



Office of Enrollment and Residency (OER) LEA Guide: *Accepting DC Financial Benefit Documentation*

It is the responsibility of each school and local education agency (LEA) to collect valid documentation to verify residency of students at the time of enrollment. There are several document types and methods enrolling persons can use to complete residency verification. For more information on the residency verification process, methods and documents, please review the [OER Handbook on the OSSE website](#).

The purpose of this document is to provide LEAs and schools with additional guidance on reviewing DC financial assistance documents¹. Valid DC financial assistance documents can come from several different DC Government agencies making it uniquely difficult for review and acceptance by enrolling school officials. Current guidance, as outlined in the OER Handbook (February 2022 version), is as follows:

Regulatory Requirement: Current official documentation of financial assistance received by the student or person seeking to enroll the student from the DC Government includes, but is not limited to, Temporary Assistance for Needy Families (TANF), Medicaid, the State Child Health Insurance Program (SCHIP), Supplemental Security Income (SSI), housing assistance, or other governmental programs.

Additional Interpretative Guidance: The document must be issued to the enrolling person within the past 12 months and be current (not expired) at the time of the school official's review of residency documentation and date of school official signature on the DC Residency Verification (DCRV) form. The document must have the same name and address of the enrolling person as identified on the DCRV. Documentation can also include a snapshot received from the enrolling person or the payment of benefits. While some documents may not include a signature of the official, the agency's title or letterhead should be present on the document. Some documents are considered recertification letters, and these should not be considered if the period for recertification has passed. For example, if the family is enrolling for the 2022-23 school year, a letter recertifying for 2021 would not be valid.

Federal financial assistance programs, except SSI, do not qualify as valid supporting documentation unless facilitated by a DC Government agency such as the Department of Human Services (DHS) or DC Housing Authority (DCHA).

The following are examples, not a definitive list, of DC financial assistance documents and factors considered in determining validity. For the purposes of this guide, all documents are assumed to apply to the correct school year at the time of enrollment.

¹ Pursuant to 5A DCMR § 5002.5, even if documentation is completed using the following guidance below, if a school/LEA reasonably concludes that additional information is needed to verify the student's residency, further documentation can be requested from the enrolling person.



Examples of Acceptable Documentation

TANF (Email)

This email is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- A snapshot of current financial benefits that are being received at the time of enrollment; and
- It is issued by a DC Government agency, the Department of Human Services (DHS).
- It also includes the agency official's contact information.

From: [Redacted]
Sent: Thursday, July 23, 2020 2:52 PM
To: [Redacted]
Subject: RE: Verification of Benefits

Good Afternoon,

Attached is the proof of income and residency for [Redacted]

[Redacted]

Summary

Help [Top of Form](#)

Assistance Unit	Eligibility	
Legal Status	Legal Status	
	Household	Page
	Dependent Child	Page
	Non Financial	Page
	Resource	Page
	Compliance	Pass
	Work Eligibility	Conditions

Benefit

Legal Status

Net Countable Income: -\$0.00

Monthly Benefit Amount: \$928.00

Government of the District of Columbia
Congress Heights Service Center
Department of Human Services
Economic Security Administration
4049 South Capitol Street NW
Washington DC 20032

From: [Redacted]
Sent: Thursday, July 23, 2020 2:30 PM
To: [Redacted]
Subject: RE: Verification of Benefits

My name is [Redacted] and I am working with [Redacted] to enroll her children in school. We are trying to prove DC residency. Is it possible for you to provide a letter or form showing her name, current address and current benefits I need to be able to add it to our residency binder. I can be reach at [Redacted] with any questions or concerns.

Social Security Administration

Date: January 14, 2020
BNC#: [Redacted]
REF: DC [Redacted]

WASHINGTON DC 20019-1816

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Information About Supplemental Security Income Payments

Beginning January 2020, the current Supplemental Security Income payment is \$ 251.45.

This is after we have withheld 78.30 to recover an overpayment.

This payment amount may change from month to month if income or living situation changes.

Supplemental Security Income Payments are paid the month they are due. (For example, Supplemental Security Income Payments for March are paid in March.)

Date of Birth Information

The date of birth shown on our records is [Redacted]

Type of Supplemental Security Income Payment Information

Suspect Social Security Fraud?

Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

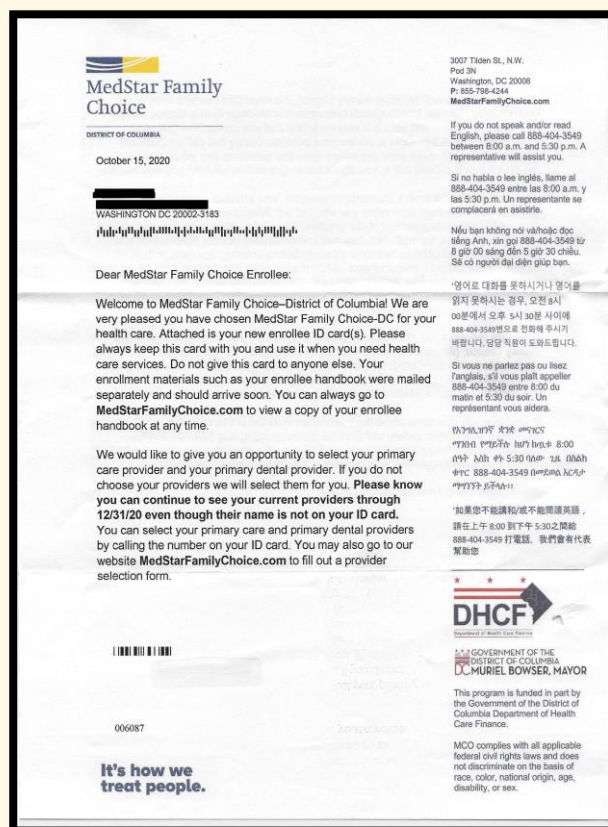
SSI Letter

This letter is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides current financial benefits that are being received at the time of enrollment; and
- The document is on Social Security Administration (SSA) letterhead.

This letter is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides current financial benefits that are being received at the time of enrollment; and
- MedStar is the organization assigned to distribute Medicaid benefits and is facilitated by a DC Government agency, the Department of Health Care Finance (DHCF).



Residents ▾ Business ▾ Government ▾ Visitors ▾ Education ▾ Jobs ▾ Online Services ▾ Mayor



Search dc-medicaid.com

Log out.
User logged in as [REDACTED]
Message Center ID is [REDACTED]

HOME HELP CONTACT US

Eligibility Inquiry Result

Recipient Eligibility Information requested / verified on: 04/21/2020

Recipient Detail

First Name:	[REDACTED]
Middle Name:	[REDACTED]
Last Name:	[REDACTED]
Recipient ID:	[REDACTED]
Recipient Address:	WASHINGTON DC 20011 - 0000
Ward/Quadrant:	OSNE
Gender:	Male
Date Of Birth:	[REDACTED]
Re-cert Date:	[REDACTED]

Plan Coverage Information

Plan Coverage:	Medicaid Children
Program Code:	221
Eligibility or Benefit Information:	ACTIVE
Begin Date:	01/01/2016
End Date:	12/31/2020
GMB Indicator:	NO
Case Number:	[REDACTED]

Service types

Service Management

Service Management Type:	MCD
Begin Date:	10/01/2017
End Date:	12/31/9999
Provider:	AMERICGROUP DISTRICT OF COLUMBIA, IN

Service types

Medicare Information

N/A

My health QP's Coverage Information

N/A

Living, Resor Care Information

N/A

Financial Liability Information

TPL Update

Remaining Service: 1 (mtd)

Please contact Conduent Provider Inquiry at (866)752-6233 or (202)906-6318 for inquiries on Procedure Specific Limitations.

