The Commonwealth of Massachusetts

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Robert Goldstein, MD, PhD
Commissioner

February 12th, 2025

Timothy Carroll
House Clerk
State House Room 145
Boston, MA 02133

Michael D. Hurley
Senate Clerk
State House Room 335
Boston, MA 02133

Dear Mr. Clerk,

Pursuant to Section 31 of Chapter 285 of the Acts of 2024, *An Act relative to treatments and coverage for substance use disorder and recovery coach licensure*, please find enclosed a report from the Department of Public Health entitled "Report on Sober Homes in Massachusetts."

Sincerely,

Robert Goldstein, MD, PHD
Commissioner
Department of Public Health

MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

KATHLEEN E. WALSH
SECRETARY

ROBERT GOLDSTEIN, MD, PhD
COMMISSIONER

Report on Sober Homes in Massachusetts

July 2025

Legislative Mandate

The following information is issued pursuant to SECTION 31. of Chapter 285 of the Acts of 2024, *An Act relative to treatments and coverage for substance use disorder and recovery coach licensure* as follows:

> *(a) The department of public health shall study alcohol and drug free housing, as defined in section 18A of chapter 17 of the General Laws, commonly known as sober homes in the Commonwealth, including the safety and recovery of sober home residents. The study shall include, but not be limited to: (i) appropriate training for operators and staff of sober homes and whether such training should be required; (ii) evidence-based methods for creating safe and healthy recovery environments; (iii) current oversight and additional oversight needed for sober homes; (iv) barriers to sober home facility improvements, including, but not limited to, fiscal constraints; and (v) different aspects, if any, between certified and noncertified sober homes. The department shall hold at least one public hearing as part of its study under this section.*
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> *(b) The department shall submit a report detailing the results of the study, along with recommendations and any proposed legislation necessary to carry out its recommendations, to the clerks of the senate and house of representatives, the joint committee on health care financing, the joint committee on public health, the joint committee on mental health, substance use and recovery and the senate and house committees on ways and means not later than July 31, 2025.*

Introduction

The Commonwealth uses the term "sober home" to refer to a privately owned residence that provides or advertises as an alcohol and drug-free living environment for individuals recovering from substance use disorders. Sober housing does not include substance use disorder residential treatment facilities or any other facility licensed pursuant to section 7 of chapter 111E. Sober homes provide structured and stable housing, emphasizing peer support and the development of recovery capital.[1] Research has demonstrated that sober housing is associated with a variety of positive outcomes for residents, including decreased substance use, reduced likelihood of return to use, lower rates of incarceration, higher income, increased employment, and improved family relationships, making it a critical asset in supporting individuals on their recovery journeys.[2,3] As of January 13, 2025, there are 200 Massachusetts Alliance for Sober Housing (MASH)-certified homes representing 3,129 certified beds across the Commonwealth.

The existing statutory and regulatory authority of the Department of Public Health Bureau of Substance Addiction Services (BSAS) is limited to licensing substance use disorder treatment facilities and programs. Since sober houses do not provide clinical or treatment services, they are not licensed or regulated by BSAS.[4]

Section 18A of Chapter 17 of the General Laws requires the establishment of a voluntary training and accreditation program for sober home operators. Certification is voluntary to ensure compliance with fair housing laws. Through a procured contract with BSAS, the Massachusetts Alliance for Sober Housing (MASH) oversees the voluntary sober home certification process and provides outreach, training, and technical assistance to sober homes or those owners/operators interested in becoming certified.

MASH is the Massachusetts state affiliate of the National Alliance for Recovery Residences (NARR), a nonprofit organization established to set and maintain high standards for recovery residences and dedicated to increasing the availability of well-managed, ethical, and supportive substance-free housing throughout the United States. As an affiliate organization of NARR, MASH developed the Massachusetts standards and code of ethics for certified sober homes based on NARR standards. MASH shares NARR's commitment to providing safe, ethical, and effective environments for recovery by ensuring all certified homes adhere to state and national standards.

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[1] Recovery capital (RC) is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery. The domains of RC include personal, family/social, and community recovery capital (White, W. & Cloud, W. 2008).

[2] Mericle, Amy A., et al. "Sober Living House Characteristics: A Multilevel Analyses of Factors Associated with Improved Outcomes." Journal of Substance Abuse Treatment, vol. 98, Mar. 2019, pp. 28–38, https://doi.org/10.1016/j.jsat.2018.12.004. Accessed 17 Jan. 2020.

[3] Polcin, Douglas L., et al. "Moving Social Model Recovery Forward: Recent Research on Sober Living Houses." Alcoholism Treatment Quarterly, vol. 41, no. 2, Jan. 2023, pp. 1–14, https://doi.org/10.1080/07347324.2023.2167528.

[4] Commonwealth of Massachusetts. 105 CMR 164.00: Licensure of Substance Use Disorder Treatment Programs. 11 Nov. 2022, www.mass.gov/regulations/105-CMR-16400-licensure-of-substance-use-disorder-treatment-programs.

NARR categorizes sober homes into four levels of care. These levels are informed by the American Society of Addiction Medicine's classification of treatment and recovery programs and differ in staffing intensity, governance, and recovery support services.

NARR Levels of Care

- Level 1 (peer-run): Homes are democratically governed. Residents vote on all decisions and follow a house manual with pre-established policies to guide the process. There is no paid or reimbursed staff or external management.
- Level 2 (managed): Homes that use house standards, rules, and peer accountability to maintain safe, healthy, structured living environments with documented policies and procedures. Owners or operators appoint a senior resident to serve as the house manager(s) and are often compensated by free or reduced rent.
- Level 3 (supervised): Homes provide a higher supervised level of support through a structured schedule and programming, including peer-based and other recovery support services. Staff members are trained, credentialed, and present to offer 24/7 support to residents.
- Level 4 (clinical): Homes integrate the social and medical model, using a combination of supervised peer and professional staff. In addition to peer-based recovery support and life skills development, they offer clinical addiction treatment services.

Sober homes in Massachusetts are categorized as NARR Level 2, which means they are privately owned residences that do not provide clinical services and utilize house rules and peer accountability to maintain safe and healthy living environments. Sober homes in Massachusetts cannot operate at NARR Levels 3 and 4, as these levels provide substance use disorder treatment services which would require licensure as a substance use disorder treatment facility by BSAS. In Massachusetts, sober homes shall not be programs licensed by BSAS or otherwise licensed by DPH pursuant to Section 7 of Chapter 111E.

