[Date]

(Client Name)
(Client Address)
Miami, Florida (ZIP)

**RE: Survivorship Rights under the Miami-Dade County CoC TBRA Program**

Dear (Head of Household Name):

We are very sorry to learn of your recent loss on _____. Please accept our condolences for the passage of (client's name).

We wish to notify you of your survivorship rights under the Miami-Dade CoC Tenant-Based Rental Assistance (TBRA) Program. Surviving member(s) of the client's family who were living with the client in the housing unit assisted under Program at the time of death are entitled to a grace period of rental assistance until the expiration of the lease currently in effect. Family members eligible to continue to receive assistance as a household are those family members who were named on the TBRA Lease Addendum at the time of your loss. Family members who join the household in the unit thereafter must pay their pro-rated share of the housing costs.

The household may be eligible for continued participation in the TBRA Program if a remaining household member meets the program's eligibility criteria.

Please make arrangements to meet with me within thirty (30) days of this letter for an income re-certification and to review if the household remains qualified for participation in the TBRA Program.

Please call _____ at _____ to schedule the appointment. Please be prepared to bring picture identification and proof of income for all members of the household (excluding roommates). Failure to do so will jeopardize your family's survivorship rights under the program.

While expiration of survivorship assistance does not require the family to move from the unit you are currently residing in, we extend the services of our Housing Navigation Services to assist you in identifying other housing options prior to expiration of survivorship assistance.

Once again, please accept our condolences. Please do not hesitate to call me with any questions you may have prior to our appointment. My phone number is _____.

Sincerely,

[Name of Housing Specialist]
[Name of PSH Provider]