New Inquiry

WEB REGISTRATION

PROVIDER - Secure Options

- ☐ Claim Templates
- ☐ Inquiry Options
- ☐ Claims Entry
- ☐ Communication Options
- ☐ Enter PA Request
- ☐ Submission Options
- ☐ TPL Update
- ☐ Message Admin Options
- ☐ Org Admin Options
- ☐ User Admin Options

PROVIDER

- ☐ Fee Schedule
- ☐ Pricing Methods
- ☐ Frequently Asked Questions
- ☐ General Billing Type
- ☐ Managed Care Information
- ☐ Provider
- ☐ Bulletin/Transmittals
- ☐ Provider Payment Methods
- ☐ Provider Notices
- ☐ Provider Type Specific Information
- ☐ Provider Information & Forms
- ☐ Statistics
- ☐ Trading Partner Information
- ☐ Training Materials/CBT
- ☐ WINASAP 5010 Software

VISIT

- ☐ DOS
- ☐ Liberty Healthcare
- ☐ Department of Health
- ☐ Department of Behavioral Health
- ☐ Connection

REPORT FRAUD AND ABUSE

- ☐ Medical Fraud Inquiry

Terms of Usage · Privacy Policy · Browser Compatibility · Site Map · Help

Medicaid Snapshot

This snapshot is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides current financial benefits that are being received at the time of enrollment; and
- The snapshot identifies a Medicaid coverage plan and the DC Government logo is present on the document.

Low Income Home Energy Assistance Program (LIHEAP) Benefits

This document is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides current financial benefits that are being received at the time of enrollment; and
- It provides proof of benefits offered by a DC Government agency, Department of Energy and Environment (DOEE).

LIHEAP Benefits - [REDACTED] (XXXX-XX-XXXX) (System)

SSN: XXX-XX-XX [REDACTED]

Name: [REDACTED]
Address: [REDACTED]
Zip: 20003 Washington, DC

Home Phone: [REDACTED]
Date of Birth: [REDACTED]
Type of Dwelling: Single-Family
Heating Vendor: Electric
Annual Income: \$8652.00
Established: 2/4/2020 12:00:00 AM
Last Revision: 2/4/2020 11:43:38 AM

Gender: F
Living Arrangement: Own

Verification of Income:
1. Award Letter 2. Other

Total Household Members: 4
Under 3: 0 3 to 5: 0
19 to 59: 3 60 and over: 0

	Vendor	Account #	Account Name	To
Regular:	PEPCO	[REDACTED]	[REDACTED]	Did Not Apply for Benefit
Emergency:	No Benefit Provided			Did Not Apply for Benefit
Special:	No Benefit Provided			Did Not Apply for Benefit

Application Affirmation and Authorization to Verify Income

- I swear (or affirm) that the information on this application, and all information I have submitted, is true, correct and complete to the best of my knowledge, ability and belief, and/or imprisonment for making false statements. My signature on this application grants to verify the information that I have provided.
- I understand that I will be notified if this application is denied.
- I hereby authorize the utility companies and Eligible Telecommunications Carrier (ETC) to provide information for the purpose of allowing DOEE and the effectiveness of services provided to consumers by DOEE.

I understand that I am obligated to pay for my utility bills, regardless of approval or denial.

[REDACTED]

DHS Case Manager Verification Letter

This letter is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides current financial benefits that are being received at the time of enrollment; and
- It is issued by a DC Government agency (DHS).

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

★ ★ ★

Family Services Administration

June 10th, 2020

To Whom It May Concern,

My name is [REDACTED] and I am [REDACTED] Rapid Rehousing Case Manager. This letter is to verify [REDACTED] residency. [REDACTED] currently resides at [REDACTED] WDC 20019 with her [REDACTED] children [REDACTED] and [REDACTED]. If you have any questions or concerns please contact me at [REDACTED] or [REDACTED]@dc.gov.

Sincerely,

[REDACTED]

Vocational Development Specialist
DHS, Rapid Rehousing Program

2100 MLK Ave S.E. Washington D.C. 20020 (202) 698-1860

Return this portion with your payment

Remit to:
FRSP
1133 North Capitol Street, NE
Washington DC, 20002

Lease Number: [REDACTED]
Tenant Account: [REDACTED]
Due Date: 09-01-2020
Amount Due: \$48.00
Amount Enclosed: \$

Washington, DC 20020
20020

Return the top portion with your payment. Keep this portion for your record.

PAYMENTS RECEIVED AFTER THE 25TH OF THE MONTH WILL BE POSTED THE FOLLOWING MONTH

DC DEPARTMENT of HUMAN SERVICES		Charges	Payments	Balance
08/01/20	Tenant Rent (08/2020)	274.00	0.00	274.00
09/01/20	Tenant Rent (09/2020)	274.00	0.00	548.00
Current	30 Days	60 Days	Over 90	Current Owed
274.00	274.00	0.00	0.00	548.00

PLEASE WRITE YOUR TENANT ACCOUNT: [REDACTED] ON THE CHECK/MONEY ORDER

Please refer to the back for important information related to this rent bill.

Keep this portion for your records

DHS Housing Bill

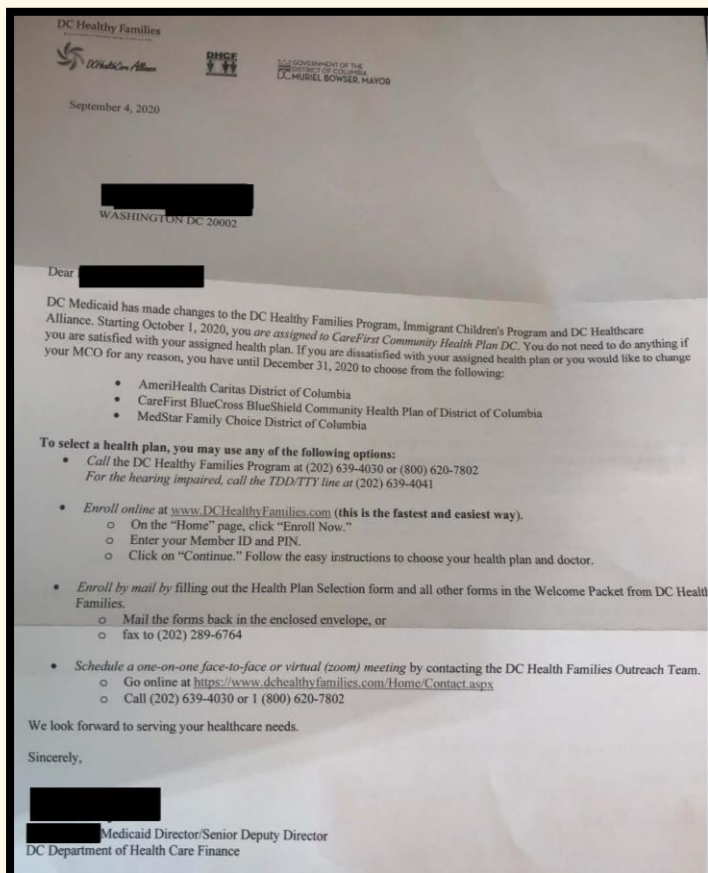
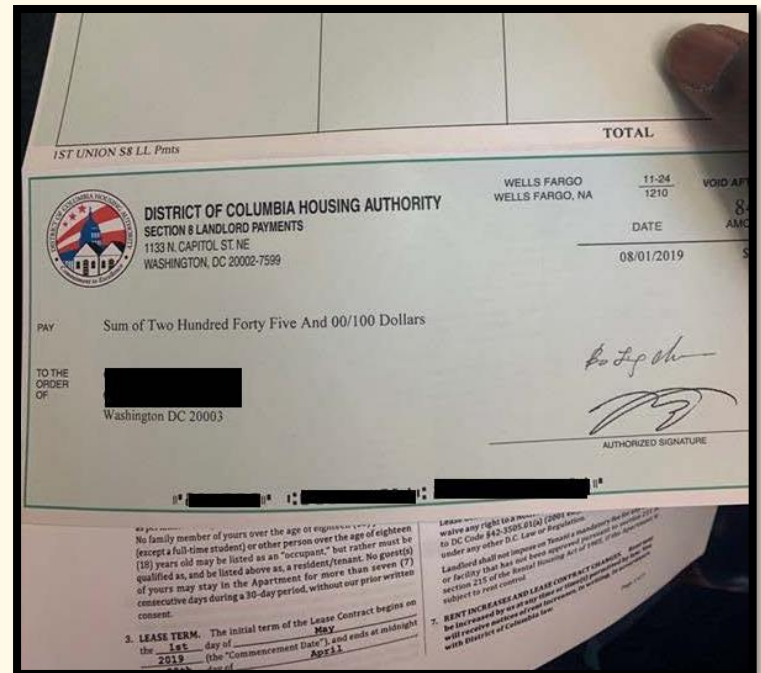
This document is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides a summary of charges, payments of rent and implies the receipt of DC financial assistance; and
- It is issued by a DC Government agency (DHS).

