CITY OF HARTFORD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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LUKE A. BRONIN
Mayor

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Health Director

Relocation Assistance Program Comparable Unit Referral Form

Date: _____ Primary Resident Name: _____Displacement Address:

Resident's Phone Number: _____ | City of Hartford HHS Rep.: _____ Title _____

Please fill out the section below based on the property in which you were displaced.						
Number of Rooms	**Number of BEDROOMS**	**Address of Displacement**	**Monthly Rent**	**List Included Utilities**		**Cold Flat**
			$			

Please fill out the table based on the prospective apartment referrals.									
Date of View	Number of Rooms	Number of **Bedrooms**	Prospective Address	Monthly Rent $	Included Utilities -or- Cold Flat (No Utilities Included)		Contact Name & Number of Prospective Location	**Initial Box – Whether Selected** or **Declined** the Offer.	
1.								**Accepted by:**	**Declined by:**
2.								**Accepted by:**	**Declined by:**

A SIGNATURE FROM HEALTH & HUMAN SERVICE IS REQUIRED ON THIS FORM:

Resident: By signing you are certifying your decision. **Print Name: _____ Signature: _____ Date: _____**

-AND/OR-

HHS Representative.: By signing you are certifying the resident's responses. **Print Name: _____ Signature: _____Date: _____**