_\_\_\_  
Date

Mail or Fax Application Form to: [DSHA Program Coordinator]

Toll-Free Phone: 1-888-363-8808  
Fax: (302)739-6122  
TDD: (302)739-7482

## **ELIGIBILITY INFORMATION**

### **PRELIMINARY SCREENINGS**

If you or other household members:

- Have ever been evicted from federally-assisted housing;
- Owe any money to any public housing authority;
- Have been arrested in the past year or convicted in the past five years for either drug-related or violent criminal activity; or
- Have ever been convicted of manufacture or production of methamphetamine;
- Are subject to a registration requirement under a State sex offender registration program,

You MAY be ineligible for the State Rental Assistance Program. Call the office for more information. Toll free 1-888-363-8808.

### **INCOME ELIGIBILITY**

To be eligible for a State Rental Assistance Program subsidy, an applicant must be 18 years of age (or within 60 days of 18<sup>th</sup> birthday) or older, must have access to continuing home- or community-based supportive services, and must meet the Income Limits below:

<b>Household size</b>	<b>State Median Income</b>	<b>30%</b>
1	\$48,800	\$14,650
2	\$55,850	\$16,750
3	\$62,850	\$18,850
4	\$69,850	\$20,950
5	\$75,350	\$22,600
6	\$81,000	\$24,300
7	\$86,500	\$25,950
8	\$92,175	\$27,650

The maximum income limit for the Delaware State Rental Assistance Program is 30% of median income shown above.