DCHA Check

This check is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides current financial benefits that are being received at the time of enrollment; and
- It is issued by a DC Government agency, DC Housing Authority (DCHA).



DC Medicaid Plan Selection Letter



This letter is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides current financial benefits that are being received at the time of enrollment; and
- It is issued by a DC Government agency (DHCF).

Health Care Ombudsman Letter

This document is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides current financial benefits that are being received at the time of enrollment; and
- It is issued by a DC Government agency, DC Health Care Ombudsman.

 **GOVERNMENT OF THE DISTRICT OF COLUMBIA**
Office of Health Care Ombudsman and Bill of Rights 

August 12, 2021

RE: Proof of Insurance Coverage for [REDACTED]

To Whom It May Concern:

This letter serves as proof that [REDACTED] is enrolled in the District of Columbia Immigrant Children's Program. [REDACTED] is currently enrolled in a managed care plan with CareFirst Community Health Plan District of Columbia. Any questions pertaining to benefits will be addressed by Member Services at (855) 326-4831. Below is a brief overview of [REDACTED] most recent eligibility span.

Name	ID Number	Insurance Coverage Type	Effective Dates
[REDACTED]	[REDACTED]	CareFirst Community Health Plan DC	04/01/2020 – present


Should you have any questions, please do not hesitate to call me on [REDACTED] or e-mail me at [REDACTED]

Sincerely,
[REDACTED]
Health Care Ombudsman

DHS ESA Letter

This document is acceptable because:

- It is issued to the same name and address of the enrolling person as identified on the DCRV;
- It is issued in the past 12 months and current;
- It provides current financial benefits that are being received at the time of enrollment; and
- It is issued by a DC Government agency (DHS).

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES 

Economic Security Administration
Division of Program Operations
Call Center
64 New York Avenue NE
Washington, D.C. 20002

Date: [REDACTED]

RE: [REDACTED]

To Whom It May Concern:

The customer is in receipt of one of the following Program Services as listed below:
Household Members: [REDACTED]
Address: [REDACTED]


TANF \$ 430.00 Until 7/31/2021

MEDICAID (ACTIVE) Until 1/31/2022

Should you have any questions, please contact case worker on (202) 727-5355.

Sincerely,
DHS Call Center

This document is acceptable because:

- 

GOVERNMENT OF THE DISTRICT OF COLUMBIA
 Department of Human Services

CONFIRMATION OF FAMILY RE-HOUSING AND STABILIZATION PROGRAM ASSISTANCE

Washington, DC [Redacted] April 1, 2021

(X) Short or Medium-term Monthly Rental Subsidy*

Months Covered: _____ Year: _____

CLIENT BEGINS MONTHLY PAYMENTS ON: May 1, 2021

TOTAL MONTHLY RENTAL AMOUNT	SUBSIDY PORTION	FAMILY RENT PORTION
\$1,800.00	\$1,376.00	\$424.00

Note: Any change in the family income must be notified to TCP immediately.

TCP Staff Signature: [Redacted]

FRSP Participant Signature: [Redacted]

☒ RPI

* You will pay your monthly rental portion to:

DCHA
 64 New York Ave NE
 Washington, DC 20002

OR

Wells Fargo
 Department of Human Services
 C/O DCHA-FRSP
 P.O. Box 49002
 Baltimore, MD 21297-4902

☐ DHS Assistance

* You will pay your monthly rental payment directly to your landlord rental office.

DHCA Housing Bill

This document is acceptable because:

- 8

OSSE has identified Unemployment Insurance (UI) benefits distributed by the DC government as a valid supporting residency document for persons enrolling in a DC public school or public charter school. Because UI benefits are based on the location of employment and not where the recipient physically resides, use of UI benefits for residency verification must meet the following requirements to demonstrate DC residency:

