Missouri Department of Mental Health
Rental Assistance Program (RAP)
Rapid Rehousing Application

IMPORTANT: PLEASE READ BEFORE BEGINNING A NEW APPLICATION

WHAT IS RENTAL ASSISTANCE PROGRAM (RAP)?

RAP is a rapid rehousing housing program that provides medium- to long-term rental assistance to bridge the gap between housing crisis and permanent housing. The amount of assistance is limited to a maximum of 24 months of rental assistance. RAP also pays a security deposit at initial move-in, and some tenants may qualify for a utility credit. Assisted rental units are inspected prior to move-in and after 12 months to assure housing quality standards, and participants must recertify their household income, household composition, case management status, and permanent housing plan after 12 months.

Because of the time limit on assistance, agencies and community support workers who submit applications on behalf of clients in need are expected to provide intensive support to help assure a transition to permanent housing after the end of RAP assistance.

WHO IS ELIGIBLE?

• You must have one of the disabilities listed on Attachment A in the application.
• You must be receiving services for either a mental illness or a substance use disorder from a DMH-contracted provider agency (not necessarily in connection with a disabling condition).
• You must be experiencing a current housing crisis that if left unaddressed will result in eviction and/or homelessness.
• You must have a plan to transition to permanent housing or self-sufficiency (such as being on a wait list for Section 8, public housing, or income-based housing).
• You must have a combined household income of no more than 50% of your Area Median Income.
• You can be either an adult or minor member of your household (an adult head of household applies on behalf of a minor).

WHO CAN SUMBIT AN APPLICATION?

• Applications must come from a community support worker or other employee of a DMH-contracted service provider involved in providing community support services. That person and the Head of Household fill out the application jointly.
• Applications cannot be accepted directly from persons in need of assistance or from any agency not contracted with DMH.

CRITICAL ITEM: You must include a signed and dated letter written on agency letterhead by the community support worker describing in detail the nature of the housing crisis being experienced by the household. Be sure to describe in detail the Head of Household’s situation and why the household lacks resources to obtain safe, decent and stable housing. The letter may also need to provide information describing the Head of Household’s permanent housing plan.

GENERAL INFORMATION:

• For questions about how to fill out this application, or about an application’s status, email mailto:dirk.cable@dmh.mo.gov or call 573-526-3125, or call 800-364-9687 and ask for Dirk Cable.
• FAX completed application to the DMH Housing Unit at 573-526-7797, or email encrypted or password-protected applications to dirk.cable@dmh.mo.gov.
• Please do NOT email applications without encryption or password-protection—it violates HIPAA regulations observed by the Department of Mental Health.
The purpose of this checklist is to help you complete an application for RAP. Please do not send this page with the application.

☐ Sections 1-7 of the Application are filled out completely and signed as required.

☐ The Head of Household has signed the Head of Household Certifications (Section 7).

☐ **Attachment A** (Verification of Disability) is completely filled out with ONE option checked and is signed by a person with the proper credentials.

☐ **Attachment B** (Permanent Housing Plan) is completely filled out and all required documentation is included with this application.

☐ **Attachment C** (Authorization for Disclosure of Consumer Medical /Health Information) is completely filled out and signed by the Head of Household and a witness.

☐ A **letter** is enclosed describing in detail the nature of the household’s housing crisis and the reasons for requesting this assistance.
SECTION 1. HEAD OF HOUSEHOLD (HOH) INFORMATION

First Name: _______________________   Middle ____________________________  Last Name: __________________________________

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

Is the HOH, or anyone who will live with the HOH, required to register with the MO State Highway Patrol Sex Offender Registry?

☐ Yes  ☐ No  If “Yes,” state the name of the person: __________________________________________________________

(Persons convicted of sex offenses are not excluded from eligibility; the question is asked for housing placement purposes only.)