Findings

A. "Appropriate training for operators and staff of sober homes and whether such training should be required."

Sober homeowners and operators are required to attend the "MASH Sober Housing 101 for Potential Operators Training" prior to applying for voluntary MASH certification. This two-day training provides operators with information on MASH Standards, the certification process and required documentation, and the benefits of certification. It includes topics such as learning the role, function, and operations of sober housing, Fair Housing, ADA compliance, and inspection requirements. MASH offers this training in both English and Spanish. Training participants engage in an interactive overview of specific standards, leadership qualities, and ethical parameters, and are trained in implementing best practices for safe and healthy sober houses, including how to create policies and procedures that align with the MASH standards.

MASH requires that peer mentors and managers at MASH-certified homes attend "Peer Manager Training" designed to help peer managers understand their role and function as leaders in the

home, attain the information needed to comply with MASH standards, and recognize and understand how to implement best practices for safe and healthy sober houses that promote long-term recovery in the local community. This six-hour training covers topics like Ethics, Conflict Resolution, and Boundaries, among others. Although it is not part of the initial certification process, it is necessary for maintaining certification and is usually offered four times a year.

It is important to note that sober homes are predicated on the social model of recovery, which emphasizes the role of peers in providing support and learning through shared lived experiences rather than structured training.[5] In this model, the supervision of residents is primarily the responsibility of the home's owner or operator and the house manager or mentor, who is usually a long-term resident.

B. Evidence-based methods for creating safe and healthy recovery environments.

In 2023, the Substance Abuse and Mental Health Services Administration (SAMHSA) published "**Best Practices for Recovery Housing**," outlining 11 best practices for all sober homes. These practices offer a framework designed to enhance and build on existing guidelines for sober housing.[6]

The NARR Recovery Residence Standards are recognized by SAMHSA as a national best practice for certifying levels of quality of care in recovery residences. These standards were developed with input from key regional and national recovery housing organizations, providers at various support levels, and recovery support stakeholders. SAMHSA acknowledges sober or recovery housing that meets these standards as an evidence-based practice and has allocated grant funds to provide technical assistance to promote and facilitate NARR credentialing in states where a credentialing process has not been established. As an affiliate organization of NARR, MASH has developed the Massachusetts standards and code of ethics for certified sober homes based on NARR standards.

C. Current oversight and additional oversight needed for sober homes.

Individuals in recovery who are not currently using substances are protected from discrimination under the federal Fair Housing Amendments Act (FHAA), the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, Massachusetts General Laws (M.G.L.) 151B, and the Massachusetts Zoning Act, M.G.L. c. 40 § 3. These laws protect individuals with disabilities from discrimination in housing, access to government programs, and access to public places. All

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[5] Conceptually, the social model perspective views addiction and recovery as occurring via a reciprocal interaction between the individual and his or her social environment (Wright, 1990). To maximize the beneficial effects of SLHs, service providers create a physical setting, social environment, and shared sense of responsibility among residents that supports recovery (Wittman, et al., 2014). Fundamental characteristics of the social model approach include a goal of abstinence from alcohol and illicit drugs, peer support, resident input into house decisions, and resident participation in household tasks such as cooking and cleaning. (Polcin, et. al. 2023)

[6] Substance Abuse and Mental Health Services Administration. Best Practices for Recovery Housing. Publication No. PEP23-10-00-002. Rockville, MD: Office of Recovery, Substance Abuse and Mental Health Services Administration, 2023.

residences must comply with applicable federal and state anti-discrimination laws. These laws also limit the ability of state and local governments to establish regulatory, zoning, or land use requirements specifically directed at sober housing owners/operators or residents, including regulations in the form of mandatory licensure, registration, certification, or training requirements.[7]

The Fair Housing Amendments Act prohibits state and local governments from imposing any licensure, regulatory, certification, zoning, land use, health and safety, or other requirements on sober homes that have a discriminatory intent or effect. Because of these restrictions, the Commonwealth cannot establish a mandatory certification or licensure process for sober homes. Instead, BSAS established a voluntary certification process in 2016.

Sober homes are incentivized to be certified, as state agencies and their vendors, including treatment programs, hospitals, and probation and parole can only refer clients to certified sober homes. Only certified sober homes can access state funding and only certified sober homes are listed on MASH's public-facing website.

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[7] The FHAA prohibits housing discrimination on the bases of disability in the sale or rental of housing or in the provision of services or facilities in connection with housing. 42 U.S.C. § 3604(f)(1)-(2). The FHAA prohibits discrimination by individuals, and by local, state and federal government. Individuals in treatment or recovery from substance use who are not currently using substances are protected under the FHAA. (*See*, e.g., *Oxford House, Inc. v. Town of Babylon*, 819 F.Supp. 1179, 1182 (E.D.N.Y. 1993); *U.S. v. Southern Management Corp.*, 955 F.2d 914, 921-23 (4th Cir. 1992)). In application, the FHAA prohibits local and state governments from imposing any licensure, regulatory, certification, zoning, land use, health and safety, or other requirements on sober homes that have a discriminatory intent or effect.

Under the FHAA, state or local laws that facially discriminate against housing for persons with disabilities, such as sober homes, are subject to heightened court scrutiny. *See Community House, Inc. of Boise Idaho*, 490 F.3d 1041, 1050 (9th Cir. 2007); *Larkin v. State of Michigan Dep't of Social Services*, 89 F.3d 285, 290 (6th Cir. 1996); and *Bangerter v. Orem City Corp.*, 46 F.3d 1491, 1503-04 (10th Cir. 1995). Under that standard, the government bears the burden to show with reliable studies or evidence that the law (1) benefits the persons in recovery, or (2) responds to legitimate safety concerns, rather than being based on stereotypes. With respect to both requirements, the law must be the least restrictive means to achieve the government's interest. If a nondiscriminatory alternative exists, the facially discriminatory law is invalid under the FHAA. Applying this standard, federal courts have repeatedly rejected state and local efforts to regulate sober homes. (See, e.g., *Nevada Fair Housing Center, Inc. v. Clark County, NV*, 565 F.Supp. 2d 1178 (D. Nev. 2008) (invalidating group home statute imposing spacing requirements and establishing registry of group homes for disabled) and *Jeffrey O. v. City of Boca Raton,* 511 F. Supp. 2d 1339 (S.D. Fla. 2007) (invalidating local ordinance barring sober homes from residential areas and occupancy limit of three unrelated people in residential area)).