- | DISTRICT OF COLUMBIA DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF UNEMPLOYMENT COMPENSATION
MONETARY DETERMINATION | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------------------|---------------------------|
| MAIL DATE: _____ | PROGRAM _____ | AMERICAN JOB CENTER _____ | DEPENDENT ALLOWANCE _____ |
| CLAIMANT INFORMATION | | | |
| Claimant's Name: _____ | | SSN: _____ | |
| Claimant's Address: _____ | | | |
| Benefit Year Begins: _____ | | Maximum Weekly Benefit Amount: _____ | |
| Benefit Year Ends: _____ | | Maximum Potential Benefit Amount: _____ | |
| <p>The base period of a claim is defined as either the first four of the last five completed calendar quarters or the last four completed calendar quarters immediately preceding the date the benefit year begins. Only wages earned during this time period are used to compute the weekly benefit amount. The weekly benefit amount is one-twenty-sixth of the highest base period calendar quarter of wages not to exceed the maximum allowable by law. The maximum benefit amount is twenty-six times the weekly benefit amount.</p> | | | |
| <p>THE BASE PERIOD OF THIS CLAIM IS _____ to _____. The wages reported to DOES by the named employers during each of the quarters of the base period of this claim are listed in the following table.</p> | | | |
| Employer Name | TOTAL REPORTED | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| TOTAL REPORTED | | | |
| <input type="checkbox"/> Information furnished by the claimant at the original claim interview raised no eligibility or disqualification issue.
<input type="checkbox"/> A potential eligibility and/or disqualification issue currently exist with this claim. All available facts will be considered and a decision will be issued to interested parties. | | | |
| BASED ON THE INFORMATION ABOVE YOU ARE MONETARILY | | | |
| <input checked="" type="checkbox"/> ELIGIBLE FOR BENEFITS / HAVE SUFFICIENT BASE PERIOD WAGES
<input type="checkbox"/> INELIGIBLE / HAVE INSUFFICIENT WAGES IN THE BASE PERIOD | | | |
| <p>If you worked during the base period outside of the District of Columbia, or for the federal government, or if you were in the military service, wages from such employment may not be shown on your initial Monetary Determination. In order for these wages to be added, you must advise DOES that you worked outside of the District of Columbia, or for the federal government, or if you were in the military service, so we can request your wages be transferred to the District. Your claim will be re-determined when these wages are received, and a revised Notice of Monetary Determination will be mailed to you. Carefully review every Notice of Monetary Determination that you receive.</p> <p>IF YOU DISAGREE WITH THIS DETERMINATION YOU MAY MAKE A REQUEST FOR RECONSIDERATION WITHIN 15 DAYS OF THE MAIL DATE.</p> <p>Requests for Reconsideration: This monetary determination will become final unless you mail a request for reconsideration to: Benefits Division, Department of Employment Services, 4088 Minnesota Avenue NE, DC 20019.</p> <p>The request must include evidence that you had wages during the base period of this claim in addition to the wages indicated above. This evidence should include an affidavit signed by yourself certifying the wages you are reporting are true and correct. You may use DOES Form 193 which you can download from our website at does.dc.gov, or you can request a copy of the form by contacting us at 202-724-7000, or by reporting to your local American Job Center. Further, this evidence should include copies of paystubs, W2s from the employer(s), SF Form 90 (Federal Employment), DD214 (Military Employment) Copy 4, and any other documentation that supports your claim of additional wages in the base period.</p> <p>Failure to provide new evidence of additional wages paid during the base period listed above (evidence as described in this section) will result in denial of your request for reconsideration.</p> <p>This notice concerns only monetary/wage credit issues pursuant to section 7 of the District Unemployment Compensation Act (D.C. Official Code § 51-107). This notice does not affect any other eligibility or unemployment separation decisions made pursuant to Sections 9 and 10 of the Act (D.C. Official Code §§ 51-109 and 51-110).</p> | | | |
| CLAIMANT'S COPY | | | |
- UC400C.FRM REV-(02/19)

9

Examples of Unacceptable Documentation

SNAP Work Requirements Letter

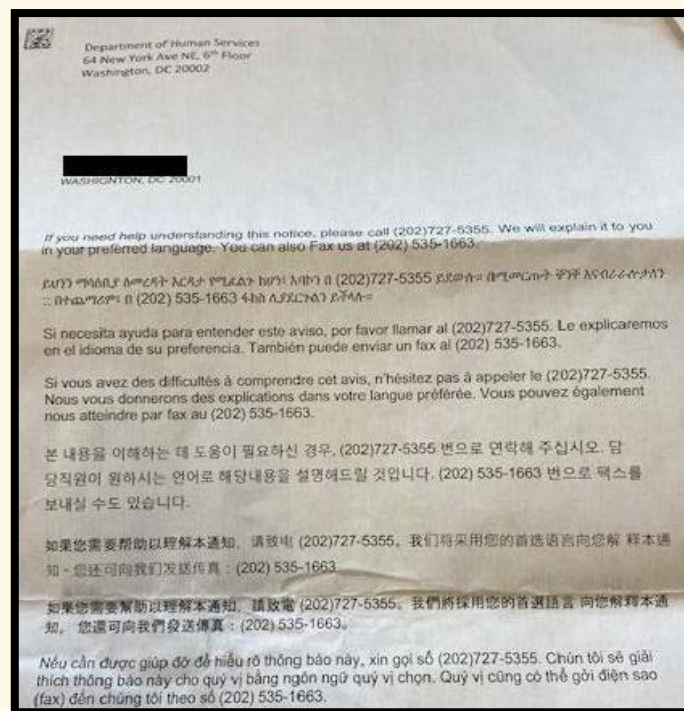
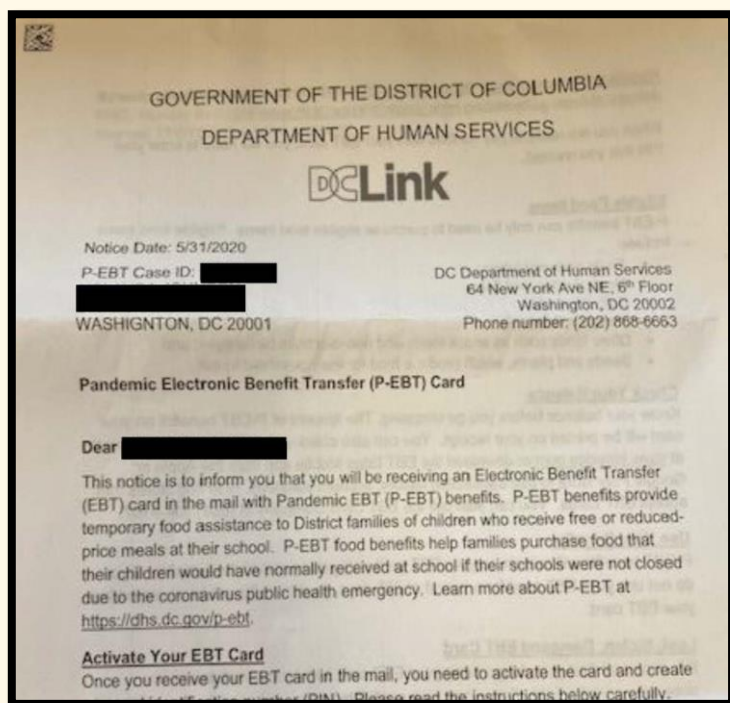
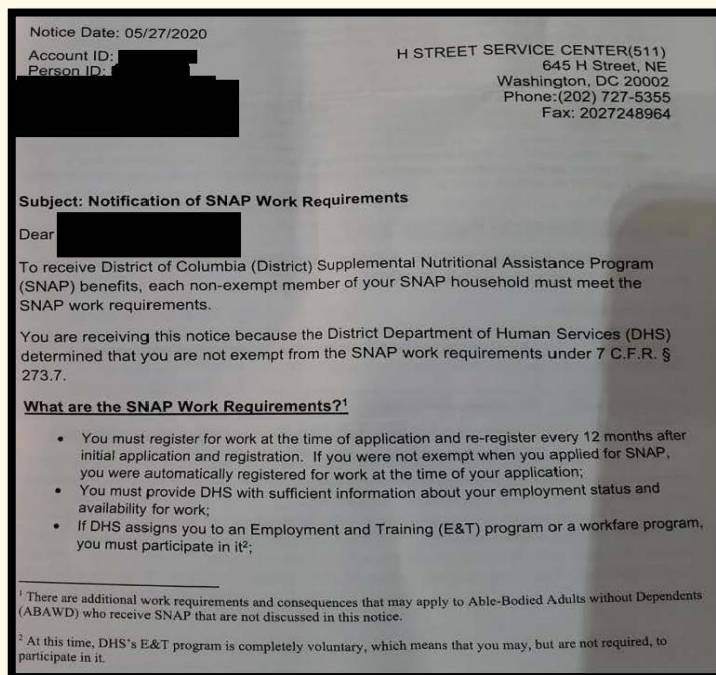
This letter is unacceptable because:

- It is stating eligibility requirements and does not provide proof of financial benefits being received by the enrolling person.

P-EBT

This letter is unacceptable because:

- This financial benefit is temporary and not current.



