

**Domestic Violence Action Form – Provider Information**

**\*\*DO NOT SCAN INTO CLIENT RECORD\*\***

Date:		Service Provider:	
Client Last Name:		Location:	
Client First Name:		Case ID #:	
Case Mgr. Name:		Contact Info:	

For all FHEPS B/ LINC 3/ CityFEPS/ CityFHEPS DV survivors requesting a **transfer**:  
 List the names of all household members who will be moving into the new apartment:

\_\_\_\_\_

\_\_\_\_\_

Does your household now include the person identified as the abuser when you first received the rental assistance?  Yes  No

**For any case, including CityFHEPS or FHEPS, indicating a domestic violence experience:**

Are you currently experiencing a domestic violence situation?  Yes  No

Above noted Provider has offered the following information after domestic violence was disclosed or identified during the assistance process with \_\_\_\_\_:

➤ Please place a ✓ next to services offered to the client.

- \_\_\_\_\_ 1) Offered assistance contacting the New York City Domestic Violence Hotline (800-621-4673) to obtain immediate safety planning and referral information.
- \_\_\_\_\_ 2) Offered a referral to HRA’s Non-Residential Domestic Violence Prevention Services.
- \_\_\_\_\_ 3) Offered information regarding how to access services at the NYC Family Justice Centers in all five New York City boroughs.
- \_\_\_\_\_ 4) Received written confirmation of active engagement in domestic violence services with \_\_\_\_\_ provider in the community.

**Client Statement:**

If applicable, please provide information explaining why you feel safe remaining in your apartment or, for transfer requests, moving to a new apartment:

**(Turn Page)**

I, \_\_\_\_\_, certify that the Provider:

- Provided me with the options listed on the previous page regarding domestic violence information and services.
- For clients staying in their current apartment, the Provider offered me a move option and I am choosing to remain in my current apartment.

\_\_\_\_\_  
 Client's Signature Date

\_\_\_\_\_  
 Provider Staff Signature Date

**Do you have a medical or mental health condition or disability?** Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

**Updated Review:**

\_\_\_\_\_  
 Date reviewed with client Client's Signature

\_\_\_\_\_  
 Provider Staff Signature

**TO BE COMPLETED BY HRA OFFICE OF DOMESTIC VIOLENCE ONLY FOR FHEPS B/ LINC3/ CityFEPS /CityFHEPS DV SURVIVORS TRANSFER CASES ONLY**

Reviewed the HRA system for the above household composition and found:

\_\_\_\_\_ none of the members listed include the person who made you eligible for HRA Shelter.

\_\_\_\_\_ the person who made you eligible for HRA Shelter is listed above.

\_\_\_\_\_ no information available.