COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE CHIEF DEPUTY DIRECTOR

HOUSING ASSISTANCE PROGRAM - UNIVERSAL APPLICATION
INSTRUCTIONS

HOUSING ASSISTANCE PROGRAMS CHECKLIST (pg. 2)
This checklist will identify all required documentation that must be submitted when applying for any housing assistance component.

- Use this checklist to ensure you have included all the required documents.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO BRILLIANT CORNERS
This form must be completed when applying for any housing assistance program.

- The form must be signed and dated by the client / personal representative.

AGENCY VERIFICATION OF HOMELESSNESS
This form must be completed when applying for Security Deposit and Household Goods

- The form must be completed by the referring agency and signed by Case Manager and Program Head.

CERTIFICATION OF RESIDENCE IN A HOMLESS FACILITY
This form must be completed when applying for Security Deposit and Household Goods.

- Must be completed and signed by the homeless facility staff member.

REQUEST FORM (pg. 3)
This form must be completed when applying for any housing assistance program.

- Check the appropriate program that applicant is currently enrolled or check "other" and include the name of the Program.
- Check the type of housing assistance requested. If applying for more then one program check all that apply.
- Check if applicant is a Section 8 or Shelter Plus Care recipient. Check neither if it does not apply.
- Complete client and agency's information.
- Must be signed by Applicant, Case Manager and Program Manager.

DEMOGRAPHIC SHEET (pg.4)
This form must be completed when applying for any housing assistance program.

- Complete Income Status, Housing Status, and Demographic Information Sections, by checking all that apply.
- Only complete On-going Section when applying for On-going Rental Assistance.
- Only complete Eviction Prevention Section when applying for Eviction Prevention.

HOUSEHOLD GOODS REQUEST FORM (pg. 5)
Complete these forms when applying for Household Goods along with page 2 & 3.

- If applying for household goods or utilities assistance use page 5.
- Check type of utility being requested, if applying for more then one program check all that apply. ***(For DMH Directly Operated FSP ONLY)***
- Complete vendor's name, amount requested, and itemized cost.
- When applying for Household Goods list the requested items and attach merchant's invoice.
- When requesting assistance with utilities, attach utility bill.
- Must be signed by Case Manager and Program Manager.

RENTAL ASSISTANCE AGREEMENT FORM (pg. 6)
Complete this form when applicant is enrolled in a DMH Directly Operated FSP Program along with page 2 & 3.

- Complete month(s) of rental assistance being requested, and the regular monthly rent amount.
- Complete housing plan section.
- Must be signed by Applicant, Case Manager and Program Manager.

LANDLORD VERIFICATION FORM (pg. 7)
This form must be completed by Landlord when applicant is applying for Security Deposit, Eviction Prevention, and/or On-Going Rental Assistance. Submit with completed application.

- Present to Landlord for completion along with W-9 form.
- Must be signed by Applicant and Landlord.

PATH PROGRAM INDIVIDUALIZED HOUSING PLAN (pg.8)
This form must be completed when applying for PATH funds.

- Complete if applying for PATH funds
- Provide Authorization to Release Information to Homeless Management Information System (HMIS)

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
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HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION

CHECKLIST

REQUIRED DOCUMENTS
(General requirements for any Housing Assistance Program).

- ❒ Photo Identification ***and*** Social Security Card of applicant and all household members 18 years of age and older.
- ❒ Social Security Card ***or*** Birth Certificate for any child in the household under the age of 18.
- ❒ Applicant's Income Verification dated **within 30 days** (i.e., payroll stubs, verification of receipt of SSI, SSDI or SDI Benefits).
- ❒ If the client is a **Section 8 or Shelter Plus Care recipient**, attach one of the following items:
  - ❒ ***Letter of Determination**** from the City Housing Authority, or;
  - ❒ Verification of ***Lease Approval**** from the County Housing Authority.

**These letters stipulate (1) tenant and landlord respective shares of rent and (2) statement that the unit has been inspected and approved.*

- ❒ If the applicant is NOT a **Section 8** or **Shelter Plus Care** recipient**,** the following documents **MUST** be provided with the application:
  - ❒ Signed copy of the Lease Agreement and;
  - ❒ Verification of Property Ownership (Deed of Trust, Property Tax Bill or a notarized letter verifying ownership.)
- ❒ **Completed W-9 Form by the VENDOR/PROPERTY OWNER/PROPERTY MANAGEMENT AGENCY**

EVICTION PREVENTION
(Required documents for Eviction Prevention, in addition to the general required documents indicated above).