Home Purchase Assistance Program (HPAP) Eligibility Notification Letter

This two-page packet is unacceptable because:

- It is an approval to participate and does not provide proof of financial benefits being received by the enrolling person.

The greater of \$500 **OR** 50% of the amount of liquid (non-retirement) assets greater than \$3,000. Any additional amounts required to complete the closing will be your responsibility.

4. Acknowledgement and Agreement of Terms:
Please sign, date and return this form acknowledging your agreement with these terms within 5 days of receipt of this letter.

5. Expiration of Your Eligibility
Your eligibility for the HPAP second trust loan expires on Aug 20, 2020. You will be required to submit a new application if you have not completed the process by this date.

6. Required Homeownership Training Certification:
Immediately upon receipt of this notification you must contact either the Community Based Organization ("CBO") where you applied for HPAP, or any of the other three Homeownership CBOs listed at www.dhcd.dc.gov/page/homeownership-cbos to receive instructions on taking the homeownership training that is required for this program. Upon your successful completion of the homeownership training, you will receive your training certificate. Please email a copy of your certificate to DCHFA.

7. What You Must Do to Complete the Home Buying Process:
Within the first 12 Months or not later than Aug 20, 2020 you must:

- Complete pre-purchase homeownership training (see 6 above);
- Select your home and execute a sales contract.

After executing a sales contract you must:

- Have the home you are purchasing inspected by a **Licensed Home Inspector** (<https://entp.hud.gov/dapp/html/insplook.cfm>) and provide a copy of the inspection report to DCHFA for review and acceptance. If required, the seller/buyer must correct any defects identified and the home must be re-inspected;
- Obtain a **termite inspection report** and submit a copy to DCHFA for review and approval (required on all properties with the exception of condominium units located on the 4th floor or above)
- Obtain a firm commitment (approval) for a first trust mortgage;
- Work with your first trust lender to select a title company to perform settlement, and ensure lender submits complete package of information to DCHFA, including homeowners insurance and title documentation as instructed by DCHFA.

If you have any questions concerning HPAP loan processing, please contact DCHFA, Single Family Programs, at (202) 777-1600 or SingleFamilyPrograms@dchfa.org. Once your HPAP loan has been approved, please instruct your settlement company to contact the closing department at (202) 777-1600 or SingleFamilyPrograms@dchfa.org.

Sincerely,

HPAP Loan Processor

Acknowledged By:

Borrower _____ Date _____

Borrower _____ Date _____

NOTIFICATION OF ELIGIBILITY (NOE) FOR THE HOME PURCHASE ASSISTANCE PROGRAM ("HPAP")

The HPAP Program is funded by the D.C. Department of Housing and Community Development

District of Columbia Housing Finance Agency ("DCHFA")
Single Family Programs
815 Florida Avenue, NW
Washington, DC 20001
Phone: (202) 777-1600; Email: SingleFamilyPrograms@dchfa.org

Date: August 21, 2019

Borrower(s): _____
Address: _____
Washington, DC 20020

We are pleased to notify you of your eligibility for a second trust loan under the District of Columbia's Home Purchase Assistance Program.

Please note that the maximum first trust loan amount cannot exceed \$453,100 for this program.

1. Your DC Home Purchase Assistance Program Second Trust Loan:

We have determined your eligibility based upon the following information provided on your application:
Total Annual Household Income: \$ 75,059.90
Household Size: 3
If there are any changes in income, debts or household size, please contact our office immediately. Failure to communicate changes in your status will affect your eligibility.

Based upon the guidelines of the program, your second trust loan amount may not exceed
\$ 44,000.00. The maximum loan amount includes \$4,000.00 for closing cost assistance.

The exact amount of your second trust loan will be determined after you have been approved for a first trust mortgage and you have contracted on a property. The HPAP loan will provide financing of the gap between the first trust mortgage you qualify for and the price of the property up to the maximum HPAP assistance indicated above.

The provision of your second trust loan is contingent upon the availability of funds from the government of the District of Columbia.

2. Selecting Your Home:

This Notice of Eligibility DOES NOT IMPLY any mortgage loan approval or commitment to lend. Please work with your first trust lender on qualifying for a first trust mortgage loan amount and your home price affordability. The home purchase price you can afford will reflect the combination of the first trust loan and the HPAP second trust loan amounts.

Remember the HPAP program limits the maximum first trust loan amount to \$484,350.



3. Your Contribution to the Down Payment:
Under the HPAP program guidelines, the minimum you must contribute of your own funds as a down payment (including Earnest Money Deposit) on your home is:

Department of Human Services Homeless Prevention Program (DHSHP) Agreement

This document is unacceptable because:

- This specific document is an approval for rental assistance for a residence in *another jurisdiction*; and
- The enrolling person would no longer be a DC resident.
- This document would be acceptable if it was for a DC residence.

DocuSign Envelope ID: [REDACTED]

May 14, 2020

Department of Human Services Homeless Prevention Program (DHSHP)
Rental Assistance Diversion Agreement

This agreement is between Ms. [REDACTED] and [REDACTED] (customer- HMIS # [REDACTED]/telephone number [REDACTED]). The family has been temporarily diverted to Ms. [REDACTED] aunt [REDACTED] at [REDACTED] and also sometimes visiting with Ms. [REDACTED] grandfather Mr. [REDACTED] in the same building [REDACTED]. Ms. [REDACTED] has identified a new unit which she plans to rent. Ms. [REDACTED] was recently approved for a unit with located at [REDACTED], Ms. [REDACTED] has submitted a copy of her approval Letter. The landlord, [REDACTED] has requested May's Pro Rate Rent and June's Rent in the amount of \$2,593.55 and security deposit of \$3,350.00. Ms. [REDACTED] was referred to ERAP, and she was approved for \$1800.00 worth of assistance on 5/14/2020. Customer is seeking rental assistance for her move in expenses.

Agreement:
As part of the Department of Human Services Homeless Prevention Program plan for customer, [REDACTED], all parties agree to the following:

1. DHSHP agrees to provide \$3,500.00 on behalf of customer toward her move in expenses.
2. The rental payment will be made payable to [REDACTED]
3. The check will be made out and mailed to [REDACTED]
4. Customer will be responsible for the remaining balance amount of \$643.55. This payment shall be made by May 15, 2020. Customer will provide CM with proof of payment.
5. Customer will be responsible for the full monthly rent in the amount of \$1675.00 beginning July 1, 2020.
6. Customer understands that this will be a onetime assistance.

Plan:

1. Customer will continue her online classes with [REDACTED] as she is expected to graduate in July/2020
2. Customer Mr. [REDACTED] will continue to report to his job with [REDACTED] to maintain his employment.
3. Customer will open up a secure credit line with her financial institution to build up her credit score
4. Customer will modify her budget to maintain monthly expenses.

