

**DHCD Supplemental Rehab Requirements
Pre-Rehabilitation Work Write Up Checklist**

Property Address_____

[] **Termite Inspection**

_____ Name of Inspector

_____ Name of Company

_____ Date of Inspection

YES ☐ NO ☐ Treatment Required?

_____ Date of Treatment

[] **Chimney Inspection**

_____ Name of Inspector

_____ Date of Inspection

Type of Repairs Needed_____

[] **Debris Removal**

Debris to be Removed_____

[] **Electrical Inspection**

_____ Name of Electrical Inspector

_____ Date of Electrical Inspection

Electrical Deficiencies Found_____

[] **Weatherization**

_____ Date of Blower Door **PRE**-test _____ CFM @ 50 pas

_____ Name of Tester

YES ☐ NO ☐ **R-38 Ceiling Insulation?**

YES ☐ NO ☐ Storm Door Present at Front and Rear

Weatherization Deficiencies Found _____

[] **Special Physical Needs Assessment**

YES ☐ NO ☐ Is house occupied by someone with special needs?

Description of Needs _____

[] **Smoke Detector(s) Present** Hard Wired # _____ Battery Powered # _____

Description of Needs _____

The Rehabilitation Specialist hereby certifies that all known deficiencies listed on the DHCD Supplemental Rehab Requirements Post-Rehab Completion Checklist have been addressed and are included in the Work Write Up for repair at the house specified.

Signature of Rehabilitation Specialist

Date

Reviewed by:

Signature of Housing Program Administrator

Date

THIS FORM TO BE SUBMITTED BY THE REHAB SPECIALIST TO THE HOUSING PROGRAM ADMINISTRATOR ALONG WITH THE PRE-INSPECTION FORM AND COMPLETED WORK WRITE UP PRIOR TO SOLICITING BIDS.

DHCD Supplemental Rehab Requirements Post-Rehabilitation Completion Checklist

Property Address _____

Check the answer which best describes rehabilitation efforts.

YES

NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do all housing quality deficiencies appear to have been repaired and does the house now meet DHCD HQS? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does it appear that all work items have been completed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the occupant offer any complaints (if yes, list under comments)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the homeowner, if different, offer any complaints (if yes, list under comments)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the construction activities comply with the adopted community standards? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there evidence of an inspection for termites, pests, lead based paint, and chimneys? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have all debris, abandoned vehicles, and derelict structures been removed from the property? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the inspection reveal that weatherization measures were taken and at least R-38 ceiling insulation is present?
Blower Door POST test _____ CFM @ 50 pas |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the unit occupied by a disabled or elderly person? |
| <input type="checkbox"/> | <input type="checkbox"/> | If yes, were improvements appropriately made? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the electrical system adequate to meet any additional load? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did construction require an electrical service upgrade? |

Is the workmanship ☐ Good ☐ Adequate ☐ Poor

Comments: _____

The Rehab Specialist and the Housing Program Administrator hereby certify that this report accurately summarizes the housing rehab work performed on the house noted.

Rehabilitation Specialist

Date

Housing Program Administrator

Date

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