- ❒ *Notice to Evict* with the date of eviction clearly stated. (i.e., 3 day notice, 30 day notice)
- ❒ Evidence that the applicant has resided in the unit for at least 6 months (lease agreement)

HOUSEHOLD GOODS
(Required documents for Household Goods, in addition to the general required documents indicated above).

- ❒ Original receipt or vendor's invoice. (Internet generated invoice, must submit receipt of items purchased.)
- ❒ Verification that applicant was homeless prior to moving into current residence.

DMH - DIRECTLY OPERATED FSP AND WELLNESS CENTERS
(Required documents for applicants enrolled in Directly Operated FSP & Wellness Center Programs for any housing assistance request, in addition to the general required documents indicated above).

- ❒ Signed Rental Assistance Agreement Form. (FSP Only)
- ❒ Completed *CSS Request Form* must be signed by the Applicant, Case Manager, and the Mental Health Clinical Program Head. This form **MUST** accompany Housing Assistance Applications.
- ❒ Signed SSP-14 Form

PATH PROGRAMS
(Required documents when applicant is applying for PATH funds; Move-In, Eviction, Utilities, and Rehab)

- ❒ PATH Program Individualized Housing Plan
- ❒ Authorization to Release PHI to HMIS

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
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HOUSING ASSISTANCE PROGRAMS – UNIVERSAL APPLICATION

REQUEST FORM

Please check all that apply:

Applicant is currently enrolled in: ❑ CRS ❑ PEI/CORS ☐ FSP ❑ Wellness ☐ FCCS ☐ PATH ☐ Other_____

Type of assistance applicant is applying for:

❑ Security Deposit ❑ Eviction Prevention ❑ On-going Rental Assistance **(DMH Directly Operated FSP requesting more than one month)**

❑ Household Goods ❑ Utility Assistance **(PATH Applicants and DMH Directly Operated FSP ONLY)** ❑Rental Assistance

Is applicant a recipient of: ❑ Section 8 ❑ Shelter Plus Care ❑ Neither

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Applicant's Name: _____ Phone:(_____) _____

Head of Household: _____ Phone :(_____) _____
(If different from applicant)

Current Address: _____ City:_____Zip:_____

MIS #: _____ SSN: _____ DOB: _____

Agency Name: _____

Address: _____ City: _____ Zip: _____

Case Manager/Housing Specialist: _____

Phone: (_____) _____ Fax: (_____) _____ Email:_____

The agency declares and certifies each of the following statements to be true and correct:

1. The agency is currently providing mental health services and case management to the applicant and has verified the income and identification of all members of the applicant's household.
2. The agency has provided information to the applicant on tenant-landlord rights and tenant responsibilities, including the appropriate treatment of rental property, appropriate behavior within the neighborhood, and the importance of timely payment of rent.
3. The applicant is eligible to participate in this program and has a documented income source that can reasonably be expected to cover the proposed rent and living expenses.
4. The applicant has assured the agency that they have not received eviction prevention or security deposit assistance through the Housing Assistance Program in the last 12 months.

Applicant: _____ _____
Signature Date

Case Manager/
Housing Specialist: _____ _____
Signature Date

Program Manager: _____ _____
Signature Date

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
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INCOME STATUS

What is your total monthly income? $ _____ Total monthly expenses? $ _____

What is your current source(s) of income? (Check all that apply.)

❑ Employment
❑ General Relief
❑ Child Support
❑ CalWORKS (TANF)
❑ Social Security Retirement
❑ State Disability Insurance
❑ Unemployment Insurance
❑ Supplemental Security Income
❑ Veteran's Administration Pension
❑ Family/Friend
❑ None
❑ Other (Specify) _____

Please give a brief description of why applicant needs housing assistance:

_____

_____

HOUSING STATUS

Are you currently homeless? ❑ Yes ❑ No
(If you do not have a permanent place to live, you are considered homeless)

Number of occasions of homelessness in the last 3 years: _____

What is the length of your current episode of homelessness:

❑ Less than 2 days
❑ 31- 90 days
❑ Over 1 year
❑ 2-30 days
❑ 91 days to 1 year
❑ Unknown

Location of your current episode of homelessness:

❑ SA 1 Antelope Valley
❑ SA 2 San Fernando Valley
❑ SA 3 San Gabriel Valley
❑ SA 4 Metro
❑ SA 5 West LA
❑ SA 6 South LA
❑ SA 7 South East
❑ SA 8 Harbor

Length of your previous episode of homelessness:

❑ Less than 2 days
❑ 31- 90 days
❑ Over 1 year
❑ 2-30 days
❑ 91 days to 1 year
❑ Unknown

Current Housing Status (check all that apply):

❑ Shelters
❑ Abandon House
❑ Hospital
❑ Motels/Agency Paying
❑ Transitional Housing
❑ Jail/Prison
❑ Foster Care
❑ Safe Haven
❑ Permanent Housing
❑ Living in a Car
❑ Family/Friend
❑ Garage
❑ Motels/Agency Paying
❑ Substance Abuse Treatment Facility
❑ Risk of Eviction
❑ Don't Know
❑ Refused

What circumstance(s) led to your current homelessness?