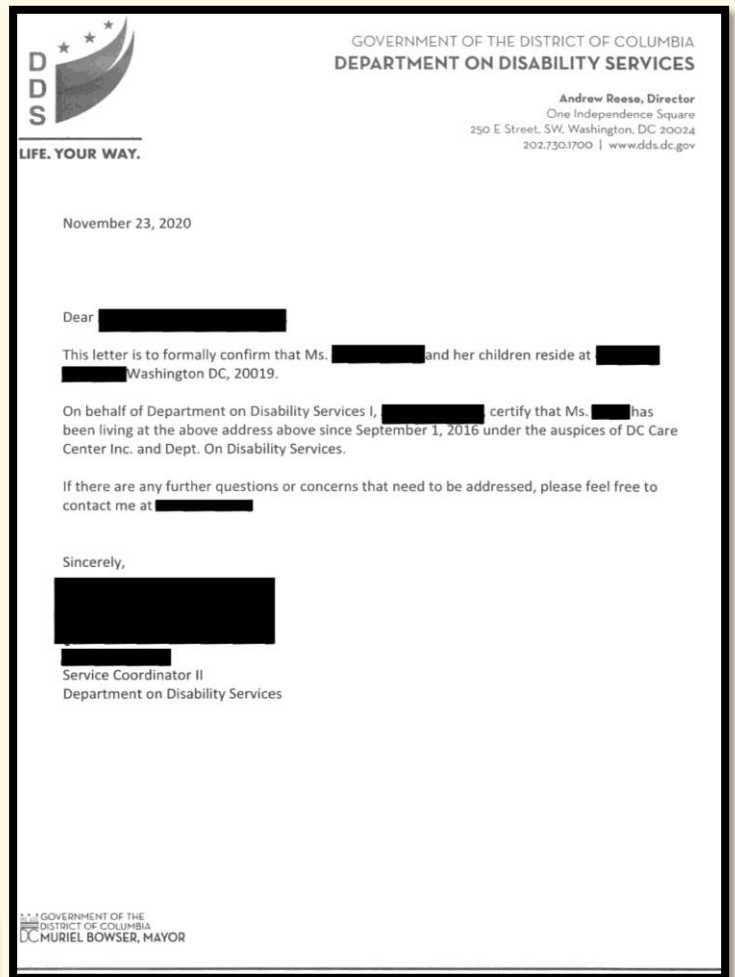
DHSHP will provide this assistance as a onetime offering. By signing this agreement, all parties acknowledge and accept the terms of this diversion plan.

[REDACTED] 5/14/2020
DocuSigned by: [REDACTED] Date 5/14/2020

Department on Disability Services (DDS) Letter

This letter is unacceptable because:

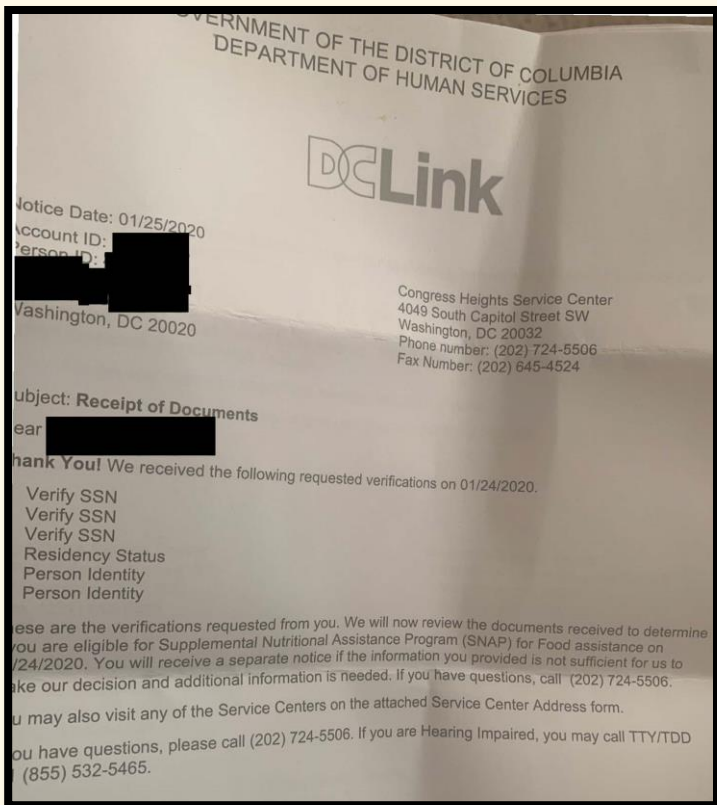
- It does not provide proof of financial benefits provided by a DC Government agency or being received by the enrolling person.



DC Link Verification Request

This letter is unacceptable because:

- It is confirming the receipt of documents and does not provide proof of financial benefits being received by the enrolling person.



Department of Employment Services (DOES) Claimant Profile

This two-page document is unacceptable because:

- It does not meet the specific requirements for Unemployment Insurance Benefits documents, as outlined in the OER Handbook:
 - The enrolling person must present their Monetary Determination Letter
 - The enrolling person must present a paystub dated 60 days preceding the mail date on the Monetary Determination Letter
 - The paystub must show DC withholding amount greater than zero for both the current tax year and

11/24/2020 [DOES Home | Unemployment Insurance FAQs](#)

webs unemployment services

You are logged in as **XXX-XX-XX** [Home | Log Off](#)

Payment History

This page displays information about the weeks for which the District of Columbia has received claim forms from you.

Weeks Submitted Awaiting Processing

Week Ending	Submitted Date/Time	Status
None		

Weeks Processed (27/58)

Week Ending (Fecha en que termina la semana reclamada)	Paid Date (Fecha de pago)	Paid Amount (Cantidad pagada)	Payment Method (Método de pago)	Filing Method (Método de solicitud)	Notes (Notas)
9/13/2020		0		Internet	Your claim has been received as of 9/13/2020 is not payable because your earnings exceed what is allowable under the D.C. law.
Adjustment	10/9/2020	300	Direct Deposit	Internet	Adjustment Check for week ending 9/13/2020.
9/27/2020	9/28/2020	19	Direct Deposit	Internet	Benefits were reduced from earnings deduction in the amount of \$420.00.
10/30/2020		0		Internet	Your claim has been received as of 10/30/2020 is not payable because your earnings exceed what is allowable under the D.C. law.
11/3/2020		0		Internet	Your claim has been received as of 11/3/2020 is not payable because your earnings exceed what is allowable under the D.C. law.
Adjustment	9/12/2020	680	Direct Deposit	Internet	Adjustment Check for week ending 9/13/2020.
11/5/2020	8/15/2020	251	Direct Deposit	Internet	Benefits were reduced from earnings deduction in the amount of \$27.00.
9/12/2020	8/25/2020	286	Direct Deposit	Internet	

Please Note: If you choose direct deposit, funds will normally be deposited into the account you have designated by the second business day after the date we have authorized benefit payment. For example, if we authorize benefit payments on Monday night, funds should be deposited in your account by Wednesday.

Please allow 10 calendar days for receipt of any benefit check. If a check is not received within 10 calendar days, please call 724-7990 or 1-877-319-7348. You may also call these numbers if you have any questions about the weeks shown above.

ON POINT TECHNOLOGY, INC.

<https://does.dnnetworks.org/ClaimantServices/payhistory.aspx>

1/2

11/24/2020 [DOES Home | Unemployment Insurance FAQs](#)

webs unemployment services

You are logged in as **XXX-XX-XX** [Home | Log Off](#)

Claimant Profile

Profile Information

Filed Date: (MM/YYYY)	Benefit Year Begin Date: (MM/YYYY)	Benefit Year End Date: (MM/YYYY)
Address:	State:	Telephone:
City:	WASHINGTON	Cell phone:
Ward:	5	
Zip Code:	20002	Email Address:
Zip Code Ext:		
Withhold Federal Income Tax:	Yes	Withhold DC Income Tax:
1099 G Form:		
Paperless Options:	- DON'T MAIL ME A PAPER COPY	
Payment Method:	Direct Deposit(Active)	
Address Change Date:	(MM/YYYY)	
TAA Date 1:	(MM/YYYY)	
TAA Date 2:	(MM/YYYY)	
Petition Number:	000000	

General Program Information

Program Name (Nombre de programa)	Determination Date (Fecha de determinación)	Effective Date (Fecha de vigencia)	Maximum Benefit Amount (Cantidad máxima de beneficio)	Weekly Benefit Amount (Cantidad de beneficio semanal)	Total Paid (Total pagado)	Balance (Saldo de cuenta)	Weeks (Semanas)
Regular UI	8/5/2020	8/2/2020	\$5,515.00	\$366.00	\$536.00	\$6,380.00	26
EUC08 / Tier 1							
EUC08 / Tier 2							
EUC08 / Tier 3							
EUC08 / Tier 4							
Extended Benefits							
DC Benefits							
Extension Training							
Fund Swap							
Dependents Allowance					\$0.00		
Disaster Unemployment Assistance							

* FUNDS NO LONGER AVAILABLE, PROGRAM HAS EXPIRED.

