Annual Self-Certification for Special Needs

Project Name: _____

Self-Certification Report Period:

From: _____ (date of last report) To: _____ (date of last report)

Contact Information:

Project Sponsor: _____ Phone: _____
Primary Service Provider: _____ Phone: _____

1. Changes During Report Period

Were there any changes in the financing of service programs during the reporting period that will affect the delivery of Special Needs Requirements:

☐ YES ☐ NO

If "YES" please discuss with the Asset Manager.

2. Current Resident Information

Number of households currently meeting special needs requirements _____
Total number of Apartment Community residents being served within special needs definition _____

3. Service Providers (please attach additional pages if needed)

Please list requested information for all service providers, whether individuals or organizations/institutions, and whether services are provided on site or off site.

Provider Name	Address	Phone Number	Contact Person

4. Service Utilization – Services Your Special Needs Program Offers

Please indicate the number of residents who have used each of the following services at least once during the reporting period (only those that apply to your special needs program). For workshops/classes, please show total, with break-out information in shaded cells (below).

_____	Service Coordinator	_____	Workshops and seminars
_____	Case management/crisis intervention	_____	Health and safety
_____	Mental health services	_____	Financial issues
_____	Individual/group counseling/support	_____	Access to communication
_____	Interpreter program services	_____	Other
_____	Medication monitoring/support	_____	Classes at local schools/colleges
_____	Information and referral	_____	Computer skills
_____	Health education, screening, assessment	_____	Life skills
_____	Nutrition services	_____	Employment skills
_____	Social/recreational activities	_____	Job training
_____	Legal services	_____	Other
_____	Assistive Animal/Devices	_____	Van transportation to services

Comments:

5. Service Budget Information

Please provide budget information for your previous and current fiscal years, including costs of staff and services combined

Previous year budgeted funding level:	FY: _____	$ _____
Previous year actual funding level:	FY: _____	$ _____
Current year budgeted funding level:	FY: _____	$ _____

6. Certification of Accuracy of Information Provided

I hereby certify that the information provided in this "Self-Certification for Special Needs" is true and correct and reflects the status of the Development as of the date of this report.

Signed by: _____ Date: _____

Title: _____

Organization: _____