County of Los Angeles - Department of Mental Health
Countywide Housing, Employment and Education Resource Development
Federal Housing Subsidies Unit

HACoLA HOMELESS SECTION 8 APPLICATION COVERSHEET & CHECKLIST - (rev. 04/04/14)

Client Name:_____ SS#:_____
Name of Agency:DMH /_____ Service Area: _____ Supr. District _____
Housing Liaison:_____ Case Manager:_____
Housing Liaison Phone #:_____ Case Manager Phone #:_____
Housing Liaison Fax #:_____ Case Manager Fax #:_____
Housing Liaison email:_____ Case Manager email:_____

In order to expedite the process of reviewing your referrals, please read the questions thoroughly and fill in the forms completely. Please place a check mark next to the documents listed below that are included in this application packet and arrange forms in the following order:

_____ 1. Application Coversheet and Checklist (DMH form)
_____ 2. Certification of No Conflict of Interest (HACoLA form – Signed by client)
_____ 3. Certification of No Conflict of Interest (DMH form – Signed by Case Manager)
_____ 4. Homeless Section 8 Client Agreement (DMH form – Signed by client)
_____ 5. Homeless Section 8 Service Provider Responsibility Form, 2 pgs. (DMH form)
_____ 6. Authorization for Request or Use/Disclosure of PHI (MH 677 HMIS), 2 pgs. (DMH form)
_____ 7. Authorization for Request or Use/Disclosure of PHI (MH 677 HACoLA), 2 pgs. (DMH form)
_____ 8. LACDMH Notice of Privacy Practices: Acknowledgement of Receipt, 1 pg. (DMH form)
_____ 9. Housing Intake and Needs Assessment, 3 pgs. (DMH form)
_____ 10. Affordable Care Act Certification Form (DMH form)
_____ 11. HMIS Intake and Enrollment Form, 10 pgs. (LAHSA form)
_____ 12. Agency Referral Letter (Include detailed homelessness history and explanation of address on ID if different from current address & why client can't return there.)
___ Third Party Verification Letter (from shelter, transitional residence, etc., on agency letterhead)
_____ 13. Application for Rental Assistance – Homeless Sec. 8 Program, 16 pgs. (not on the web, contact FHSU)
_____ 14. Program Referral Form - Homeless
_____ 15. Homeless Program Application Checklist
_____ 16. Readiness Evaluation
_____ 17. Homeless Condition Certification, 7pgs.
_____ 18. Verification of Disability
_____ 19. Homeless Program – Out of Service Area Agreement
_____ 20. Declaration of Eligibility for Assisted Housing Programs
_____ 21. Verification Consent Form
_____ 22. Listing of Non-Contending Family Members
_____ 23. Move-In Notification Agreement
_____ 24. Reasonable Accommodation Certification
_____ 25. Criminal Background Screening Policy Acknowledgement (Must be completed by all adults)
_____ 26. Criminal Background Consent, 2 pgs (Must be completed by all adults)
_____ 27. Parent/Guardian Authorization for Housing Authority to Obtain Sex Offender Registration Information of a Minor (Complete for **each** household member between the ages of 13 through 17 years old.)
_____ 28. Debts Owed to Public Housing Agencies and Terminations, 2 pgs.
_____ 29. Verification of Income
___ Current **Original** CalWORKs/General Relief (GR) Notice of Action (if applicable)
___ Current **Original** Social Security Award Letter (if applicable)
___ Copy of current bank statements for **all** accounts (includes account holder's full name & entire account #)
___ Employment Letter (if applicable) (from employer for **each** household member who is employed)
___ Copies of last 3 pay stubs (if applicable)
_____ 30. Identification Documents
___ Copies of CA ID/DL for **each** household member age 18 or older
___ Copies of Social Security Card for **each** household member
___ Copies of Birth Certificate for **each** household member

Housing Authority of the County of Los Angeles
Assisted Housing Division ♦ 700 W. Main Street
Alhambra, CA 91801

For Office Use	
ID:	

CERTIFICATION OF NO CONFLICT OF INTEREST

By signing below, I certify that I am not, nor is any person listed on my Housing Authority application for rental assistance an officer, employee, or relative of an officer or employee of the Housing Authority of the County of Los Angeles, the County of Los Angeles Department of Mental Health, or a local or federal government agency who formulates policy or influences decisions with respect to federally funded rental assistance programs or a public official or member of the local governing body or member of Congress.

_____
Print Name

_____ _____
Signature *Date*

Los Angeles County – Department of Mental Health
Countywide Housing, Employment and Education Resource Development
695 South Vermont Avenue, 10th floor, Los Angeles CA 90005

For Office Use	
ID:	

CERTIFICATION
OF
NO CONFLICT OF INTEREST

By signing below, I certify that I am not an officer, employee, or relative of an officer or employee of the Housing Authority of the County of Los Angeles and have no other known conflict of interest.

