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

HOUSING ASSISTANCE PROGRAM - UNIVERSAL APPLICATION
INSTRUCTIONS FOR COMPLETING FORMS

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.

REQUEST FOR ASSISTANCE FORM (pg. 3)
This form must be completed when applying for any housing assistance program.
- Check the program where the applicant is currently receiving services or check "other" and include the name of the program.
- Check the type of housing assistance requested. If applying for more than one program, check all that apply.
- Check if the applicant is a recipient of a tenant based subsidy, MHSA project based housing, Market Rate Apartment or Other and indicate the other type of housing.
- Complete applicant and agency information.
- Must be signed by Applicant, Case Manager and Program Manager.

INCOME STATUS, FAMILY COMPOSITION and EVICTION PREVENTION FORM (pg. 4)
The top portion of the form must be completed when applying for any housing assistance program.
- Complete family composition, income status, location of most recent homeless episode sections, by checking all that apply.
- Only complete Eviction Prevention Section when applying for Eviction Prevention.

HOUSEHOLD GOODS / REHABILITATION / UTILITIES REQUEST FORM (pg. 5)
Complete these forms when applying for Household Goods / Utilities / Rehabilitation.
- Check type of utility being requested, if applying for more than one utility check all that apply.
- 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' security deposits and turning on fees, attach utility bill.
- Must be signed by Case Manager and Program Manager.

ON-GOING RENTAL ASSISTANCE AGREEMENT FORM (pg. 6)
This form is only applicable for DMH Directly Operated FSP Programs applying for on going rental assistance.
- 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.
- 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 any housing assistance component.
- Check the appropriate strategy, target date and accomplished date for each of the three goals.
- Must be signed by the client and the case manager.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR HMIS
This form must be completed when applying for any housing assistance program.
- Must be signed and dated by the client / personal representative.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO BRILLIANT CORNERS
This form must be completed when applying for any housing assistance program.
- Must be signed and dated by the client / personal representative. The application cannot be submitted to Brilliant Corners without this signed form.

HAP HMIS SUPPLEMENTAL INFORMATION FORM
This form must be completed when applying for any housing assistance program.
- Must be signed and dated by the client and agency staff. Completing these data elements is a requirement of the funding source. CHEERD will enter the data into the HMIS.

AGENCY VERIFICATION OF HOMELESSNESS
This form must be completed when applying for Security Deposit, Utility Deposit, and Household Goods.
- Must be completed by the referring agency and signed by Case Manager and Program Manager.

CERTIFICATION OF RESIDENCE IN A HOMELESS FACILITY
This form must be completed when applying for Security Deposit, Utility Deposit, and Household Goods.
- Must be completed and signed by the homeless facility staff member.

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

HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION
CHECKLIST

REQUIRED DOCUMENTS FOR ANY HOUSING ASSISTANCE PROGRAM REQUEST

- ❒ Photo Identification of applicant and all household members 18 years of age and older.
- ❒ Authorization For Use/Disclosure of Protected Health Information for HMIS
- ❑ HAP HMIS Supplemental Information Form
- ❒ Completed W-9 Form by the Vendor/property owner/property management agency
- ❒ Authorization For Use/Disclosure of Protected Health Information for Brilliant Corners
- ❒ Agency Verification of Homelessness (*not used for Eviction Prevention*)
- ❒ Certification of Residence in a Homeless Facility (*not used for Eviction Prevention*)
- ❒ PATH Program Individualized Housing Plan

ADDITIONAL REQUIRED DOCUMENTS FOR SECURITY DEPOSIT

- ❒ Applicant's Income Verification dated **within 30 days** (i.e., payroll stubs, verification of receipt of SSI, SSDI or SDI Benefits).
- ❒ If the applicant is a recipient of a **Tenant Based Subsidy such as Section 8 or Shelter Plus Care**, 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 **Tenant Based Subsidy** recipient**,** a signed copy of the Lease Agreement.