SECTION 2. REFERRING AGENCY CONTACT INFORMATION

CSW Name: ______________________________________________________________________________________________________

Agency: ________________________________________________________  City:  ____________________________________________

Office Phone: (________) __________________________________ Alt. Phone: (________) ____________________________________

Fax: (________) ____________________________________________

Email: ___________________________________________________ @ _____________________________________________________

SECTION 3. OTHER ADULTS IN THE HOUSEHOLD (Age 18+)

Use an additional copy of this page if the household has more than one other adult aside from the Head of Household.

First Name: _______________________   Middle ____________________________  Last Name: __________________________________

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

SECTION 4. MINORS IN THE HOUSEHOLD (Age 17 and <)

Use additional copies of this page if the household has more than three minors.

First Name: _______________________   Middle ____________________________  Last Name: __________________________________

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

Does the Head of Household have legal custody of this minor?  ☐ Yes  ☐ No

If “yes,” please specify: ☐ full custody  ☐ joint custody (minor lives with or will live with the HOH at least 50% of the time)

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

First Name: _______________________   Middle ____________________________  Last Name: __________________________________

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

Does the Head of Household have legal custody of this minor?  ☐ Yes  ☐ No

If “yes,” please specify: ☐ full custody  ☐ joint custody (minor lives with or will live with the HOH at least 50% of the time)

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

First Name: _______________________   Middle ____________________________  Last Name: __________________________________

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

Does the Head of Household have legal custody of this minor?  ☐ Yes  ☐ No

If “yes,” please specify: ☐ full custody  ☐ joint custody (minor lives with or will live with the HOH at least 50% of the time)

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

<table>
<thead>
<tr>
<th>DMH Housing Use Only</th>
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</thead>
<tbody>
<tr>
<td>Forms:</td>
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<tr>
<td>App complete ☐</td>
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<td>Eligibility:</td>
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<td>DM3700 ☐</td>
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<td>Division(s) Paying:</td>
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<td>ADA ☐</td>
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<tr>
<td>Referral:</td>
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<tr>
<td>Processing Center</td>
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</tbody>
</table>
SECTION 5. INCOME

HOH: have you, or anyone who lives with you or will live with you, received income from any source in the past 30 days?
☐ Yes  ☐ No  If “yes,” please specify below:

• Source of income (do not include non-cash sources such as food stamps and WIC): ____________________________________
  ____________________________________

• Total amount received per month from all sources: $____________________

SECTION 6. HEAD OF HOUSEHOLD CERTIFICATIONS

HOH: please read the paragraphs below and then sign to show that you have read the information, understand it and agree to it.

✓ I understand that if I am approved to receive assistance from the Department of Mental Health’s Rental Assistance Program (RAP), I agree to comply with all of the rules of the program.
✓ I understand that RAP rental assistance is limited to a maximum of 24 months of assistance.
✓ I understand that I must comply with the terms of the Permanent Housing Plan included in this application so that I can transition from RAP assistance to permanent housing.
✓ I understand that I must report all increases and decreases in my income to my local processing center agency within 30 days of the change in income.
✓ I understand that as a RAP participant I am required to comply with the terms of my lease.
✓ I certify that all information provided by me is accurate and complete to the best of my knowledge. I also understand that making false statements or providing false information is grounds for denial or termination of rental assistance.

__________________________
(Print Name of Head of Household)

__________________________
(Signature of Head of Household)

_________ / _________ / _________
(Date)

SECTION 7. REFERRING AGENCY CERTIFICATIONS

COMMUNITY SUPPORT WORKER: please read the following and indicate your understanding and agreement by signing below.

✓ I understand that by referring this Head of Household to the Department of Mental Health’s Rental Assistance Program (RAP), my agency is committing to providing support services for the Head of Household necessary for the securing of a rental unit and for the successful implementation of the Permanent Housing Plan included in this application.
✓ I understand that RAP rental assistance is limited to a maximum of 24 months of assistance, and that I will provide a level of support necessary to ensure that the Head of Household can transition to permanent housing or self-sufficiency within that time period.
✓ I will ensure that all school-age children in the household are properly enrolled in school and are connected to the appropriate services within the community, including early childhood education programs.
✓ I will attend the initial RAP orientation meeting with the Head of Household at the local processing center agency, once the Head of Household has been approved to receive RAP assistance.
✓ I certify that all information provided by me is accurate and complete to the best of my knowledge. I also understand that making false statements or providing false information is grounds for denial or termination of rental assistance.

