Lane County Move On Continuum of Care Local Preference Referral Form

Email complete Referral Packet
to:
HSDHelpDesk@co.lane.or.us

Date: ________________________________

Referring Staff Name
and Organization: ____

Staff Phone Number and Email: _______________________________________

Client Documentation (check all that client currently possesses) This will be required within 14 business days of post-date on Section 8 packet. Valid legal identification Documentation of Social Documentation of Social Security Number	Documentation of Income (Social Security benefits, Employment, Other sources of income)	Documentation of disability (Social Security Insurance award letter, benefits letter etc.)	Verification of assets Verification of Live In Care provider

-Please remember to submit HUD form 92006 Emergency Contact with this Referral.
-We will be unable to send you correspondence regarding the applicant unless "Copies of Correspondence" is written and checked on the "Other" line on this form.

Applicant Name: ____

Applicant Social Security Number: ____

Applicant Mailing Address (Required): ____

Applicant Phone Number and Email: ____

Other Family Member Names and Ages: ____

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Check all that apply for applicant:

- At least one adult in the household has zero income
- This household has a Live in Aide
- Head of household has a disability
- Household needs an ADA unit

Preferred Method to Receive Section 8 packet:

- Mail to Referring Organization
- Mail to Applicant at above address
- Email: ______________________________
- Pick up at Day Island lobby