ADDITIONAL REQUIRED DOCUMENTS FOR EVICTION PREVENTION

- ❒ *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).

ADDITIONAL REQUIRED DOCUMENTS FOR HOUSEHOLD GOODS

- ❒ The vendor's invoice which must be attached to the application.
- ❒ Signed copy of the Lease Agreement.

ADDITIONAL REQUIRED DOCUMENTS FOR UTILITY ASSISTANCE

(Utility assistance includes paying the utility security deposits and turning on fees)

- ❒ Utility bills from the utility companies.
- ❒ Signed copy of the Lease Agreement.

ADDITIONAL REQUIRED DOCUMENTS FOR ANY DIRECTLY OPERATED FSP CLIENT APPLYING FOR ON-GOING RENTAL ASSISTANCE

- ❒ Signed Rental Assistance Agreement Form.

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

HOUSING ASSISTANCE PROGRAMS – UNIVERSAL APPLICATION

REQUEST FOR ASSISTANCE 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 only)**

❑ Household Goods ❑ Utility Assistance

Is applicant a recipient of: ❑Tenant Based Subsidy (Section 8/Shelter+Care) ❑ MHSA Project Based ❑ Market Rate Apartment ❑ Other Housing_____

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

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

Current Address: _____ City:_____Zip:_____

IS #: _____ 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 _____ _____
Print Name Date

Program Manager: _____ _____
Signature Date

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE CHIEF DEPUTY DIRECTOR
HOUSING ASSISTANCE PROGRAMS – UNIVERSAL APPLICATION
INCOME STATUS / FAMILY COMPOSITION / EVICTION PREVENTION REQUEST FORM

INCOME STATUS

What is the applicant's total monthly income? $ _____ **Total monthly expenses?** $ _____

Indicate the source(s) of income on the HMIS Intake and Enrollment Form, page 2.

FAMILY COMPOSITION

Family Type:
- ❒ Single Adult
- ❒ Adult w / child
- ❒ Adult w / children
- ❒ Two Adults
- ❒ Two Adults w / child
- ❒ Two Adults w / children

Number of Children
- ❒ 1
- ❒ 2
- ❒ 3
- ❒ 4
- ❒ 5 or more

Give a brief description of why the applicant needs housing assistance:

Location of the applicant's most recent 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

EVICTION PREVENTION REQUEST
(Only complete if applying for eviction prevention funding)

Monthly rent $_____

How many months has the applicant lived at the present address? _____ Months

Amount behind in rent:
$ _____

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

Is the client in imminent risk of losing his/her housing within the next 14 days? YES___ NO___

Has the applicant received one of the following? (*Please state date notice was received)*

❑ 3 Day Notice to Pay or Quit (Date: _____)

❑ 5 day Marshall Notice to Vacate (Date: _____)

❑ 30 day Notice (Date: _____)

❑ Unfavorable Court Judgment (Date: _____)

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

HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION

ONLY COMPLETE IF APPLYING FOR HOUSEHOLD GOODS / REHABILITATION / UTILITIES

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 applicants are subject to purchase limits as stated in the CSS Expenditure Coding Guide).

Case Manager/Housing Specialist: _____ _____
Signature Date

Program Manager _____ _____
Print Name Date

Program Manager: _____ _____
Signature Date

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

HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION

ON-GOING RENTAL ASSISTANCE REQUEST 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, such as Shelter Plus Care, Section 8, Rapid Rehousing or any other rent contributions program), but not later than 3 business days after the change occurs.

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)

Housing Plan:_____

_____

_____

ON-GOING RENTAL ASSISTANCE

Type of housing for which you are requesting a subsidy:

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

Requested length of subsidy in months:_____

I,_____ *(Applicant's 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, the County is in no way a party to the rental agreement I have with the landlord.