__________________________
(Print Name of Community Support Worker)

__________________________
(Signature of Community Support Worker)

_________ / _________ / _________
(Date)
INSTRUCTIONS: This form identifies the Head of Household’s disability, and may be completed only by a person who is licensed by the State of Missouri, or who has a credential recognized by the State of Missouri, to make one of the diagnoses listed below.

1) Please check a box below to indicate which disability the Head of Household has.

2) Please indicate your professional licensure by checking a box below, and provide your license or credential number.

3) Please print your name, sign your name, and the date you completed this form.

The Missouri Department of Mental Health’s Rental Assistance Program (RAP) requires applicants to have a disability to be considered eligible. RAP uses the definition of disability used by HUD’s housing assistance programs:

A condition that is expected to be of long-continued and indefinite duration; is expected to substantially impede this person’s ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.

Please evaluate whether or not the person named below has a disability using the above definition.

The following person, ______________________________________________________ (name),

- [ ] Has been diagnosed with a serious mental illness.
- [ ] Has been diagnosed with both a serious mental illness and a chronic alcohol or drug use disorder.
- [ ] Has been diagnosed with a chronic alcohol use disorder and/or a chronic drug use disorder.

My profession is:
- [ ] Advanced Practice Registered Nurse
- [ ] Licensed Clinical Social Worker
- [ ] Licensed Professional Counselor
- [ ] Medical Doctor
- [ ] Psychiatrist
- [ ] Psychologist

License or credential number (required):

________________________________________________________________________________

(Print Name of Person Verifying Disability)  (Signature of Person Verifying Disability)

_________ / _________ / _________  
(Date)
HEAD OF HOUSEHOLD NAME: ____________________________________________

INSTRUCTIONS: To qualify for the Rental Assistance Program (RAP), the Head of Household must have a plan to transition to permanent housing, and must be willing to aggressively pursue the plan with the help of the referring agency throughout the 24 months of RAP assistance. This form lists three options for transitioning to permanent self-sufficient housing.

Please indicate at least one plan that the HOH will follow while receiving RAP assistance by checking the box next to the type of plan. Then read each part of the chosen plan carefully. Check the boxes to indicate agreement with the plan, fill in requested information, and provide documentation as required.

☐ PLAN 1: OBTAIN PERMANENT SUPPORTIVE HOUSING (such as DMH’s Shelter Plus Care program)

1. Minimum Requirements: both of the items below must be true for this to be a valid plan for the HOH.
   - The HOH must be homeless according to HUD’s definition the night before this application is submitted to DMH (if you’re not sure what the definition of homelessness is, visit DMH’s Web site at: http://dmh.mo.gov/housing/housingunit/shelterpluscare.html#whoiseligible -- scroll down to “Who Is Homeless?”).
   - The HOH has been assessed for housing assistance needs by the local coordinated entry process. DMH Housing will verify the assessment has been done by contacting the coordinated entry agency. Please provide the following information:
     - Date of assessment: ________ / ___________ / __________
     - What city did the assessment take place in? ____________________________________________________________
     - What is the name of the agency that did the assessment? __________________________________________________

   For more information about coordinated entry, visit the DMH Web site at: http://dmh.mo.gov/housing/housingunit/shelterpluscare.html

2. Required Strategies: the HOH and the community support worker (CSW) must understand and be willing to work on these strategies; and will be required to report on their status after 12 months in RAP.
   - The HOH and/or the CSW are responsible checking on the status of the HOH with the coordinated entry agency at least once per month, to ensure the HOH remains active on the agency’s prioritization list.
   - The HOH and the CSW must work to prepare the HOH for transition to permanent housing. This includes:
     - Improving income through employment and/or by applying for SSI or other appropriate disability-related assistance;
     - Applying for and obtaining sources of non-cash benefits (such as Food Stamps/SNAP) and health insurance; and
     - Resolving any past debts to landlords, property management companies, public housing agencies, and utility companies.