Additional/Reopened Claims Submitted Awaiting Processing

None

Additional/Reopened Claims Processed

None

ON POINT TECHNOLOGY, INC.

<https://does.dnnetworks.org/ClaimantServices/profile.aspx>

1/2

Child and Family Services Agency (CFSA) Letter

This letter is unacceptable because:

- It does not provide proof of financial benefits being received by the enrolling person.
- A letter from a DC government agency only stating the residential address is not acceptable.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

April 14, 2021

To Whom It May Concern,

This letter is intended to serve as proof of DC residency for the [REDACTED] family. [REDACTED] currently resides at [REDACTED] [REDACTED] and [REDACTED] children. [REDACTED] and [REDACTED] are household members and listed on [REDACTED] lease.

If you have any further questions regarding DC residency for the [REDACTED], please feel free to reach out to me directly.

Sincerely,

[REDACTED]

[REDACTED] LGSW
Social Worker, Permanency Administration
[REDACTED]

Form **1095-B** Health Coverage

Department of the Treasury
Internal Revenue Service

Do not attach to your tax return. Keep for your records.
Go to www.irs.gov/Form1095B for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2
2020

Part I Responsible Individual

1 Name of responsible individual - First name, middle name, last name
[REDACTED]

2 Social security number (SSN) or other TIN
[REDACTED]

3 Date of birth (if SSN or other TIN is not available)
[REDACTED]

4 Street address (including apartment no.)
[REDACTED]

5 City or town
WASHINGTON

6 State or province
DC

7 Country and ZIP or foreign postal code
[REDACTED]

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes):
C

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

10 Employer name
[REDACTED]

11 Employer identification number (EIN)
[REDACTED]

12 Street address (including room or suite no.)
[REDACTED]

13 City or town
[REDACTED]

14 State or province
[REDACTED]

15 Country and ZIP or foreign postal code
[REDACTED]

Part III Issuer or Other Coverage Provider (see instructions)

16 Name
DC DEPT HEALTH CARE FINANCE(DHCF) DC MEDICAID

17 Employer identification number (EIN)
[REDACTED]

18 Contact telephone number
[REDACTED]

19 Street address (including room or suite no.)
ONE JUDICIARY SQUARE, 441 4TH ST NW SUITE 1000S

20 City or town
WASHINGTON

21 State or province
DC

22 Country and ZIP or foreign postal code
[REDACTED]

Part IV Covered Individuals (Enter the information for each covered individual.)

(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 [REDACTED]	[REDACTED]	[REDACTED]		X					X	X	X	X	X	X	X
24															
25															
26															
27															
28															

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Form 1095-B (2020)

1095-B Health Coverage

This letter is unacceptable because:

- It does not provide proof of current financial benefits being received by the enrolling person, only prior year.

U.S. Department of Housing and Urban Development (HUD) Letter and Certification

This three-page packet is unacceptable because:

- This financial assistance is not distributed or facilitated through a DC Government agency.

Capitol Gateway Family
201 58th Street NE
Washington, DC 20019

October 15, 2019

Washington, DC 20019

Dear _____

This is to notify you that on the basis of our recent review of your income and family composition your rent has been adjusted to **\$87.00**. The new rent is effective beginning **11/1/19**.

This notification amends Paragraph 4 of your lease agreement, which sets forth the amount of rent you pay each month.

Please visit the site office to sign within 7 days of receipt to sign and receive a copy of the HUD 50059 (if you have not already done so). The HUD 50059 must be signed by the head of household, co-head, spouse and all other adult members of the Household. The copy of the HUD 50059 provides the information on your income that we used to calculate your new rent and the amount of rental assistance, if any, HUD pays monthly on your behalf.

You may call 202-396-4922 if you wish to arrange a meeting to discuss this change.

Thank you for your cooperation.

Sincerely,

Assistant Property Manager

Capitol Gateway Family LP does not discriminate on the basis of disability status in the admission to or access to, or treatment or employment in, its federally assisted programs and activities.



Owner's Certification of Compliance U. S. Department of Housing and Urban Development
with HUD's Tenant Eligibility and Rent Procedures

Office of Housing
Federal Housing Commissioner

OMB Approval No. 2502-0204
(Exp. 06/30/2017)

Section B. Summary Information

1. Project Name: Capital Gateway Single Family Rental

2. Subsidy Type: 12. Effective Date: 11/1/2019

3. Secondary Subsidy Type: 13. Anticipated Voucher Date: 11/1/2019

4. Property ID: 14. Next Recertification Date: 11/1/2020

5. Project Number: 15. Project Move-In Date: 11/1/2019

6. Contract Number: 16. Certification Type: R

7. Project IMAK ID: 17. Action Processed: 27. 236 Basis/RMR Rate: 28. Market Rent: 29. Contract Rent: 30. Prev. Subsidy Type: 31. Gross Rent: 32. TTP at RAO Conversion: 283.00

8. Plan of Action Code: 18. EIV Indicator: 29. Contract Rent: 30. Prev. Subsidy Type: 31. Gross Rent: 32. TTP at RAO Conversion: 283.00

9. Next Owner Project? 19. EIV Indicator: 29. Contract Rent: 30. Prev. Subsidy Type: 31. Gross Rent: 32. TTP at RAO Conversion: 283.00

10. Previous Housing Code: 20. Prev. Subsidy Type: 31. Gross Rent: 32. TTP at RAO Conversion: 283.00

11. Displacement Status Code: 31. Gross Rent: 32. TTP at RAO Conversion: 283.00

33. No. 34. Last Name: 35. First Name: 36. MR: 37. Rel. Stat: 38. Sex: 39. Race: 40. Lth: 41. Birth Date: 42. Special Status: 43. SSN: 44. ID Code: 45. SSN Exp: 46. Com Code: 47. Alien Reg. Number: 48. Age: 49. Work Codes

1. 2. 3. 4. 5. 6. 7. 8.