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

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

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

COUNTY OF LOS ANGELES
OFFICE OF THE CHIEF DEPUTY DIRECTOR

HOUSING ASSISTANCE PROGRAMS - UNIVERSAL APPLICATION
SECURITY DEPOSIT/EVICTION PREVENTION/ON GOING RENTAL ASSISTANCE

LANDLORD VERIFICATION FORM
(To be completed by Landlord)

I intend to rent a unit/shared room to:_____
Print Name of Tenant

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**

Complete if applying for Security Deposit and/or Rental Assistance.

Security deposit amount: $_____

Regular month's rent: $_____

Tenant's subsidized rent portion: $_____

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: _____/_____/_____

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**:_____/_____/_____

This form is not an agreement but only a confirmation of the amount of monies reflected in the rent/lease agreement and does not hold the County liable for any damages to the property caused by the tenant

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

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

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

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*

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name	Last Name
Street Address	City, State, Zip
IS Number / Birth Date	( ) Phone Number

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Countywide Housing Employment and Education Resource Development Division to use and/or to disclose my PHI, as described below, to Los Angeles Homeless Service Authority (LAHSA)/Homeless Management Information System (HMIS).

REDISCLOSURE NOTICE:
I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:
The following information will be disclosed in accordance with Projects for Assistance in Transitioning from Homelessness (P.A.T.H) grant reporting requirements such as: demographics, services, veteran status, co-occurring disorders, homeless history, outcomes (whether client was assisted with household goods, security deposits, maintenance, rehabilitation/repairs, eviction prevention and utility deposits.

Purpose of Disclosure:
My PHI will be used to coordinate services and comply with P.A.T.H. grant reporting and outcome data requirements.
Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

NOTICE

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.

LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.

EXPIRATION DATE

Expiration Date: Date may not exceed five (5) years from the date signed. If no expiration date is indicated, expiration date will expire five (5) years from the date signed. This authorization is valid until: _____

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to LAC-DMH Countywide Housing, Employment, and Education Resource Development, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

_____ _____

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so: _____

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION
HOUSING ASSISTANCE PROGRAM
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

I authorize the use and disclosure of my Protected Health Information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name	Last Name
Street Address	**City, State, Zip**
IS Number	**Birth Date**	**Phone Number** ( )

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Los Angeles County Department of Mental Health (LACDMH) and/or Brilliant Corners to use, receive, share, and/or disclose my PHI, as described below, to property owners; property management companies; and/or vendors of appliances, furniture, and/or other household goods in order to assist homeless individuals with move-in assistance such as security deposits, household goods, eviction prevention, ongoing rental assistance, utility assistance and minor rehabilitative repairs funded by LACDMH.

REDISCLOSURE NOTICE:

I understand that my PHI that is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Used, Received and/or Disclosed:
Information contained in the Housing Assistance Program – Universal Application such as acknowledgment of currently receiving mental health services, verification of other medical conditions or co-occurring disorders, demographics, income, current address, social security number, employment information, the length of homelessness, and any additional information that would assist an individual/family applying for move in assistance funds under the Housing Assistance Program. In addition, any information required for data collection, program evaluation and/or monitoring such as program affiliation, homeless verification, demographics, use of funds, duration of housing stay, income, and frequency, type and financial value of mental health services.

Purpose of Disclosure:
My PHI may be used to determine eligibility and implementation of the LACDMH funded Housing Assistance Program administered by Brilliant Corners for security deposits, assistance with locating and/or maintain permanent housing, advocacy and/or program implementation with property owners or property management companies and compliance with data collection and monitoring/evaluation requirements of the program.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION
HOUSING ASSISTANCE PROGRAM
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

NOTICE

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. *LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.*

EXPIRATION DATE

Expiration Date: This authorization remains valid until the individual or family has vacated the unit that a security deposit or ongoing rental assistance was paid on their behalf, and/or indicated complete satisfaction with any household goods or other services purchased on their behalf under the Housing Assistance Program.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to **LACDMH Countywide Housing, Employment, and Education Resource Development - Housing Policy and Development Unit, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005**. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

Housing Assistance Program - Supplemental Information

Section 1: Identification – Complete for ALL HAP applicants.