3. Barriers: please check all of the following items that apply to the household (not just the HOH individually) that may be a barrier to successfully transitioning to permanent supportive housing, and add any additional ones in the space provided.
   - Conviction for manufacturing methamphetamines on assisted housing property
   - Felony criminal history
   - Sex offender registration requirement
   - Misdemeanor criminal history
   - One prior eviction by court order
   - Multiple prior evictions by court order
   - Poor credit
   - Bankruptcy
   - Zero income
   - Owe $ to a Public Housing Agency (how much? $________)
   - Owe $ to a landlord (how much? $________)
   - Owe $ to a utility (how much? $________)
   - Broken leases (HOH moved out without notice to owner)
   - Bad landlord references
   - Lack of transportation
   - Other barriers not listed above: __________________________________________________________________________

4. Additional: add any information about activities or strategies that may be relevant to this plan that the HOH is currently engaged in or plans to engage in.

________________________________________________________________________________________________________
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________________________________________________________________________________________________________
________________________________________________________________________________________________________
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________________________________________________________________________________________________________

Missouri Dept. of Mental Health
Application for RAP - Rapid Rehousing
Revised June 2016
HOH NAME: __________________________

PLAN 2: OBTAIN A PERMANENT HOUSING SUBSIDY OR SUBSIDIZED HOUSING (Section 8, Public Housing, Income-Based Housing for Disabled and/or Elderly)

1. Minimum Requirement:

☐ The HOH must be on a wait list for either a Housing Choice Voucher program (a.k.a. Section 8), or for Public Housing, both of which are typically offered by a Public Housing Agency (PHA); or must be on a wait list for income-based housing for disabled and/or elderly persons.

2. Required Documentation: include with this application the documentation described below, for whichever type of housing was applied for (include documentation for both if both were successfully applied for).

☐ Include with this application a copy of any letter, form, or written notice provided by the PHA to which the HOH applied for Section 8 or public housing that documents that the HOH’s application was accepted and that he/she is on a wait list for that program. NOTE that a copy of the application to the program is not sufficient; the document must specify acceptance of the application and wait list status.

☐ Include with this application a copy of any letter, form, or written notice provided by the agency or company that manages the income-based housing to which the HOH applied for housing. NOTE that a copy of the application to the agency or company is not sufficient; the document must specify acceptance of the application and wait list status.

3. Required Strategies: the HOH and the CSW must understand and be willing to work on these strategies; and will be required to report on their status after 12 months in RAP.

☐ Wait List Purges. Agencies that offer subsidized housing (especially PHAs) periodically purge their wait lists to remove people who may have left the area or who no longer need assistance. They do this by sending a letter to the last known address of the person waiting for assistance, and if they don’t receive a reply within a specified time, the person is dropped from the wait list. It’s therefore essential that both the HOH and the CSW maintain ongoing contact with the PHA, agency, or company the HOH applied to. The HOH must open and read all mail in a timely manner and respond immediately to such requests. The HOH and/or the CSW must also contact the PHA, agency or company once every three months to request a verbal update on the HOH’s wait list status.

☐ Wait List Preferences. Many PHAs offer wait list preferences for households with certain characteristics, and it is essential that the HOH and the CSW know what these preferences are and how they work at the PHA where the HOH has applied for assistance. Preferences may include: working households, disabled, elderly, families with minor children, and residence in a specific city or county. The HOH and CSW must ensure that the PHA has granted the HOH any preference to which he/she is entitled. All eligible RAP applicants should qualify for a disability preference if one is given.