In *Human Resource Research and Management Group, Inc., et al. v. County of Suffolk*, 687 F. Supp.2d 237 (E.D.N.Y. 2010), the federal district court struck down four provisions of a local ordinance that applied to "substance abuse houses:" (1) a site-selection provision establishing a notice and approval procedure to assess the desirability of the proposed substance abuse housing in the area under consideration; (2) a requirement that each substance abuse house must have a "certified site manager" living on site 24-hours per day, seven days a week; (3) a limitation of six individuals receiving substance abuse services in the house; and (4) a licensing requirement, which included a fee and an inspection provision. The court ruled that because the ordinance on its face applied to housing for persons recovering from substance use disorder, the law was subject to heightened scrutiny under the FHAA. Applying that standard, the court found that the local government failed to prove, using studies or other reliable evidence, that the requirements of the ordinance served to further any legitimate government interest, and that the requirements were the least restrictive way to advance that interest.

The Department of Public Health has no authority over non-certified sober homes; however, all sober homes are subject to existing state and local laws and regulations applicable to all residential properties, including building and fire codes.

Voluntarily certified sober homes must meet specific standards established by MASH, including regular inspections and adherence to quality guidelines. A full outline of MASH Standards, including domains, principles, and individual standards, is provided in *Appendix A*.

MASH certification requires sober homeowners or operators to do the following:

1. Attend MASH Sober Housing 101 for Potential Operators Training. This training is mandatory before the owner/operator can apply for certification.
2. Meet the NARR Recovery Residence Levels of Support, NARR Level II.
3. Adhere to the MASH Standards and the requirements for MASH certification, including administrative/operational, physical environment, recovery support, and good neighbor expectations.
4. Complete and submit the online MASH Certification Application, pay the certification fee, and pass MASH inspection.

On-site home inspections involve inspecting the property, reviewing the applicant's documentation of policies and procedures, and conducting interviews with operators. The inspection process occurs annually during the recertification of a home. The On-Site Review Checklist is provided in *Appendix B*.

The MASH grievance policy provides oversight and accountability by allowing concerns and complaints to be raised when a certified sober home is not adhering to the MASH Standards or Code of Ethics. MASH collaborates with the Recovery Homes Collaborative (RHC), an independent non-profit organization contracted by BSAS to facilitate home inspections on certification and to support the grievance procedure by processing and investigating complaints against a MASH certified home. Based on the nature of the grievance and the findings of the investigation, the MASH Ethics Committee may recommend suspending or discontinuing a sober home certification to the MASH Board of Directors, which makes the final decision.

D. Barriers to sober home facility improvements, including, but not limited to, fiscal constraints.

BSAS receives a $500,000 state appropriation, which has remained unchanged since its inception in 2016, to support the certification and oversight of sober homes. The Recovery Homes Collaborative and MASH are contracted through procurement to facilitate the certification, credentialing and oversight processes.

Owners of sober homes face financial barriers similar to those of private homeowners and landlords regarding property improvements, including rising material and labor costs, as well as the impact of fluctuating interest rates on financing options. The director of MASH noted that homeowners face additional challenges, including limited access to grant funding for sober home improvements and upgrades, the risk of drawing unnecessary and unwarranted attention from a

municipality when applying for permits, and the potential for resident displacement during construction.[8]

While various types of development can provoke opposition from community members, sober homes can face resistance based on stigma, fears of increased crime, concerns over declining property values, and other perceived negative impacts on the community. In Douglas Poclin and colleagues' study, *Community Context of Sober Living Houses*, stigma was rated as a higher obstacle than practical issues, such as not having sufficient financial resources to pay for residence in a sober home.[9]

E. Different aspects, if any, between certified and noncertified sober homes.

Regardless of certification status, all sober homes must comply with federal, state, and local housing, zoning, and anti-discrimination laws. However, additional oversight by MASH of certified sober homes requires adherence to administrative/operational, physical environment, recovery support, and good neighbor standards (*See Appendix A: MASH Standards).* Only certified sober homes may receive referrals from a state agency or vendor with a statewide contract to provide treatment services or a state agency or officer setting conditions for release, parole, or discharge, pursuant to Section 18A(h) of Chapter 17 of the General Laws.[10]

F. Findings from Sober Home Listening Session

On April 3, 2025, BSAS held a listening session in accordance with Section 31 of Chapter 285 of the Acts of 2024. Information about the session was emailed to over 250 individuals and organizations, distributed through flyers at peer recovery support centers, and shared on social media by recovery community organizations and other partners. Eighty-three individuals attended the listening session, and thirty-two testimonies were provided either orally during the session or as written statements.

	Testified	Attended
Certified Sober Homeowners/Operators	38%	28%
Works in Health and Human Services, Public Health, or Substance Use	31%	40%
Current/Former Sober Home Residents	16%	7%
Community members/allies	13%	11%
Non-Certified Sober Homeowners/Operators	3%	8%
House Managers	3%	6%

[8] Speaker One. “Bureau of Substance Addiction Services Sober Home Listening Session.” 3 Apr. 2025.
[9] Polcin, Douglas L et al. “Community Context of Sober Living Houses.” Addiction research & theory vol. 20,6 (2012): 480-491. doi:10.3109/16066359.2012.665967
[10] The General Court of the Commonwealth of Massachusetts. “General Law - Part I, Title II, Chapter 17, Section 18A.” Malegislature.gov, 2025, malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter17/Section18A.

Data analysis was conducted to identify themes that emerged during the sober home listening session, some of which fell outside the scope of this study. Key themes and study topics have been clustered into the following overarching themes. Testimony from the same individual is counted multiple times if it addressed multiple themes.

Oversight and Certification	Oversight	10
	Certification Standards	6
	Limitations and Gaps	4
Financial Constraints and Affordability	Affordability and Funding Limitations	7
	Operating Costs	6
Local and Legal Challenges	Zoning	5
	Resident Rights	1
	Municipal Inspections	1
Training	MASH Trainings	3
	Increased Support	3

Oversight and Certification

The federal Fair Housing Amendments Act (FHAA) limits the Commonwealth's and BSAS's authority to implement mandatory licensure, regulation, registration, or certification requirements directed specifically at sober home providers and residents. Still, six participants advocated for increased oversight and mandatory certifications to ensure safety and accountability for homes that operate and promote themselves as sober homes. One participant stated, "*I think that they all should be required to be MASH certified so that they do have the training that they need*." Another noted, "*Massachusetts needs some sort of sober house regulatory agency that is responsive and takes action when valid concerns are raised.*"

Participants widely recognized the value of certification for sober homes, with six individuals citing the importance of inspections, grievance procedures, and standards to ensure the safety of residents. "*I agree strongly that MASH has helped significantly reduce safety issues in sober homes that are certified... in-person safety inspections has probably saved countless lives that could have been lost to fires and other accidents*" an individual stated in their testimony.