Date: _____/ _____/ _____

First Name: _____ **Last Name:** _____

Date of Birth: _____/ _____/ _____ **SSN:** _____ - _____ - _____

Section 2: Complete this Section only if the HAP applicant is enrolled in one of the following:

- ***A DMH directly-operated FSP.***
- ***A MIT, VALOR or HOME program funded by Projects for Assistance in Transition from Homelessness (PATH).***

1. In which of the following programs is the client enrolled: ☐ DMH FSP ☐ PATH MIT ☐ PATH VALOR ☐ PATH HOME
2. Name of clinic/agency providing FSP or PATH services: _____

*** If the client is enrolled in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program, skip Sections #3-7 and sign page 7.**

Section 3: Demographics – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.

Household Type:	**Relationship to Head of Household:**	**Veteran Status** *(Have you ever served in the U.S Military?)*:
☐ Unaccompanied/Single Adult – No Children ☐ More than One Adult – No Children ☐ Single Parent with Child(ren) ☐ Two Parents with Child(ren)	☐ Self ☐ Head of Household's Child ☐ Head of Household's Spouse/Partner ☐ Head of Household's Other Relation Member ☐ Other: Non-relation Member	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused
Gender:	**Ethnicity:**	**Race** *(Check all that apply)*:
☐ Female ☐ Male ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Doesn't Identify as Male, Female or Transgender ☐ Client Doesn't Know ☐ Client Refused	☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino ☐ Client Doesn't Know ☐ Client Refused	☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Client Doesn't Know ☐ Client Refused

Section 4: Benefits, Insurance and Income – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.

Non-Cash Benefits *(Check all that apply)*:	**Health Insurance Provider** *(Check all that apply)*:
☐ None ☐ Food Stamps (CalFresh) Amount: $_____ ☐ WIC ☐ CalWORKs Child Care ☐ CalWORKs Transportation ☐ Other CalWORKs-Funded Services ☐ Temporary Assistance with Rent *(Not ongoing)* ☐ Section 8 or Other Ongoing Assistance with Rent ☐ Other: _____ Amount: $_____ ☐ Client Doesn't Know ☐ Client Refused	☐ No Health Insurance ☐ Medi-Cal ☐ Employer-Provided Health Insurance ☐ MEDICARE ☐ COBRA ☐ State Children's Health Insurance Program ☐ Private Pay Health Insurance ☐ VA Medical Services ☐ Indian Health Services Program ☐ Other: _____ ☐ Client Doesn't Know ☐ Client Refused

Housing Assistance Program - Supplemental Information

Section 4: Benefits, Insurance and Income (continued) – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.	
Income Source *(Check all that apply)*:	**Monthly Income Amount:**
☐ No financial resources	
☐ Earned Income *(employment wages/cash)*	$
☐ Unemployment Insurance	$
☐ Supplemental Security Income (SSI)	$
☐ Social Security Disability Income (SSDI)	$
☐ VA Service-Connected Disability Compensation	$
☐ VA Non-Service-Connected Disability Pension	$
☐ Private Disability Insurance	$
☐ Workers Compensation	$
☐ Temporary Assistance for Needy Families *(CalWORKs)*	$
☐ General Assistance *(General Relief (GR))*	$
☐ Retirement Income from Social Security	$
☐ Pension or Retirement Income from a Former Job	$
☐ Child Support	$
☐ Alimony or other spousal support	$
☐ Other Source (Specify:_____)	$
☐ Client Doesn't Know	
☐ Client Refused	
Total Monthly Income	***$***