☐ Exclusion From Wait List Preferences. It’s equally important for the HOH and CSW to know if the HOH will be excluded from a preference that will prevent the HOH from ever climbing to the top of the wait list. Many PHAs give preference to residents of the city or county associated with the PHA (and to applicants who work there), but still accept applications from outside that city or county. If the HOH does not reside in the city or county with the preference, they may never receive the assistance—which makes the permanent housing plan invalid. Be certain this will not be true before the HOH applies to a PHA.

☐ The HOH and the CSW must work to prepare the HOH for transition to permanent housing. This includes:

☐ Improving income through employment and/or by applying for SSI or other appropriate disability-related assistance;

☐ Saving money for a future payment of a security deposit;

☐ Applying for and obtaining sources of non-cash benefits (such as Food Stamps/SNAP) and health insurance; and

☐ Resolving any past debts to landlords, property management companies, public housing agencies, and utility companies.

4. Barriers: please check all of the following items that apply to the household (not just the HOH individually) that may be a barrier to successfully transitioning to subsidized housing, and add any additional ones in the space provided.

☐ Conviction for manufacturing methamphetamines on assisted housing property  ☐ Felony criminal history

☐ Sex offender registration requirement  ☐ Misdemeanor criminal history  ☐ One prior eviction by court order

☐ Multiple prior evictions by court order  ☐ Poor credit  ☐ Bankruptcy  ☐ Zero income

☐ Owe $ to a Public Housing Agency (how much? $________)  ☐ Owe $ to a landlord (how much? $________)

☐ Owe $ to a utility (how much? $________)  ☐ Broken leases (HOH moved out without notice to owner)

☐ Bad landlord references  ☐ Lack of transportation

☐ Other barriers not listed above: ____________________________________________________________
□ PLAN 2: OBTAIN A PERMANENT HOUSING SUBSIDY OR SUBSIDIZED HOUSING (Section 8, Public Housing, Income-Based Housing for Disabled and/or Elderly)—continued

5. Additional: add any information about activities or strategies that may be relevant to this plan that the HOH is currently engaged in or plans to engage in.

_________________________________________________________________________________________________________________

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_________________________________________________________________________________________________________________
HOH NAME: ____________________________________________

☐ PLAN 3: OBTAIN PRIVATE MARKET RENTAL HOUSING THAT DOES NOT EXCEED 40% OF GROSS HOUSEHOLD INCOME

1. Minimum Requirements:

☐ The HOH must have a realistic plan to generate enough household income that will allow the household to rent in the open market at a rate that is at least approximately at the affordable level, i.e., 30% of gross household income. 40% is considered rent-burdened, but for purposes of the HOH’s plan, can be considered acceptable as a goal. Examples from various Missouri counties of what would be required to rent a one-bedroom apartment using HUD’s 2016 Fair Market Rent standard, which also includes the cost of basic utilities:

<table>
<thead>
<tr>
<th>County</th>
<th>Monthly Household Income Needed to Rent a One-Bedroom Unit at 30% of Gross Income</th>
<th>Monthly Household Income Needed to Rent a One-Bedroom Unit at 40% of Gross Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jackson (Kansas City)</td>
<td>$2403</td>
<td>$1802</td>
</tr>
<tr>
<td>St. Louis</td>
<td>$2150</td>
<td>$1612</td>
</tr>
<tr>
<td>Boone (Columbia)</td>
<td>$2183</td>
<td>$1637</td>
</tr>
<tr>
<td>Jasper (Joplin)</td>
<td>$1687</td>
<td>$1265</td>
</tr>
<tr>
<td>Cole (Jefferson City)</td>
<td>$1587</td>
<td>$1190</td>
</tr>
<tr>
<td>Saline (Marshall)</td>
<td>$1570</td>
<td>$1178</td>
</tr>
</tbody>
</table>

For most people with disabilities, renting in the open market in the larger cities is out of reach for a single individual without having a college degree or a certificate in a trade or profession. A single person whose sole income is SSI will not be able to afford to rent in the open market on their own unless someone is willing to rent to them at well below the market rate.