Four individuals noted that certification does not guarantee adherence to standards or prevent unethical practices among some homes. "*Certified does not always mean better, and non-certified does not always mean worse*," noted one respondent. Another stated, "*A lot of the unethical and illegal activity that occurs in a lot of our sober living houses, even though they are MASH certified*." There was also some concern about the lack of responsiveness when concerns about certified homes were raised and went unaddressed. "*We reported serious safety concerns at two certified homes, overcrowding, life safety violations, and structural issues. Despite repeated calls and emails, we've received no response, and both homes remain certified.*"

The overall sentiment regarding MASH was positive, with eight individuals expressing satisfaction with MASH's credentialing process, standards, or training. However, some participants raised concerns about the lack of responsiveness and suggested revisiting the board structure to avoid any perceived conflicts of interest that might arise from homeowners serving on the board.

Financial Constraints and Affordability

Seven individuals raised concerns about high rent, affordability, and lack of rental assistance scholarships for residents of sober homes. One participant stated, "*I think the cost is incredibly high when we're looking at some of these sober homes in Worcester. Most are $800 to $900 a month.*" Another said, "*Many residents rely on scholarships from organizations to pay for housing fees, and they often do not provide the residents the time they need to start working and get on their feet.*" Others also expressed that the current scholarships (grants) for rent are underfunded and insufficient to support the growing demand.

Six testimonies highlighted issues with high operating costs and rising housing expenses, including increasing property values, utility costs, and insurance rates. "*It's not affordable to purchase a home with the interest rates here. Utilities are astronomical, supplies are astronomical, insurance to insure sober homes is astronomical*," one respondent noted. Another stated, "*MASH recently partnered with the Fletcher Group research team to conduct a study on the sober housing financial landscape in Massachusetts, and the study found that the median annual cost of operating a sober home was over $102,000.*" There was also support of grants to help certified sober homes keep up to date on safety and codes.

Local and Legal Challenges

Five individuals reported that municipalities are attempting to require sober homes to register as rooming or lodging houses, or as commercial properties, resulting in legal proceedings for some homeowners. "*We have a court case coming up where they're trying to force us to license as a lodging house. And my understanding was we were safe under the Fair Housing Act, and we shouldn't have to do that*," an individual stated during testimony.

Other topics within this theme include local oversight of sober homes and renters' rights. One participant stated that all sober homes should be required to be certified, allowing municipal inspectional services departments to inspect them. Another individual spoke about issues regarding the removal of residents who were not compliant with remaining drug or alcohol-free, as sober home residents are extended the same "renters' rights" that require a court eviction process for removal.

Training

Three participants cited the required training as part of the certification process for owner/operators as necessary and valuable. "*I think MASH has done a wonderful job providing training to sober homeowners and operators and managers...it's a good thing that MASH does to provide the training free of charge. I hope that that continues, and the training continues to evolve*," stated a respondent. The participant also said, "*As far as house managers, sober homeowners and operators should really be in charge of the training for their managers*." Although it can also be considered a local challenge, two respondents indicated that it would be helpful for municipalities to be educated about sober homes and their role in the recovery ecosystem, with a respondent stating, "*Some help training cities and towns about sober homes and the purpose of housing people in recovery would be greatly appreciated*."

G. Recommendations

Recommendations reflect the findings of this study, including feedback from the listening session, to enhance and strengthen sober housing in the Commonwealth.

Explore Additional Funding Opportunities

Since 2016, BSAS has supported sober home certification and oversight with a $500,000 annual state budget allocation. Increased funding could support a variety of activities, including but not limited to increased staffing for certification and oversight entities, providing technical assistance to homes that are at risk of losing certification or new homes seeking certification, facilitating additional training for certified home operators and managers, and supporting the collection of a uniform set of data variables for use in quality improvement efforts.

Currently, the Commonwealth is utilizing funding from the U.S. Department of Housing and Urban Development's (HUD) Recovery Housing Program (RHP) to provide rental vouchers to individuals seeking to move into a certified sober home but who have little or no income, as well as to current residents of certified sober homes who have resided in the home less than 55 days at time of application and need financial assistance to maintain their housing. This funding is contingent upon appropriations by HUD. Given federal fiscal uncertainty and the Commonwealth's limited capacity to backfill lost federal funds with state dollars, the Commonwealth should evaluate how it would address any potential gap in the event of a budget cut. Lastly, for sober homes facing financial strain, they may also consider exploring utility group purchasing power opportunities as a cost-saving measure.

Improve Collaboration with Municipalities

BSAS, MASH, and sober homes should continue to establish strong relationships with municipalities, including local officials, businesses, and residents. It is important to address common misconceptions, stigma, and concerns surrounding sober homes and highlight the benefits of sober living and sober housing on the community.

Appendix A: MASH Standards

The MASH Standard has four domains: Administrative and Operational, Physical Environment, Recovery Support, and Good Neighbor. Each domain includes core principles that establish the underlying beliefs that drive MASH's expectations for sober homes. The core principles are followed by individual standards that establish the minimum criteria for certification.

Administrative and Operational Domain

A. Core Principle: Operate with Integrity

1. Are guided by a mission and vision
    a. A written mission statement that corresponds with MASH core principles
    b. A vision statement that corresponds with MASH core principles as stated in this document
2. Adhere to legal and ethical codes and use best business practices
    a. Documentation of legal business entity (e.g. incorporation, LLC documents or business license).
    b. Documentation that the owner/operator has current liability coverage and other insurance appropriate to the level of support.
    c. Written permission from the property owner of record (if the owner is other than the sober home operator) to operate a sober home on the property.
    d. A statement attesting to compliance with nondiscriminatory state and federal requirements.
    e. Operator attests that claims made in marketing materials and advertising will be honest and substantiated and that it does not employ any of the following:
        - False or misleading statements or unfounded claims or exaggerations;
        - Testimonials that do not reflect the real opinion of the involved individual;
        - Price claims that are misleading;
        - Therapeutic strategies for which licensure and/or counseling certifications are required but not applicable at the site; or
        - Misleading representation of outcomes.
    f. Policy and procedures that ensure the following conditions are met if the residence provider employs, contracts with or enters into a paid work agreement with residents:
        - Paid work arrangements are completely voluntary.
        - Residents do not suffer consequences for declining work.
        - Residents who accept paid work are not treated more favorably than residents who do not.
        - All qualified residents are given equal opportunity for available work.
        - Paid work for the operator or staff does not impair participating residents' progress towards their recovery goals.
        - The paid work is treated the same as any other employment situation.