❑ Reduction in Benefits
❑ Problems with Landlord
❑ Victim of Domestic Violence
❑ Crime Victim
❑ Substance Abuse
❑ Eviction
❑ Jail
❑ Family/Friend Unable to Provide Aid
❑ Loss of Job
❑ Acute Illness
❑ Problems with Tenants or Spouse
❑ Disability
❑ Hospitalization
❑ Other _____

DEMOGRAPHIC INFORMATION

Gender:

❑ Male
❑ Female
❑ Transgender Male to Female
❑ Transgender Female to Male
❑ Other
❑ Don't Know
❑ Refused

Military Service:

❑ Veteran
❑ Non-Veteran
❑ Unknown

Marital Status:

❑ Single
❑ Married
❑ Divorced
❑ Separated
❑ Widowed
❑ Never Married

Family Type:

❑ Single Adult
❑ Adult w/child
❑ Adult w/children
❑ Two Adults
❑ Two Adults w/child
❑ Two Adults w/children

# of Children:

❑ 1
❑ 2
❑ 3
❑ 4
❑ 5 or more

Is the applicant:

❑ Pregnant
❑ Frail Elderly

Please check and list other co-occurring disorders:

❑ Medical/Physical Condition _____ ❑ Substance Abuse _____ ❑Other _____ Unknown_____

Ethnicity:

❑ Non-Hispanic/Non-Latino
❑ Hispanic/Latino
❑ Asian
❑ Don't Know
❑ Refused

Race:

❑ American Indian or Alaskan Native
❑ Black or African American
❑ White
❑ Native Hawaiian or Other Pacific Islander
❑ Two or More Races
❑ Don't Know
❑ Refused

EVICTION PREVENTION REQUEST:

(must be filled out If applying for eviction prevention)

Does the client:

❑ Rent ❑ Own Monthly rent/mortgage $_____

How long have you lived at your present address? _____

Amount behind in rent/mortgage: $ _____

Note: The payment of rent in arrears cannot exceed one month's rent plus a reasonable documented late charge.

Have you received one of the following? (*Please state date notice was received)*

❑ 3 Day Notice to Pay or Quit _____
❑ 5 day Marshall Notice to Vacate _____
❑ 30 day Notice _____
❑ Unfavorable Court Judgment _____

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HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION

HOUSEHOLD GOODS/REHABILITATION/UTILITIES REQUEST FORM

Applicant's Name: _____

Agency Name: _____ _____

UTILITY REQUEST: ❒ **Electricity** ❒ **Water** ❒ **Gas**

VENDOR INFORMATION:

Vendor _____Amount requesting: $_____

Contact: _____ Phone: (____) _____

Vendor: _____ Amount requesting: $_____

Contact: _____ Phone: (____) _____

Please list items that are being purchase (attach additional sheet if necessary)

VENDOR NAME	DESCRIPTION OF ITEMS	COST		
		UNIT COST	QUANTITY	TOTAL COST
			TOTAL AMOUNT OF REQUEST:	

CERTIFICATION

The agency declares and certifies each of the following statements to be true and correct:

- The agency has verified that the applicant is in need of the requested items and that the requested expenditures are consistent with program guidelines.
- The agency has verified and explained to applicant that the request is not to exceed the limited lifetime allocation of $1000 for appliances, furniture and other household expenses. (FSP & Wellness applicants are subjected to purchase limits as stated in the CSS Expenditure Coding Guide).

Case Manager/
Housing Specialist: _____ _____
Signature Date

Program Manager: _____ _____
Signature Date

SIX-MONTH RENTAL ASSISTANCE AGREEMENT FORM
(DMH Directly Operated FSP ONLY)

As a condition of the Full Service Partnership Rental Assistance Program, I agree to have the County of Los Angeles Department of Mental Health issue a check payable to my landlord each month up to 6 months. This rental assistance payment will be in the amount of $....., for each of the months that I am eligible.

I agree to:

- Work with my Case Manager to (1) find other housing options if needed, (2) participate in establishing benefits to continue rental payments and, (3) assume responsibility of my entire monthly rent.
- Immediately notify my Case Manager of any changes in housing cost or housing composition (including receipt of any other subsidized housing, [i.e. Section 8 or any other rent contributions program]), but not later than 3 business days after the change occurs.

