

FAAST Housing Referral & Needs Assessment Form

Please assist The Florida Alliance for Assistive Technology and Services (FAAST) to support you in your need for safe, accessible, and affordable housing by completing the following questions.

NAME of Client: _____

Sex: Male Female

Birth date: _____ **Age:** _____

ADDRESS: _____

County: _____

PHONE NUMBERS: Home Phone # _____ Cellular # _____

Name of Alternate Contact Person: _____

Relationship to you: _____ **Phone #:** _____

Please provide the name and phone number of the counselor assigned to you.

BSCIP Case Manager: _____ **Telephone #** _____

CMS Nurse: _____ **Telephone#** _____

DISABILITY: Please check the appropriate response:

Developmental Hearing Mobility Vision Speech

Learning Physical Other If other, describe _____

Current Housing Needs:

Affordable housing: Accessible housing: Home modifications: Home Ownership

What is your monthly income amount? \$ _____

Source(s) of income: Employment SSI SSDI Other _____

Are you a Section 8 Voucher recipient? Yes, monthly amount _____ No

Do you want us to contact you to assist you further with your housing concerns?

Yes: No: If yes, when is the best time to contact you between 9am to 5pm? _____

Thank you for your cooperation.