- Wages are commensurate with marketplace value and at least minimum wage.
- The arrangements are viewed by a majority of the residents as fair.
- Paid work does not confer special privileges on residents doing the work.
- Work relationships do not negatively affect the recovery environment or morale of the home.
- Unsatisfactory work relationships are terminated without recriminations that can impair recovery.

g. Policy and procedure that ensures refunds consistent with the terms of a resident agreement are provided within 10 business days, and preferably upon departure from the home.

h. Staff must never become involved in residents' personal financial affairs, including lending or borrowing money, or other transactions involving property or services, except that the operator may make agreements with residents with respect to payment of fees.

i. A policy and practice that provider has a code of ethics that is aligned with the MASH code of ethics. There is evidence that this document is read and signed by all those associated with the operation of the sober home, to include owners, operators, staff and volunteers.

j. Policy and procedures that ensure all residents are age eighteen or older at time of admission.

3. Be financially honest and forthright

a. Prior to the initial acceptance of any funds, the operator must inform applicants of all fees and charges for which they will be responsible. This information needs to be in writing and signed by the applicant.

b. Use of an accounting system which documents all resident financial transactions such as fees, payments and deposits.

- Ability to produce clear statements of a resident's financial dealings with the operator within reasonable timeframes.
- Accurate recording of all resident charges and payments.
- Payments made by 3rd party payers are noted.

c. A policy and practice documenting that a resident is fully informed regarding refund policies prior to the individual entering into a binding agreement.

d. A policy and practice that residents be informed of payments from 3rd party payers for any fees paid on their behalf.

4. Collect data for continuous quality improvement

a. Policies and procedures regarding collection of resident's information. At minimum, data collection will protect individual's identity, be used for continuous quality improvement, be part of day-to-day operations, and regularly reviewed by staff and residents (where appropriate).

B. Core Principle: Uphold Residents' Rights

5. Communicate rights and requirements before agreements are signed

a. Documentation of a process that requires a written agreement prior to committing to terms that includes the following:

- Resident rights
- Financial obligations and agreements
- Services provided
- Recovery goals
- Relapse policies
- Policies regarding removal of personal property left in the residence

6. Protect resident information
    a. Policies and procedures that keep residents' records secure, with access limited to authorized staff.
    b. Policies and procedures that comply with applicable confidentiality laws.
    c. Policies protecting resident and community privacy and confidentiality.

C. Core Principle: Create a culture of empowerment where residents engage in governance and leadership

7. Involve residents in governance
    a. Evidence that some rules are made by the residents that the residents (not the staff) implement.
    b. Grievance policy and procedures, including the right to take grievances that are not resolved by the house leadership to the operation's oversight organization for mediation.
    c. Verification that written resident's rights and requirements (e.g. residence rules and grievance process) are posted or otherwise available in common areas.
    d. Policies and procedures that promote resident-driven length of stay.
    e. Evidence that residents have opportunities to be heard in the governance of the residence; however, decision making remains with the operator.
8. Promote resident involvement in a developmental approach to recovery
    a. Peer support interactions among residents are facilitated to expand responsibilities for personal and community recovery.
    b. Written responsibilities, role descriptions, guidelines and/or feedback for residence leaders.
    c. Evidence that residents' recovery progress and challenges are recognized and strengths are celebrated.

D. Core Principle: Develop Staff Abilities to Apply the Social Model

9. Staff model and teach recovery skills and behaviors
    a. Evidence that management supports staff members maintaining self-care.
    b. Evidence that staff are supported in maintaining appropriate boundaries according to a code of conduct.
    c. Evidence that staff are encouraged to have a network of support.
    d. Evidence that staff are expected to model genuineness, empathy, respect, support and unconditional positive regard.
10. Ensure potential and current staff are trained or credentialed appropriate to the residence level
    a. Policies that value individuals chosen for leadership roles who are versed and trained in the Social Model of recovery and best practices of the profession.

b. Policies and procedures for acceptance and verification of certification(s) when appropriate.

11. Staff are culturally responsive and competent
    a. Policies and procedures that serve the priority population, which at a minimum include persons in recovery from substance use but may also include other demographic criteria.
    b. Cultural responsiveness and competence training or certification are provided.
12. All staff positions are guided by written job descriptions that reflect recovery
    a. Job descriptions include position responsibilities and certification/licensure and/or lived experience credential requirements.
    b. Job descriptions require staff to facilitate access to local community-based resources.
    c. Job descriptions include staff responsibilities, eligibility, and knowledge, skills and abilities needed to deliver services. Ideally, eligibility to deliver services includes lived experience recovering from substance use disorders and the ability to reflect recovery principles.
13. Provide Social Model-Oriented Supervision of Staff
    a. Policies and procedures for ongoing performance development of staff appropriate to staff roles and residence level.
    b. Evidence that supervisors (including top management) create a positive, productive work environment for staff.

Physical Environment Domain

E. Core Principle: Provide a Home-like Environment

14. The residence is comfortable, inviting, and meets residents' needs
    a. Verification that the residence is in good repair, clean, and well maintained.
    b. Verification that furnishings are typical of those in single family homes or apartments as opposed to institutional settings.
    c. Verification that entrances and exits are home-like vs. institutional or clinical.
    d. Verification of 70+ sq. feet for the first bed and 50+ sq. feet per additional bed.
    e. Verification that there are bathroom ratios of 8:1 for women's and 10:1 for men's.
    f. Verification that each resident has personal item storage.
    g. Verification that each resident has food storage space.
    h. Verification that laundry services are accessible to all residents.
    i. Verification that all appliances are in safe, working condition.
15. The living space is conducive to building community
    a. Verification that a meeting space is large enough to accommodate all residents.
    b. Verification that a comfortable group area provides space for small group activities and socializing.
    c. Verification that kitchen and dining area(s) are large enough to accommodate all residents sharing meals together.

d. Verification that entertainment or recreational areas and/or furnishings promoting social engagement are provided.