Section 5: Homelessness History – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.	
1. What is the client's current housing situation? ***(Check Only One Answer from A, B, C or D Below)***	**2. How long has the client been in this housing situation?** ***(Check Only One Answer from A, B or C Below)***
A. Literally Homeless Situations: ☐ Place not meant for habitation *(e.g. a vehicle, an abandoned building, a bus/train/subway station/airport or anywhere outside including the streets)* ☐ Emergency shelter, including a hotel/motel paid for with an emergency shelter voucher ☐ Safe Haven ☐ Interim Housing *(Check only if the client is chronically homeless <u>AND</u> has a housing voucher <u>AND</u> has not yet moved into permanent housing but is staying in a temporary housing situation including an emergency shelter or Safe Haven)*	***A. For Literally Homeless Situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused
B. Institutional Situations ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center	***B. For Institutional Situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused

Housing Assistance Program - Supplemental Information

Section 5: Homelessness History (continued) – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.

C. Transitional & Permanent Housing Situations ☐ Hotel/motel paid for without an emergency shelter voucher ☐ Housing owned by client, no ongoing housing subsidy ☐ Housing owned by client, with ongoing housing subsidy ☐ Permanent housing for formerly homeless persons where client is using a subsidy specifically for persons who are homeless (e.g. Shelter Plus Care) ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with a VASH subsidy ☐ Rental by client, with a VA Grant and Per Diem/Transition in Place (GPD TIP) subsidy ☐ Rental by client, with ongoing housing subsidy not specifically for persons who are homeless ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons *(including homeless youth)* as defined by HUD	***C. For Transitional & Permanent Housing Situations:*** ☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused
D. Other ☐ Client doesn't know ☐ Client refused	

If the client is currently staying in an Institutional, Transitional or Permanent Housing Situation (Section 5 "1B" or "1C"), then answer the following:

3. On the night before the client began staying in an Institutional, Transitional or Permanent Housing Situation, where was the client staying? ***(Check Only One Answer)***	☐ Place not meant for habitation *(e.g. a vehicle, an abandoned building, a bus/train/subway station/airport or anywhere outside including the streets)* ☐ Emergency shelter, including a hotel/motel paid for with an emergency shelter voucher ☐ Safe Haven ☐ Interim Housing *(Check only if the client was chronically homeless AND had a housing voucher AND had not yet moved into permanent housing but was staying in a temporary housing situation including an emergency shelter or Safe Haven)* ☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center ☐ Hotel/motel paid for without an emergency shelter voucher ☐ Housing owned by client, no ongoing housing subsidy ☐ Housing owned by client, with ongoing housing subsidy ☐ Permanent housing for formerly homeless persons where client is using a subsidy specifically for persons who are homeless (e.g. Shelter Plus Care) ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with a VASH subsidy

Housing Assistance Program - Supplemental Information

Section 5: Homelessness History (continued) – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.	
	☐ Rental by client, with a VA Grant and Per Diem/Transition in Place (GPD TIP) subsidy ☐ Rental by client, with ongoing housing subsidy not specifically for persons who are homeless ☐ Residential project or halfway house with no homeless criteria ☐ Staying or living in a family member's room, apartment or house ☐ Staying or living in a friend's room, apartment or house ☐ Transitional housing for homeless persons *(including homeless youth)* as defined by HUD ☐ Client doesn't know ☐ Client refused
4. If the client was in a place not meant for habitation, an emergency shelter, a Safe Haven or Interim Housing the night before he/she began staying in an Institutional, Transitional or Permanent Housing Situation, how long did the client stay in that place?	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know ☐ Client refused

If the client is currently staying in a place not meant for habitation ("on the streets"), an emergency shelter, a Safe Haven or Interim Housing *(as indicated in Section 5 "1A")* or was in one of these places on the night before the client began staying in an Institutional, Transitional or Permanent Housing Situation *(as indicated in Question #3)*, then answer Questions #*5-7*:	
5. What approximate date did the client start staying on the streets, in an emergency shelter, in a Safe Haven or in Interim Housing?	_____/ _____/ _____
6. In the past three years, how many times did the client return to the streets, an emergency shelter or a Safe Haven after being housed? *(Number of times the client has been on the streets or in an emergency shelter or Safe Haven in the past three years including today)*	☐ One Time ☐ Two Times ☐ Three Times ☐ Four or More Times ☐ Client Doesn't Know ☐ Client Refused
7. In the past three years, what is the total number of months that the client has spent homeless on the streets, in an emergency shelter or in a Safe Haven?	☐ One Month (this time is the first month) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ More than 12 months ☐ Client Doesn't Know ☐ Client Refused