Describe below, or in the letter written by the CSW that will accompany this application, how the HOH will achieve enough household income to rent in the open market:

☐ Check if this information is included in the attached letter from the referring agency CSW.

_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________

2. Required Documentation: include with this application any relevant documentation of the HOH’s plan, such as proof that the HOH is currently a full-time student, is working toward a professional or trade certificate, or similar.

3. Required Strategies: the HOH and the CSW must understand and be willing to work on these strategies; and will be required to report on their status after 12 months in RAP.

☐ The HOH and the CSW must work to prepare the HOH for transition to permanent housing. This includes:

  ☐ Improving income through employment and/or by applying for SSI or other appropriate disability-related assistance;
  ☐ Saving money for a future payment of a security deposit;
  ☐ Applying for and obtaining sources of non-cash benefits (such as Food Stamps/SNAP) and health insurance; and
  ☐ Resolving any past debts to landlords, property management companies, public housing agencies, and utility companies.
4. **Barriers:** please check all of the following items that apply to the household (not just the HOH individually) that may be a barrier to successfully transitioning to open market rental housing, and add any additional ones in the space provided.

- [ ] Felony criminal history
- [ ] Sex offender registration requirement
- [ ] Misdemeanor criminal history
- [ ] One prior eviction by court order
- [ ] Multiple prior evictions by court order
- [ ] Poor credit
- [ ] Bankruptcy
- [ ] Zero income
- [ ] Owe $ to a landlord (how much? $________)
- [ ] Owe $ to a utility (how much? $________)
- [ ] Broken leases (HOH moved out without notice to owner)
- [ ] Bad landlord references
- [ ] Lack of transportation
- [ ] Other barriers not listed above: ____________________________

5. **Additional:** add any information about activities or strategies that may be relevant to this plan that the HOH is currently engaged in or plans to engage in.

________________________________________________________________________________________
________________________________________________________________________________________
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________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
I, (full name): ____________________________________________________________________________

Social Security Number: _______ - _______ - _______  Date of Birth: _______ / _______ / _______

hereby authorize the MISSOURI DEPARTMENT OF MENTAL HEALTH (DMH) and the programs, agencies and persons listed below to communicate and disclose to one another written and verbal information regarding my protected health information:

DMH rent subsidy processing center
Homeless management information data system (HMIS)
U.S. Department of Housing and Urban Development (HUD)
local housing authority
rental property owner or manager

The purpose of the disclosure is to obtain information used to secure and/or maintain rental assistance and housing through DMH’s rent subsidy programs Shelter Plus Care and/or Rental Assistance Program, or through a local housing authority.

DMH does not have my permission to disclose the following items: _________________________________________________
____________________________________________________________________________________________________

I understand that my medical/health information records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that by signing this authorization, I am allowing the release of my protected health information. The protected health information in my record may include mental/behavioral health information, information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol/drug abuse, and/or a developmental disability.

I understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished by written request and may be for specific items or the entire release. To revoke this consent, mail a signed written request to revoke consent to: Missouri Department of Mental Health, Housing Director, 1706 East Elm Street, Jefferson City, MO, 65101.

I understand that this consent remains effective until I am no longer a participant in the DMH rent subsidy program, unless I specify expiration on the following date, or based on the following event or special condition: __________________________
____________________________________________________________________________________________________

I understand that while signing this consent form is not a precondition to being declared eligible for housing assistance, DMH cannot complete the process of delivering such assistance to me unless I sign this consent form. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Would you like a copy of this consent form?  Please initial: (          ) YES  (          ) NO

Signature of Consumer: __________________________________________ Date: _________ / _________ / __________

Signature of Witness: ____________________________________________  Date: _________ / _________ / __________

Signature of Parent/Guardian/Representative:
_____________________________________________________________  Date: _________ / _________ / __________

Guardian/Representative: please include a description of authority to act on Consumer’s behalf: ________________________
____________________________________________________________________________________________________