F. Core Principle: Promote a Safe and Healthy Environment

16. Provide an alcohol and illicit drug free environment
    a. Policy prohibits the use of alcohol and/or illicit drug use or seeking.
    b. Policy lists prohibited items and states procedures for associated searches by staff.
    c. Policy and procedures for drug screening and/or toxicology protocols.
    d. Policy and procedures that address residents' prescription and non-prescription medication usage and storage consistent with the residence's level and with relevant state law.
    e. Policies and procedures that encourage residents to take responsibility for their own and other residents' safety and health.
17. Promote Home Safety

    Operator will attest that electrical, mechanical, and structural components of the property are functional and free of fire and safety hazards.
    Operator will attest that the residence meets local health and safety codes appropriate to the type of occupancy (e.g. single family or other) OR provide documentation from a government agency or credentialed inspector attesting to the property meeting health and safety standards.
    Verification that the residence has a safety inspection policy requiring periodic verification of:
    - Functional smoke detectors in all bedroom spaces and elsewhere as code demands,
    - Functional carbon monoxide detectors, if residence has gas HVAC, hot water or appliances
    - Functional fire extinguishers placed in plain sight and/or clearly marked locations,
    - Regular, documented inspections of smoke detectors, carbon monoxide detectors and fire extinguishers,
    - Fire and other emergency evacuation drills take place regularly and are documented (not required for Level I Residences)
18. Promote Health
    a. Policy regarding smoke-free living environment and/or designated smoking area outside of the residence.
    b. Policy regarding exposure to bodily fluids and contagious disease.
19. Plan for emergencies including intoxication, withdrawal and overdose
    a. Verification that emergency numbers, procedures (including overdose and other emergency responses) and evacuation maps are posted in conspicuous locations.
    b. Documentation that emergency contact information is collected from residents.
    c. Documentation that residents are oriented to emergency procedures.
    d. Verification that Naloxone is accessible at each location, and appropriate individuals are knowledgeable and trained in its use.

Recovery Support Domain

G. Facilitate Active Recovery and Recovery Community Engagement

20. Promote meaningful activities
    a. Documentation that residents are encouraged to do at least one of the following:
        - Work, go to school, or volunteer outside of the residence
        - Participate in mutual aid or caregiving
        - Participate in social, physical or creative activities
        - Participate in daily or weekly community activities
21. Engage residents in recovery planning and development of recovery capital
    a. Evidence that each resident develops and participates in individualized recovery planning that includes an exit plan/strategy
    b. Evidence that residents increase recovery capital through such things as recovery support and community service, work/employment, etc.
    c. Written criteria and guidelines explain expectations for peer leadership and mentoring roles
22. Promote access to community supports
    a. Resource directories, written or electronic, are made available to residents.
    b. Staff and/or resident leaders educate residents about local community-based resources.
23. Provide mutually beneficial peer recovery support
    a. A weekly schedule details recovery support services, events and activities.
    b. Evidence that resident-to resident peer support is facilitated:
        - Evidence that residents are taught to think of themselves as peer supporters for others in recovery
        - Evidence that residents are encouraged to practice peer support interactions with other residents

H. Core Principle: Model Prosocial Behaviors and Relationship Skills

24. Maintain a respectful environment
    a. Evidence that staff and residents model genuineness, empathy, and positive regard.
    b. Evidence that trauma informed or resilience-promoting practices are a priority.
    c. Evidence that mechanisms exist for residents to inform and help guide operations and advocate for community-building.

I. Core Principle: Cultivate the Resident's Sense of Belonging and Responsibility for Community

25. Sustain a "functionally equivalent family" within the residence by meeting at least 50% of the following:
    a. Residents are involved in food preparation.
    b. Residents have a voice in determining with whom they live.
    c. Residents help maintain and clean the home (chores, etc.).
    d. Residents share in household expenses

e. Community or residence meetings are held at least once a week.
f. Residents have access to common areas of the home.

26. Foster ethical, peer-based mutually supportive relationships among residents and staff
    a. Engagement in informal activities is encouraged.
    b. Community gatherings, recreational events and/or other social activities occur periodically.
    c. Transition (e.g. entry, phase movement and exit) rituals promote residents' sense of belonging and confer progressive status and increasing opportunities within the recovery living environment and community.
27. Connect residents to the local community
    a. Residents are linked to mutual aid, recovery activities and recovery advocacy opportunities.
    b. Residents find and sustain relationships with one or more recovery mentors or mutual aid sponsors.
    c. Residents attend mutual aid meetings or equivalent support services in the community.
    d. Documentation that residents are formally linked with the community such as job search, education, family services, health and/or housing programs.
    e. Documentation that resident and staff engage in community relations and interactions to promote kinship with other recovery communities and goodwill for recovery services.
    f. Residents are encouraged to sustain relationships inside the residence and with others in the external recovery community

Good Neighbor Domain

J. Core Principle: Be a Good Neighbor

28. Be responsive to neighbor concerns
    a. Policies and procedures provide neighbors with the responsible person's contact information upon request.
    b. Policies and procedures that require the responsible person(s) to respond to neighbor's concerns.
    c. Resident and staff orientations include how to greet and interact with neighbors and/or concerned parties.
29. Have courtesy rules
    a. Preemptive policies address common complaints regarding at least:
        - Smoking
        - Loitering
        - Lewd or offensive language
        - Cleanliness of the property
    b. Parking courtesy rules are documented.

Appendix B: ON-SITE REVIEW CHECKLIST

Certain NARR/Massachusetts Alliance for Sober Housing standards require "evidence" or "verification" that the practice of the organization applying for certification meets this standard. The Massachusetts Alliance for Sober Housing gathers evidence and verifies compliance through an on-site review. All organizations seeking certification by MASH are required to provide evidence or verification of the following listed elements. If an element is missing, MASH may request that you update your documentation and/or practice or provide a formal response. During the on-site review, reviewers will ask questions about your organizations policies and procedures and verify that the organization is implementing the practices as written in the documentation. Note: MASH considers the term staff to mean any individual in a role of authority within a certified sober home.

Operator: _____

House: _____

Standard		Comment
Current MASH Standards	❑ Operator has read and is familiar with the current MASH standards.	
2i. A policy and practice that provider has a code of ethics that is aligned with the NARR code of ethics. There is evidence that this document is read and signed by all those associated with the operation of the sober home.	❑ Operator is able to show the interviewer copies of the Code of Ethics signed by operator and peer leaders.	Show interviewer.
3.b. Use of an accounting system which documents all resident financial transactions such as fees, payments, and deposits.	❑ Accounting system reflects all charges and payments, including those from 3rd parties.	Provide financial statement for one current resident.
3.c. A policy and practice documenting that a resident is fully informed regarding refund policies prior to the individual entering into a binding agreement.	Please tell me how you document fees/charges? How do you provide a receipt when asked?	Review resident agreement to confirm refund language.
3.d. A policy and practice that residents be informed of payments from 3rd party payers for any fees paid on	How do you inform residents that you have received payments for them by 3rd party payors? ❑ I inform residents about our refund policy prior to	