Housing Assistance Program - Supplemental Information

Section 6: Wellness – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.	
Does the client identify as having any of the following (#1-6 below):	
1. <u>AIDS/ HIV</u>?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused
***If Question #1 was answered as "Yes," then the following questions are required:**	
1a. Does the client expect this to substantially impair his/her ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
1b. Does the client have documentation of the disability and severity on file?	☐ No ☐ Yes
1c. Is the client currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
2. <u>A Chronic Health Condition</u>? *A Chronic Health Condition is defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include but are not limited to:* ***heart disease*** *(including coronary heart disease, angina, heart attack and any other kind of heart condition or disease);* ***severe asthma****; diabetes;* ***arthritis-related conditions*** *(including arthritis, rheumatoid arthritis, gout, lupus or fibromyalgia);* ***adult onset cognitive impairments*** *(including traumatic brain injury, post-traumatic distress syndrome, dementia and other cognitive related conditions);* ***severe headache/migraine****;* ***cancer****;* ***chronic bronchitis****;* ***liver condition****;* ***stroke****; or* ***emphysema****.*	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused
***If Question #2 was answered as "Yes," then the following questions are required:**	
2a. Does the client expect this to be of long-continued and indefinite duration AND substantially impair his/her ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
2b. Does the client have documentation of the disability and severity on file?	☐ No ☐ Yes
2c. Is the client currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
3. <u>A Physical Disability</u>?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused
***If Question #3 was answered as "Yes," then the following questions are required:**	
3a. Does the client expect this to be of long-continued and indefinite duration AND substantially impair his/her ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
3b. Does the client have documentation of the disability and severity on file?	☐ No ☐ Yes

Housing Assistance Program - Supplemental Information

Section 6: Wellness (continued) – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.	
3c. Is the client currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
4. <u>A Current Drug or Alcohol Problem</u>?	☐ No ☐ Alcohol* ☐ Drug* ☐ Both Alcohol and Drug* ☐ Client Doesn't Know ☐ Client Refused
***If Question #4 was answered as "Alcohol", "Drug" or "Both Alcohol and Drug," then the following questions are required:**	
4a. Does the client expect this to be of long-continued and indefinite duration AND substantially impair his/her ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
4b. Does the client have documentation of the disability and severity on file?	☐ No ☐ Yes
4c. Is the client currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
4d. How was the client's drug and/or alcohol problem confirmed?	☐ Unconfirmed; Presumptive or Self-Report ☐ Confirmed through Assessment and Clinical Evaluation ☐ Confirmed by Prior Evaluation or Clinical Records
5. <u>A Learning Disability or Developmental Disability</u>?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused
***If Question #5 was answered as "Yes," then the following questions are required:**	
5a. Does the client expect this to substantially impair his/her ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
5b. Does the client have documentation of the disability and severity on file?	☐ No ☐ Yes
5c. Is the client currently receiving services or treatment for this condition?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused
6. <u>A Current Mental Health Condition</u>?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused

