Management Questionnaire

Date: ______________
Project: ______________
Address: ______________
City/State: ______________
Site Contact: ______________
Phone: ______________
Email: ______________

Owner: ______________
Address: ______________
City/State: ______________
Owner Contact: ______________
Phone: ______________
Email: ______________

Management Co. ______________
Address: ______________
City/State: ______________
Region Contact: ______________
Phone: ______________
Email: ______________

Syndicator: ______________
Synd. Contact: ______________
Synd. Email: ______________

How Long has the Site Manager managed this property: _________

Have you had any local code violations within the last 3 years: __________

Affirmative Fair Housing Marketing Plan (AFHMP)

1. Date the AFHM Plan was last approved: ______________ (Updated every 5 years)

~If there are no changes to the plan, a PC-E46 AFHMP Review Verification Form must be submitted with current Fair Housing Training certificates for all applicable staff.

~If there are changes to management, ownership, demographics or marketing/outreach a PC-E45 AFHMP form must be submitted with all mandatory documentation.

2. Is there a tenant selection plan? ☐ Yes ☐ No Effective Date: ____________

Special Needs Housing

Please check all that apply:

☐ ELI (Extremely Low Income) ☐ MSI (Mobility and Sensory Impairment) ☐ Transitional/Permanent Supportive Housing
☐ DD (Developmentally Disabled) ☐ EP (Elderly Persons) ☐ MI (Severe Persistent Mental Illness)
☐ SP (Single Parent) Other: _______________________________

Utility Allowance

Utility Allowance Source: ☐ Owner Paid ☐ PHA ☐ RD ☐ HUD Rent Schedule
OHFA approved: ☐ Engineer's Energy Consumption Model ☐ Utility Company Estimate ☐ HUD Utility Schedule Model
Effective Date: _____________________

Non-OHFA Funding Source(s)

Please mark all that apply: ☐ Section 8 ☐ PBA ☐ TBA ☐ RD 538 ☐ RD 515 ☐ Bonds ☐ Home ☐ PBV 811

Projects with OHFA Gap Financing—HOME/Trust

1. Are the assisted units: ☐ Floating ☐ Fixed;

If 'floating,' does the owner ensure that the rental units are comparable? ☐ Yes ☐ No

When the tenant vacates, is the Next Available Unit made available to a HOME eligible tenant? Yes No N/A

2. When Tenant's income rises above 80% AMI, is the Next Available comparable unit rented to a HOME/Trust-eligible Tenant? Yes No

3. In properties of five or more assisted units are at least 20% of the units rented at or below the LOW HOME Rent level? Yes ☐ No ☐ N/A

4. Were the assisted units initially leased to households per the Funding Agreement? ☐ Yes ☐ No

5. Are tenant leases properly executed and free of all prohibited provisions? Yes ☐ No

6. Are the tenant leases for a minimum of one year (unless otherwise agreed upon by tenant and owners)? Yes ☐ No

7. Does the owner provide adequate information to program applicants about program rules and expectations? Yes ☐ No

8. Is the Contract Rent for HOME units with project-based subsidy in compliance with the HOME rule? Yes No N/A

HOME/Trust Units

Current HDAP Recipient: __________________________ Address: ____

Total # of Assisted Units: _______ # by bedroom size: 0BD:____ 1BD:____ 2BD:____ 3BD:____ 4BD:____ 5BD:____

High Home Units:_____ # Low Home Units:______

Unit #	Date it became HOME unit		Unit #	Date it became HOME unit

*List additional units on additional page if necessary

Building/Units

Number of Buildings: ____ Total Number of Units: ____ Model Unit: ☐ Yes ☐ No

Number of Low-Income Units:____ Number of Market Rate Units: ____ Employee Unit: ☐ Yes ☐ No

List of Market Rate Units:____

811 Units:_____ Unit Numbers:____

List of Bed Bug Units, including those treated within last 30 days: ____

Number of Accessible Units: ____ List Units: ____

Total Number of Vacancies: ____

Number of Vacant units Rent Ready (or could be within 72 hours):____

Number of Vacant units Not Rent Ready (list details below):____

List Vacant Units Not Rent Ready (As Identified Above) (Use additional page if necessary)

Buildings (BIN)	Unit #	Date Vacant	Reason not Rent Ready

Resident Social/Supportive Services

1. Did the project indicate at application that supportive services would be provided? ☐ Yes ☐ No
2. Does the property offer supportive services? ☐ Yes ☐ No
   If 'yes,' specific population(s) served: ____
3. Does the property have an on-site service coordinator/counselor? ☐ Yes ☐ No
   If 'yes,' number of hours/week on site:____
4. Types of services offered: ☐ Mental Health Counseling ☐ Drug/Alcohol Addiction Counseling ☐ Housekeeping ☐ Financial/Credit Counseling ☐ Health Screening or Health Programs ☐ Meal Programs ☐ Daycare ☐ Vocational Training ☐ Youth Programs ☐ Social Events ☐ Other (please list under comments)

Comments/Other Information (Issues of which OHFA should be aware)

____

____

____

____
Completed By (Printed Name)

____
Title

____
Signature

____
Date

For OHFA Use Only

Date Reviewed for Accuracy __________ Analyst Initials __________ Follow-up Required Yes No

Comments/Clarifications

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