their behalf	signing a resident agreement and include the refund policy in a written form.	
5.a. Documentation of process that requires a written agreement prior to committing to terms that includes the following: • Resident Rights • Financial obligations, and agreements • Services provided • Recovery goals • Relapse policies Policies regarding removal of personal property left in the residence. 19.c. Documentation that residents are oriented to emergency procedures.	❑ Residents receive a formal orientation. ❑ Resident is provided with copies of the following ▫ Resident Rights ▫ Resident Agreement containing financial information ▫ Grievance process ▫ Emergency procedures ▫ House rules ▫ Communicable Disease Policy ▫ Good Neighbor Policy ▫ Policy on property left behind ▫ Process involves explaining all services that are provided as well as expectations of resident	Review resident file. Operator will offer information on their process when a resident transitions from the home. Please explain how you inform residents of your emergency procedures? Do you collect emergency contact information?
6.a. Policies and procedures that keep residents' records secure, with access limited to authorized staff.		Confirm any onsite storage of records in locked area.
7.a. Evidence that some rules are made by the residents that the residents (not the staff) implement.	Tell me how residents have a say in developing some rules?	
7.c. Verification that written resident's rights and requirements (e.g., residence rules and grievance process) are posted or otherwise available in common areas.		Verify grievance policy, resident rights, are posted or in common area
7.e. Evidence that residents have the opportunities to be heard in the governance of the residence; however, decision making remains with the operator.	Do you have weekly house meetings where residents may bring up questions, concerns, or comments?	

	❑ The residents support each other in recovery and work with the peer leader to ensure the home has a positive recovery environment?	
8.a. Peer support interactions among residents are facilitated to expand responsibilities for personal and community recovery.	How do residents provide peer support for others and model recovery principles? ❑ Residents are expected to provide peer support for others and model recovery principles	
8.c. Evidence that residents' recovery progress and challenges are recognized, and strengths are celebrated.	How are residents' recovery progress and challenges recognized? Can you provide an example?	
9.a. Evidence that management supports staff members maintaining self-care. 9.c. Evidence that staff are encouraged to have a network of support.	Is the peer leader able to take time to work on their own recovery, spend time with family, and engage in recovery support activities outside the home? ❑ The operator has a dedicated strategy to check in with staff to ensure that they can complete their duties and maintain their own recovery (if appropriate) and self-care.	
9.b. Evidence that staff are supported in maintaining appropriate boundaries according to a code of conduct.	❑ House managers/ staff are provided training on how to maintain appropriate boundaries. Give example how?	
9.d. Evidence that staff are expected to model genuineness, empathy, respect, support, and unconditional positive regard.	How do residents and peer leaders interact with one another?	
12.a. Job descriptions include position responsibilities and certification/licensure and/or	❑ I have written job descriptions that are	Review signed job descriptions during site visit.

lived experience credential requirements.	signed by peer leaders or mentors.	
13.c. Evidence that supervisors (including top management) create a positive, productive work environment for staff.	Operator demonstrates evidence of a positive work environment, including ❑ Ability for peer leaders to bring concerns to superiors ❑ Leadership model positive recovery principals ❑ Leadership are aware of any struggles and successes in the house ❑ Adequate resources are provided for peer leaders to perform their duties ❑ Peer leaders are not overworked	
15. a. Verification that a meeting space is large enough to accommodate all residents.		Interviewer confirms compliance.
15. b. Verification that a comfortable group area provides space for small group activities and socializing.		
15.c. Verification that the kitchen and dining area(s) are large enough to accommodate residents to share meals together.		
15.d. Verification that entertainment or recreational areas and/or furnishings promoting social engagement are provided.		
17.c. Verification that the residence has a safety inspection policy requiring periodic verification of:	Please tell me you practice concerning: 1. How often do you check to see all smoke and carbon monoxide detectors, and fire	

• Functional smoke detectors in all bedroom spaces and elsewhere as code demands • Functional carbon monoxide detectors, if residence has gas HVAC, hot water, or appliances, • Functional fire extinguishers placed in plain sight and/or clearly marked locations • Regular, documented inspections of smoke detectors, carbon monoxide detectors and fire extinguishers, • Fire and other emergency evacuation drills take place regularly and are documented.	extinguishers are present and operating correctly? 2. How do you document these inspections? (dated checklist?) 3. How often do you conduct evacuation drills, and how do you document them? 4. Do you have an outside gathering spot where residents should meet in the event the house needs to be evacuated?	
19.a. Verification that emergency numbers, procedures (including overdose and other emergency responses) and evacuation maps are posted in conspicuous locations.		Confirm during site visit.
19.b. Documentation that emergency contact information is collected from residents.	❑ I collect resident emergency contact information. How do you collect a resident's emergency contact information?	
19.d. Verification that Naloxone is accessible at each location, and appropriate individuals are knowledgeable and trained in its use.	❑ We have at least two doses of unexpired Naloxone in the premises and residents are informed on the location of, and the proper administration of, Narcan/Naloxone. How are the residents trained in administering Naloxone?	Confirm during site visit.

21.b. Evidence that residents increase recovery capital through such things as recovery support and community service, work/employment, etc.	❑ Operator works with resident to identify recovery community support activities and helps resident attend ❑ Operator helps resident identify recovery capital needs, and works with resident to form goals on their recovery plans to meet those needs	
22.a. Resource directories, written or electronic, are made available to residents.	What resource directories/flyers are available for residents?	Look for postings, resources. Tell operator about our resource spreadsheet.
22.b. Staff and/or resident leaders educate residents about local community-based resources.	What are some of the local resources you share with residents?	
23.a. A weekly schedule details recovery support services, events, and activities.		Review postings/calendars/schedules.
26.c. Evidence that mechanisms exist for residents to inform and help guide operations and advocate for community building.	During house meetings, are residents given the opportunity to raise issues or make suggestions?	
27. Sustain a "functionally equivalent family" within the residence by meeting at least 50% of the following (a-f)	❑ Residents are involved in food preparation. ❑ Residents have control over who they live with. ❑ Residents help maintain and clean the home e.g., chores. ❑ Residents share in household expenses. ❑ We have house meetings at least once a week. ❑ Residents have access to the common areas of the home.	
28.a. Engagement in informal activities is encouraged.	How do you encourage residents to socialize by engaging in informal	

28.c. Community gatherings, recreational events and/or other social activities occur periodically.	activities (common meals, celebrations, outside events)?
29.a. Residents are linked to mutual aid, recovery activities and recovery advocacy opportunities.	❑ We provide residents with 12 step meeting lists, info on local recovery centers, etc.
29.b. Residents find and sustain relationships with one of more recovery mentors or mutual aid.	❑ We encourage residents to attend 12 step meetings and to obtain a sponsor.
29.c. Residents attend mutual aid meetings or equivalent support services in the community.	
29.f. Residents are encouraged to sustain relationships inside the residence and with others in the external recovery community	❑ Residents are permitted to participate in recognized recovery community meetings and events that support their chosen pathway to recovery
31.b. Parking courtesy rules are documented.	Please tell me what you inform residents concerning parking in the area?