_____ _____
Print Name – Case Manager Print Name - Client

DMH /
_____
Print Agency Name

_____ _____
Signature – Case Manager Date

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

HOMELESS SECTION 8 PROGRAM CLIENT AGREEMENT

As a participant in the Homeless Section 8 Program with the Housing Authority of the City of Los Angeles (HACLA) or Housing Authority of the County of Los Angeles (HACoLA), **I agree to abide by the following program expectations**:

1. Maintain contact and meet, as necessary, with my case manager at a minimum of once monthly for a minimum of twelve (12) months after lease up if I receive my subsidy from HACLA or eighteen (18) months after lease up if I receive my subsidy from HACoLA.
2. Participate in the development of the Client Coordination Care Plan (CCCP) with my service provider team to pursue my recovery goals.
3. Participate in supportive services to pursue my recovery goals including vocational and educational assistance, life skills classes, budget and money management classes, nutritional planning, and any other supportive services as deemed necessary.
4. Receive quarterly home visits from my service provider team.
5. Abide by the terms of my lease agreement.
6. Provide a signed lease agreement to my service provider team in a timely manner.
7. Provide my service provider team with updated contact information (phone number, address, emergency contact. etc).
8. If applicable, provide my service provider team with information about any school-aged minors in my household and whether they are enrolled in school and receiving entitled benefits so that DMH can be in compliance w/ McKinney Vento's Homeless Assistance Act (42 U.S.C. 11431 et seq.).
9. _____
   _____
10. _____
    _____

Print Client's Name: _____

Client's Signature: _____ Date: _____

Case Manager's Signature: _____ Date: _____

Translated by: _____ Date: _____

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT

HOMELESS SECTION 8 PROGRAM
SERVICE PROVIDER RESPONSIBILITY FORM

To be completed and signed by the Program Agency Manager:

Name of Participant: _____

Name of Agency: DMH / _____

The program manager will ensure that the Homeless Section 8 participant will have an assigned case manager who will be responsible for the following for the duration of client participation in the program:

- Assist the client with completing the required documents by the Housing Authority of the City of Los Angeles (HACLA) or Housing Authority of the County of Los Angeles (HACoLA) and accompany the participant to the scheduled meetings with Housing Authorities.

- Assist the client in a housing search.

- Send signed lease agreements to the Federal Housing Subsidies Unit (FHSU) when received.

- Ensure that the agency remains updated regarding participant's current contact information.

- Maintain, at a minimum, monthly contact with the participant and quarterly home visits.

- Conduct needs assessments to determine appropriate linkage to community-based services such as health care, childcare, alcohol and other substance abuse, education and/or job training, and other services essential for achieving and maintaining independent living.

- Conduct ongoing assessments/evaluations to monitor progress and provide appropriate interventions as needed.

- Provide a Housing Annual Assessment form that incorporates the current housing goal to ensure compliance with housing contracts between DMH and the Housing Authorities. This should be submitted to FHSU each year on the anniversary of the lease up date.

- Update the participant's Client Care Coordination Plan (CCCP) annually and include any appropriate housing-related goals.

- Submit signed MH 677, Authorizations for Request and Use/Disclosure of Protected Health Information (PHI) to allow DMH to disclose PHI to the Housing Authority (MH 677 HACLA or MH 677 HACoLA) and to the Los Angeles Homeless Services Authority/Homeless Management Information System (MH 677 HMIS), and a signed MH 601E, Acknowledgement of Receipt of the LACDMH Notice of Privacy Practices.

- Comply with all requirements of McKinney Vento's Homeless Assistance Act (42 U.S.C. 11431 et seq.) including that they ensure and monitor that households with school-aged minors are enrolled in school and receive entitled benefits.

- Complete all required reports and any other requested documentation including the Client Home Visit Progress Report (HACLA) and Section 8 Homeless Overview (HACoLA) for a minimum of twelve (12) months from the lease up date for HACLA participants and eighteen (18) months from the leased up date for HACoLA participants. These records will be subject to audit by HUD and the local Housing Authority administering the grant.

- Participate in regularly scheduled Housing Liaison meetings to obtain updates on program requirements.

- Assist the client with completing his/her paperwork for the Annual Recertification Packet (HACLA) or Annual Re-exam Packet (HACoLA).

- If the participant is transferred to another directly-operated or contracted DMH agency/program, ensure that the new program is aware that the client is a Homeless Section 8 participant and that they understand the requirements of the program by gaining the signature of the new Program Manager on the Service Provider Responsibility form and submitting it to FHSU.

- Notify FHSU if the participant abandons his/her unit, is deceased, or terminated from Homeless Section 8.

Print Program/Agency Manager's Name: _____

Program/Agency Manager's Signature: _____

Date: _____

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

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: Department of Mental Health to use and/or to disclose my PHI, as described below, to the Los Angeles Homeless Services Authority (LAHSA)/Homeless Management Information System (HMIS) Administration.

