**FAMILY UNIFICATION PROGRAM**

**(FUP)**

**FUP-YOUTH PROGRAM RESTRICTION ACKNOWLEDGEMENT**

I acknowledge that I have been informed of the program restrictions and understand that this program is limited to 36 months unless I meet the criteria for an extension under the provisions of the Fostering Stable Housing Opportunities (FSHO) amendments.

I acknowledge that voluntary supportive services are available through the HHSA Child Welfare Services (CWS) department during the initial 36-month period of assistance and that acceptance of these services is not a condition of FUP Voucher participation.

I acknowledge that I received information about the availability of an FSS program and an offer of an FSS slot.

This program is administered in accordance with applicable Housing Choice Voucher (HCV) program regulations and requirements, as set forth in 24 CFR 982 and specified in the HACSD Administrative Plan, and in accordance with the FUP Memorandum of Agreement dated 12/12/2019 and FR 6284-N-01 Implementation of the Fostering Stable Housing Opportunities Amendments.

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Participant Name (Type or Print)

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Participant Signature Date