I agree to sign the attached SSP 14 form issued by the Social Security Administration stating that all funds paid on my behalf through the FSP Rental Assistance Program will be paid back to the Department of Mental Health upon receipt of retro-active Supplemental Security Income (SSI) check (as well as subsequent checks) or through other monies received until the balance owed to the Department of Mental Health is paid.

I understand that the rental assistance payments are temporary housing assistance issued to eligible FSP individuals and their families. I also understand that should my FSP services be discontinued within this agreement period, the rental assistance will be discontinued. I elect to accept the rental assistance payments by signing the statements below.

Documentation Status:_____(Citizen, Legal Resident, Undocumented)

Disclaimer: If you are not a legal resident and will not be eligible for SSI, you do not have to sign the SSP 14 form. If your status changes, please inform your case manager.

Housing Plan:_____

ONGOING RENTAL ASSISTANCE
FSP applicants ONLY (must be filled out if applying for Ongoing Rental Assistance)

Type of housing to which you are requesting a subsidy:

- ❑ Unemployment Insurance
- ❑ Supplemental Security Income
- ❑ Veteran's Administration Pension

Requested length of subsidy in months:_____

- ❑ Sober Living
- ❑ Shared/Collaborative Housing
- ❑ Residential Treatment Program
- ❑ Transitional Housing
- ❑ Apartment
- ❑ Other _____

I,_____ *(Participants Name)* accept rental assistance payments and agree to the terms indicated above. I also understand that although DMH is making a partial or full payment of rent and the County is in no way a party to the rental agreement I have with the landlord.

_____ _____
Participant's Name (Print) *Address, City & Zip*

_____ (____)_____ _____
Participant's Signature *Telephone* *Date*

_____ _____ _____ _____
Case Manager *Date* *Program Manager* *Date*

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HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION

LANDLORD VERIFICATION FORM

(To be completed by Landlord)

Please Print

I intend to rent a unit/shared room to:_____

The property is located at_____ _____
Street Address *Apt. #*

_____ _____
City *Zip Code*

Type of Request:

❒ **Security Deposit** ❒ **Ongoing Rental Assistance** (Directly Operated FSP **ONLY**) ❒ **Eviction Prevention**

Please complete if applying for Security Deposit OR Rental Assistance.

Security deposit amount: $_____

Regular months rent: $_____

Tenant's subsidized rent portion: $_____

Please complete if applying for Eviction Prevention.

Rent: $_____

Late charges (as stated in lease): $_____

Tenant's subsidized rent portion: $_____

Apartment/House is: ❒ Furnished ❒ Unfurnished

Rent Includes: ❒ Electricity ❒ Water ❒ Gas ❒ Trash

DATE TENANCY BEGAN/WILL BEGIN: _____/_____/_____

Please make checks payable to: _____
(Checks to be made only to the property owners or authorized Management Company)

Name of Property Owner:_____

Address:_____

Telephone Number: (____) _____/e-mail address_____

Property Owner Signature:_____ **Date:**_____/_____/_____
(or designee)

I understand that this is a Federal and/or State funded program and that abuse of this program is an offense. I certify under penalty of jury that all information that I have provided on this form is true and correct.

Applicant's Signature:_____ **Date**:_____/_____/_____

any damages to the property as caused by the tenant.

DO NOT WRITE IN THIS BOX (For Office Use Only)

Amount Approved for payment: $_____**Initialed By:**_____

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PATH Program
Individualized Housing Plan

Client Name_____ **Date of Initial Homeless Outreach**_____

Using Client's own words, identified Long-Term Housing Goal:

Goals	Strategies	Responsibility (Client/Staff)	Target Date	Accomplished Date
Goal #1 To locate housing	Types of Housing: ☐ Supportive Housing Program ☐ Shelter + Care ☐ Section 8 Voucher ☐ Person Care Home ☐ Lease own Apartment/Room/House Other_____	Case Worker and Client		
Goal #2 To access financial resources for housing	Apply for PATH funds: ☐ Move-In Assistance ☐ Eviction Prevention ☐ Household Goods Assistance ☐ Utilities Assistance ☐ Minor Rehab	Housing Policy & Development and Client		
Goal #3 Participate in mental health and other supportive services in order to retain permanent housing	Initiate services with a mental health provider as a Single Fixed Point of Responsibility with a full array of on going mental health services including: ☐ Psychiatric Services ☐ Medication Support ☐ Case Management ☐ Individual and Group Therapy ☐ Employment/Educ./Voc. Services ☐ Substance Abuse Treatment	Case Worker and Client		

Client Signature *Date* *Case Manager's Signature* *Date*