

## MHSA Housing Certification Application

Section 1. Referral Source		FOR OFFICE USE ONLY	
<input type="checkbox"/> MHSA Housing Program <input type="checkbox"/> MHSA Housing Trust Fund <input type="checkbox"/> Both		Date Received ____/____/____ <input type="checkbox"/> Approved <input type="checkbox"/> Denied   Date ____/____/____ Initials _____	
Referring Agency _____ / _____ / _____			
Address _____		City _____	Zip Code _____
Contact Name _____			Phone _____
Email _____			
Section 2. Applicant Information			
Name _____		Phone Number/Message Number _____	Date _____
Social Security Number _____		Date of Birth _____	Gender _____
Mailing Address (Address Where Mail Can Be Received) _____		City _____	Zip Code _____
			IS Number _____
Section 3. MHSA Eligibility Criteria (check all that apply)			
<input type="checkbox"/> Adult or older adult with a severe and persistent mental illness (as defined in Welfare and Institutions Code 5600.3) <input type="checkbox"/> Child/adolescent with severe emotional disturbance (as defined in Welfare and Institutions Code 5600.3) <input type="checkbox"/> Individual has a co-occurring mental health and substance abuse disorder <input type="checkbox"/> Current mental health service provider: _____			
Section 4. Homeless or At Risk of Homelessness Status (check all that apply)			
Length of most recent episode of homelessness: _____ <input type="checkbox"/> Living in an overcrowded setting in which they do not hold a lease <input type="checkbox"/> Living on the streets <input type="checkbox"/> Living in substandard housing subject to an official notice to vacate <input type="checkbox"/> Living in an emergency shelter or in transitional housing <input type="checkbox"/> Paying more than 50% of income in housing costs <input type="checkbox"/> Living in an institutional setting (e.g. jail, juvenile hall/camp, psychiatric hospital or IMD) and will be homeless upon release <input type="checkbox"/> "Doubling up" or "couch surfing" due to economic hardship <input type="checkbox"/> Lacking a fixed, regular and adequate nighttime residence <input type="checkbox"/> Living in motels, hotels, trailer parks or camp grounds <input type="checkbox"/> Temporarily living in a residential care facility <input type="checkbox"/> Victim of domestic violence who is unable to obtain housing <input type="checkbox"/> Facing eviction & unable to identify a new residence <input type="checkbox"/> Other (please explain): _____			
Section 5. Income			
<b>Sources (check all that apply):</b> <input type="checkbox"/> SSI <input type="checkbox"/> VA <input type="checkbox"/> Unemployment <input type="checkbox"/> SSDI <input type="checkbox"/> Social Security <input type="checkbox"/> None <input type="checkbox"/> SDI <input type="checkbox"/> CalWORKS <input type="checkbox"/> Other (list below): _____ <input type="checkbox"/> GR <input type="checkbox"/> Wages/salary _____		<b>Benefit Establishment Status (if applicable):</b> Type of benefit: _____ Date Application Submitted ____/____/____   Pending   Denied   Appealed Type of benefit: _____ Date Application Submitted ____/____/____   Pending   Denied   Appealed	
Section 6. Desired Location			
Address of Unit Requested (if known):		Requested Service Area(s):	
Street Address _____	Unit/Apt. _____	<input type="checkbox"/> SA 1: Antelope Valley <input type="checkbox"/> SA 2: San Fernando/Santa Clarita Valleys <input type="checkbox"/> SA 3: San Gabriel Valley <input type="checkbox"/> SA 4: Metro <input type="checkbox"/> SA 5: West <input type="checkbox"/> SA 6: South <input type="checkbox"/> SA 7: East <input type="checkbox"/> SA 8: Harbor	
City _____	State _____	Zip _____	
Section 7. Household Size			
(attach additional page if necessary)			
<input type="checkbox"/> 1 person	<input type="checkbox"/> 2 people	<input type="checkbox"/> 3 people	<input type="checkbox"/> 4 people <input type="checkbox"/> Other _____
If more than one person is checked above, complete the following:			
Name: _____	Name: _____	Name: _____	
Relationship: _____	Relationship: _____	Relationship: _____	
Date of Birth: _____	Date of Birth: _____	Date of Birth: _____	
Age: _____	Age: _____	Age: _____	
Signed Authorization to Disclose Client's Protected Health Information attached <input type="checkbox"/> Yes <input type="checkbox"/> No			
This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Codes, Civil Codes and Health Information and Portability Act (HIPPA) Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.			
Applicant Signature _____		Signature of Representative from Referring Agency _____	
Date _____		Date _____	
Send to: Department of Mental Health Housing Policy & Development Attn: Housing Coordinator 695 S. Vermont Ave, 10th floor Los Angeles, CA 90005 fax (213) 637-2336			