Housing Assistance Program - Supplemental Information

Section 6: Wellness (continued) – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.	
***If Question #6 was answered as "Yes," then the following questions are required:**	
6a. Does the client expect this to be of long-continued and indefinite duration AND substantially impair his/her ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
6b. Does the client have documentation of the disability and severity on file?	☐ No ☐ Yes
6c. Is the client currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
6d. How was the client's mental health condition confirmed?	☐ Unconfirmed; Presumptive or Self-Report ☐ Confirmed through Assessment and Clinical Evaluation ☐ Confirmed by Prior Evaluation or Clinical Records
6e. Does the client have a <u>SERIOUS MENTAL ILLNESS (SMI)</u>, and if so, how was it confirmed? A Serious Mental Illness in adults over the age of 18 is defined as a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support and rehabilitation for a long or indefinite period of time. See California Welfare and Institutions Code Section 5600.3(b)(1), "Adults and older adults who have a serious mental disorder."	☐ No ☐ Unconfirmed; Presumptive or Self-Report ☐ Confirmed through Assessment and Clinical Evaluation ☐ Confirmed by Prior Evaluation or Clinical Records ☐ Client Doesn't Know ☐ Client Refused

Section 7: Chronic Homelessness Status – Complete for any HAP applicant not in a DMH directly-operated FSP or PATH-funded MIT / VALOR / HOME program.	
1. Is the client chronically homeless? *To be chronically homeless, the client must be an unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g. a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside including the streets) and/or in an emergency shelter during that time.*	☐ No ☐ Yes

_____
Name of Clinic/Agency Staff Member Completing Form

_____ _____/ _____/ _____
Clinic/Agency Staff Member Signature **Date**

Created: 11/2016

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

AGENCY VERIFICATION OF HOMELESSNESS

CHECK THE APPROPRIATE BOXES UNDER HOMELESS OR CHRONICALLY HOMELESS

I certify that _____ is
(Name of Applicant)

☐ **HOMELESS**

- ☐ an individual who lacks a fixed, regular, and adequate nighttime residence (attach letter acknowledging current living situation along with homeless history with co-signature of program head, manager or director); or
- ☐ an individual who has a primary nighttime residence that is —
  - ☐ a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill) - (Complete and attach Certification of Residence in a Homeless Facility Form);
  - ☐ an institution that provides a temporary residence for individuals intended to be institutionalized -(Complete and attach Certification of Residence in a Homeless Facility Form); or
  - ☐ a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (attach letter acknowledging current living situation along with homeless history with co-signature of program head, manager or director).
- ☐ a victim of domestic violence who is unable to obtain housing - (attach letter explaining current circumstances with co-signature of program head, manager, or director).

OR

☐ **CHRONICALLY HOMELESS**

- ☐ homeless and lives in a place not meant for human habitation, a safe haven or in an emergency shelter, **and**
  - ☐ has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years (attach documentation of one (1) year of continuous homelessness or at least four (4) episodes of homelessness in the past three (3) years with co-signature of program head, manager or director); and
  - ☐ can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
- ☐ an individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria as noted above of this definition, before entering that facility; or
- ☐ a family with an adult head of household (or if there is not adult in the family, a minor head of household) who meets all of the criteria as noted above of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Referring Agency Name: _____

Address: _____

Case Manager's Name/Signature _____

Date: _____ Telephone Number: _____

Program Head's Name/Signature: _____ Date: _____

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

HOUSING ASSISTANCE PROGRAM

CERTIFICATION OF RESIDENCE IN A HOMELESS FACILITY

I, _____ hereby

authorize _____
to release information related to my homeless status to the Department of Mental Health.

_____ _____
(Signature) Date

CERTIFICATION

I certify that _____ stayed at _____
(Name of applicant) (Name of facility)

from _____ to _____.

Before coming to this facility, the applicant reported residing at: (Include a street address if applicable)

_____

_____

from _____ to _____.

Signature: _____ **Date:** _____
(Signature of facility staff person)

Title: _____ **Telephone:** _____

Facility: _____
(Name and address of facility)

Type of Facility:

- ☐ Emergency Shelter
- ☐ Transitional Housing
- ☐ Institution
- ☐ Residential Care Facility
- ☐ Other - Specify_____

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
| | | | – | | – | | | | |

or

Employer identification number
| | | – | | | | | | | |

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ► Date ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.