I certify that to the best of my knowledge my organization complies with the MASH standards and the checked provisions herein for all our MASH certified homes.

Signature: _____ Date: _____

Print name and title: _____

Interviewer: _____

MASH Housing Inspection Checklist

Name of Organization
Property Address
Property Owner if different
Inspectors
Type of inspection (Initial, Special or Reinspection)
Date of Inspection
Number of Bedrooms
Number of Bathrooms

HOUSE EXTERIOR	**Any comments or corrections requested**	**Pass or Fail**
Exterior Condition		
Garage Condition if applicable		
House Numbers visible from street		
Mailbox		
Condition of Foundation		
Condition of Stairs, Rails, and Porches		
Condition of Roof/ Gutters		
Condition of Exterior Surfaces		
Condition of Chimney		
Are all painted surfaces free of deteriorated paint?		
If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?		
General Comments:		

ENTRANCE	**Any comments or corrections requested**	**Pass or Fail**
Telephone Available (not mandatory)		
Rules and Bill of Rights		
Furniture in good condition		
Smoke detectors		
Electricity		
Electrical Hazards		
Security		

Window Condition
Ceiling Condition
Wall Condition
Floor Condition
Are all painted surfaces free of deteriorated paint?

If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?
General Comments:

LIVING ROOM	**Any comments or corrections requested**	**Pass or Fail**
Floor B 1 2 3 4		
Furniture in good condition		
Smoke detectors		
Electricity		
Electrical Hazards		
Security		
Window Condition		
Ceiling Condition		
Wall Condition		
Floor Condition		
Are all painted surfaces free of deteriorated paint?		
If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?		
General Comments:		

KITCHEN	**Any comments or corrections requested**	**Pass or Fail**
Floor B 1 2 3 4		
Appliances in working condition		
Smoke detectors		
Fire Extinguishes		
Hot and cold water		

Food available
Eating area present and furniture in good condition
Electricity
Electrical Hazards
Security
Window Condition
Ceiling Condition
Wall Condition
Floor Condition
Are all painted surfaces free of deteriorated paint?

If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?
General Comments:

Laundry	**Any comments or corrections requested**	**Pass or Fail**
Washer and dryer in good condition		
General Comments:		

Heating and Plumbing	**Any comments or corrections requested**	**Pass or Fail**
Adequacy of Heating Equipment		
Safety of Heating Equipment		
Ventilation / Cooling Water		
Water Heater		
Approvable Water Supply		
Plumbing		
Sewer Connection		
General Comments:		

GENERAL HEALTH AND SAFETY	**Any comments or corrections requested**	**Pass or Fail**
Access to Unit		

Fire Exits
Evidence of Infestation
Garbage and Debris
Refuse Disposal
Interior Stairs and Common Halls
Other Interior Hazards
Elevators
Interior Air Quality
Site and Neighborhood Conditions
Narcan (two kits)
Carbon Monoxide Detectors
Are all painted surfaces free of deteriorated paint?

If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?
General Comments:

BEDROOM 1	**Any comments or corrections requested**	**Pass or Fail**
Floor B 1 2 3 4		
# of beds: 1 2 3 4 ___		
Furniture in good condition		
Adequate space per person		
Smoke detectors		
Electricity		
Electrical Hazards		
Security		
Window Condition		
Ceiling Condition		
Wall Condition		
Floor Condition		
Are all painted surfaces free of deteriorated paint?		
If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?		
General Comments:		

BEDROOM 2	**Any comments or corrections requested**	**Pass or Fail**
Floor B 1 2 3 4		
# of beds: 1 2 3 4 ___		
Furniture in good condition		
Adequate space per person		
Smoke detectors		
Electricity		
Electrical Hazards		
Security		
Window Condition		
Ceiling Condition		
Wall Condition		
Floor Condition		
Are all painted surfaces free of deteriorated paint?		
If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?		
General Comments:		

BEDROOM 3	**Any comments or corrections requested**	**Pass or Fail**
Floor B 1 2 3 4		
# of beds: 1 2 3 4 ___		
Furniture in good condition		
Adequate space per person		
Smoke detectors		
Electricity		
Electrical Hazards		
Security		
Window Condition		
Ceiling Condition		
Wall Condition		
Floor Condition		
Are all painted surfaces free of deteriorated paint?		

If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?
General Comments:

BEDROOM 4	**Any comments or corrections requested**	**Pass or Fail**
Floor B 1 2 3 4		
# of beds: 1 2 3 4 ___		
Furniture in good condition		
Adequate space per person		
Smoke detectors		
Electricity		
Electrical Hazards		
Security		
Window Condition		
Ceiling Condition		
Wall Condition		
Floor Condition		
Are all painted surfaces free of deteriorated paint?		

If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?
General Comments:

BEDROOM 5	**Any comments or corrections requested**	**Pass or Fail**
Floor B 1 2 3 4		
# of beds: 1 2 3 4 ___		
Furniture in good condition		
Adequate space per person		
Smoke detectors		
Electricity		
Electrical Hazards		
Security		
Window Condition		
Ceiling Condition		
Wall Condition		
Floor Condition		

Are all painted surfaces free of deteriorated paint?

If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?
General Comments:

BATHROOM 1 **Any comments or corrections requested** **Pass or Fail**
Floor B 1 2 3 4
Half Full
Hot and cold water
Tub/Shower/Sink Toilet Working Properly
Ventilation
Electricity
Electrical Hazards
Security
Window Condition
Ceiling Condition
Wall Condition
Floor Condition
Are all painted surfaces free of deteriorated paint?

If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?
General Comments:

BATHROOM 2 Floor B 1 2 3 4 Half Full	**Any comments or corrections requested**	**Pass or Fail**
Hot and cold water		
Tub/Shower/Sink Toilet Working Properly		
Ventilation		
Electricity		
Electrical Hazards		

Security		
Window Condition		
Ceiling Condition		
Wall Condition		
Floor Condition		
Are all painted surfaces free of deteriorated paint? If not, do deteriorated surfaces exceed two square feet per room and/or is more than 10% of a component?		
General Comments:		