50. Family has Mobility Disability? 51. Family has Hearing Disability? 52. Family has Visual Disability? 53. Number of Family Members: 54. Number of Non-Family Members: 55. Number of Dependents: 56. Number of Eligible Dependents: 57. Expected family Addition-Foster: 58. Expected Family Addition-Pregnancy: 59. Expected Family Addition-Adoption:

60. Previous Head Last Name: 61. Previous Head First Name: 62. Previous Head Middle Initial: 63. Active Full Cert: 64. Previous Head ID: 65. Previous Head Birth Date:

Section D. Income Information

66. Mr. 67. Income Type Code: 68. Amount: 69. SSN Benefits Claim No.: 70. Mr. No.: 71. Description: 72. Cash Value: 73. Actual Yearly Income: 74. Date Received:

1. Social Security \$ 14,780 1. Savings Account C \$ 192 \$ 0

70. Total Employment Income \$ - 81. Total Cash Value of Assets \$ 192

71. Total Pension Income \$ 14,780 82. Actual Income from Assets \$ 0

72. Total Public Assistance Income \$ 48,550 83. HUD Passbook Rate \$ 0.06%

73. Total Other Income \$ - 84. Imputed Income from Assets \$ 0

74. Total Non-Asset Income \$ 14,780/85. Asset Income \$ 0

Section F. Allowances & Rent Calculations

86. Total Annual Income \$ 14,781 87. Deduction for Dependents (\$482 per) \$ - 108. Total Tenant Payment \$ 370

87. Low Income Limit \$ 62,100 88. Child Care Expense (work) \$ - 109. TTP Before Override \$ -

88. Very Low Income Limit \$ 48,550 89. Child Care Expense (school) \$ - 110. Tenant Rent \$ 87

89. Extremely Low Income Limit \$ 29,150 90. 3% of Income \$ 443 111. Utility Reimbursement \$ -

90. Current Income Status: EXTREMELY 101. Disability Expense \$ - 112. Assistance Payment \$ 1,602

91. Eligibility Universal Code: 2-Post 1981 102. Disability Deduction \$ - 113. Welfare Rent \$ -

92. Sec. 8 Assist. 1984 Indicator: 103. Medical Expense \$ - 114. Rent Override \$ -

93. Income Exception Code: 104. Medical Deduction \$ - 115. Hardship Exemption \$ -

94. Police / Security Tenant? 105. Elderly Family Deduction (\$400) \$ - 116. Waiver Type Code \$ -

95. Survivor of Qualifier? 106. Total Deductions \$ - 117. Eligibility Check Not Required \$ -

96. Household Citizenship Eligibility E 107. Adjusted Annual Income \$ 14,781 118. Extenuating Circumstances Code \$ -

Previous versions of this form are obsolete.
This form also replaces HUD-50059-D, -E, -F, & -G.

Owner's Certification of Compliance U. S. Department of Housing and Urban Development
with HUD's Tenant Eligibility and Rent Procedures

Office of Housing
Federal Housing Commissioner

OMB Approval No. 2502-0204
(Exp. 06/30/2017)

Section A. Acknowledgements

Read this before you complete and sign this form HUD-50059 Public Reporting Burden. The reporting burden for this collection of information is estimated to average 55 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (2502-0204), Washington, DC 20503. The information is being collected by HUD to determine an applicant's eligibility, the recommended unit size, and the amount the tenant(s) must pay toward rent and utilities. HUD uses this information to assist in managing certain HUD properties, to protect the Government's financial interest, and to verify the accuracy of the information furnished. HUD or a Public Housing Authority (PHA) may conduct a computer match to verify the information you provide. This information may be released in accordance with HUD's Computer Matching Agreement (CMA) between the Social Security Administration and the Department of Health and Human Services. You must provide all of the information requested, including the Social Security Numbers (SSNs), unless exempted by 24 CFR 5.216, you, and all other household members, have and use. Giving the SSNs of all household members, unless exempted by 24 CFR 5.216, is mandatory; not providing the SSNs will affect your eligibility approval. Failure to provide any information may result in a delay or rejection of your eligibility approval. Privacy Act Statement. The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937, as amended (42 U.S.C. 1407 et. seq.); the Housing and Urban-Rural Recovery Act of 1983 (P.L. 98-181); the Housing and Community Development Technical Amendments of 1984 (P.L. 98-479); and by the Housing and Community Development Act of 1987 (42 U.S.C. 3543). Tenant(s) Certification - I/We certify that the information in Sections C, D, and E of this form are true and complete to the best of my/our knowledge and belief. I/We understand that I/we can be fined up to \$10,000, or imprisoned up to five years, or lose the subsidy HUD pays and have my/our rent increased, if I/we furnish false or incomplete information. Owner's Certification - I certify that this Tenant's eligibility, rent and assistance payments have been computed in accordance with HUD's regulations and administrative procedures and that all required verifications were obtained. Warning to Owners and Tenants. By signing this form, you are indicating that you have read the above Privacy Act Statement and are agreeing with the applicable Certification. False Claim Statement. Warning: U.S. Code, Title 31, Section 3729. False Claims, provides a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages for any person who knowingly presents, or causes to be presented, a false or fraudulent claim; or who knowingly makes, or causes to be used, a false record or statement; or conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

Certification Summary from Page 2

Name of Project: Capital Gateway Single Family Rental Effective Date: 11/1/2019 Certification Type: IR Anticipated Voucher Code: 1

Head of Household: 370.00 \$ 370.00 \$ 1,602.00 \$ 87.00 \$

Unit Number: _____ Estimating Circumstances Code: _____

Tenant Signatures

Head of Household: _____ Date: 10/15/19 Other Adult: _____ Date: 10/15/19

Spouse/Co-Head: _____ Date: _____ Other Adult: _____ Date: _____

Other Adult: _____ Date: _____ Other Adult: _____ Date: _____

Other Adult: _____ Date: _____ Other Adult: _____ Date: _____

Other Adult: _____ Date: _____ Other Adult: _____ Date: _____

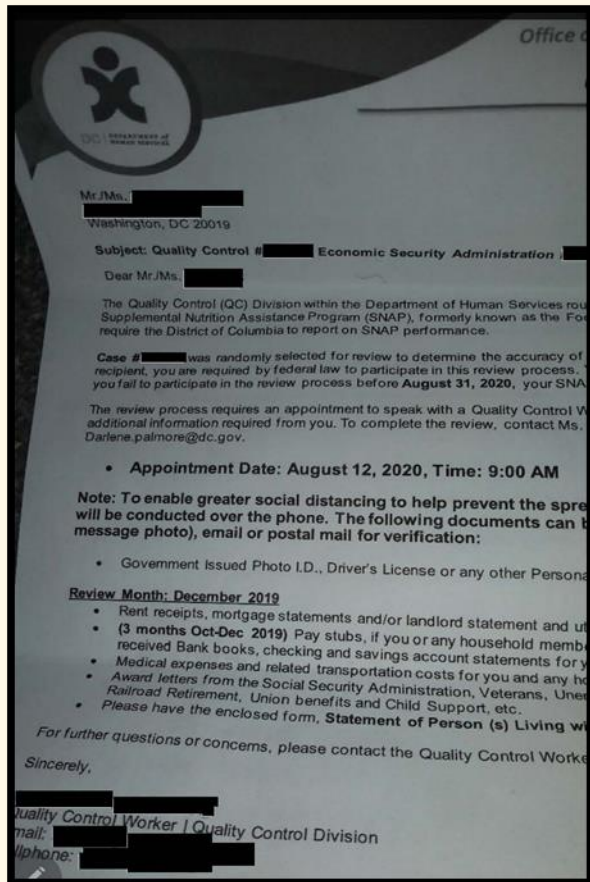
Other Adult: _____ Date: _____ Other Adult: _____ Date: _____

Owner/Agent Signature

Owner/Agent: _____ Date: 10/15/19

Previous versions of this form are obsolete.
This form also replaces HUD-50059-D, -E, -F, & -G.





DHS Quality Control Division

This letter is unacceptable because:

- It does not provide proof of financial benefits being received by the enrolling person.
- Essential information in the document is cut-off and current receipt of benefits can not be confirmed.