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:

Information contained in the Section 8, Special Program application such as verification of disability, demographics, financial information, current and previous addresses, social security number, proof of citizenship/legal residency, employment information and any additional information that would assist an individual/family to obtain housing. Also, any information required to maintain housing such as frequency, type and financial value of services.

Purpose of Disclosure:

My PHI may be used for determination of eligibility for the Section 8 Special Program, assistance with locating and/or maintaining housing, and to meet all of the requirements of the housing program such as entering information into the Homeless Management Information System managed by LAHSA. This information will also be used to coordinate services and track client information.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

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

N O T I C E

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 Section 8 Special Program participant is no longer receiving housing subsidy services through Department of Mental Health's grant with City and/or Housing Authorities.

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 Federal Housing Subsidies 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:

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

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: Department of Mental Health to use and/or to disclose my PHI, as described below, to the Housing Authority of the County of Los Angeles (HACoLA), Special Needs Housing Unit.

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:

Information contained in HACoLA's housing subsidy application such as verification of disability, demographics, financial information, current and previous addresses, social security number, proof of citizenship/legal residency, employment information and any additional information that would assist an individual/family to obtain housing. Also, any information required to maintain housing such as frequency, type and financial value of services.

Purpose of Disclosure:

My PHI may be used for determination of eligibility for housing subsidies assistance, with locating and/or maintaining housing, and to meet all of the requirements of the housing program such as providing quarterly and annual reports.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

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

N O T I C E

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 housing subsidies program participant is no longer receiving services through Department of Mental Health's grant with HACoLA.

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 Federal Housing Subsidies 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:

LAC-DMH NOTICE OF PRIVACY PRACTICES: *Acknowledgement of Receipt* Effective Date: September 23, 2013

TRANSLATION ☐ NO ☐ YES

This Acknowledgement was translated into _____ for the client and /or responsible adult*

_____ _____
PRINT NAME OF TRANSLATOR DATE

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Los Angeles County - Department of Mental Health (LAC-DMH). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://dmh.lacounty.gov/ or on request from our Treatment Team.

I acknowledge receipt of the *Notice of Privacy Practices* of LAC-DMH**.**

Signature: _____ Date:_____
(Client/Responsible Adult)

*Responsible Adult = Guardian, Conservator, or Parent of Minor when required (See Minor Consent)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Treatment Team Member:_____ Date:_____

Reasons why the acknowledgement was not obtained:

- ☐ Client refused to sign (see progress notes for explanation)
- ☐ Other Reason or Comments:

_____

_____

_____

_____

_____

_____

Los Angeles County –Department of Mental Health
Notice of Privacy Practices

Effective: **September 23, 2013**

NOTICE OF PRIVACY PRACTICES (NPP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING /PROTECTED HEALTH INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting your information. We refer to this information as "Protected Health Information" or "PHI". We create a record of the care and services you receive from Los Angeles County-Department of Mental Health ("LAC-DMH"). We need this record to provide you with quality care and to comply with certain legal and payment requirements.

This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI. We are required by law to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices concerning your PHI; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

We use and disclose PHI in many ways. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories required by law.

For Treatment We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, nursing and medical students, or LAC-DMH personnel who are involved in taking care of you. For example, a doctor treating you for a chemical imbalance may need to know if you have problems with your heart because some medications may affect your blood pressure. We may share your PHI for treatment in order to coordinate the different things you need, such as prescriptions, blood pressure checks and lab tests, and to determine a correct diagnosis.

For Payment We may use and disclose PHI about you so that the treatment and services you receive at LAC-DMH may be billed and payment may be collected from you or on your behalf from an insurance company or a third party. For example, we may need to give your health plan information about testing that you received at our facilities so your health plan will pay us or reimburse you for those services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose PHI about you for our LAC-DMH business operations. These uses and disclosures are necessary to run our organization and make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also gather PHI about many of LAC-DMH clients to decide what additional services our facilities should offer, what

services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, nursing and medical students, and other personnel for review and learning purposes. We may also compare the PHI we have with PHI from other organizations and providers to determine how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of PHI so others may use it to study health care and health care delivery without learning the identify of any clients.

For Appointment Reminders We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or medical care at LAC-DMH clinics.

For Your Own Information We may use and disclose PHI to tell you about your own health condition, such as your test results, to tell you about or recommend possible treatment options or alternatives, and to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care We may disclose PHI about you to a family member or other person you designate if you give us permission to do so. We may also tell certain family members about your presence in our facility but only if the law permits us to do so. We may share PHI about you when necessary for a claim for aid, insurance, or medical assistance to be made on your behalf.

For Health Information Exchange (HIE)We, along with other health care providers in the Los Angeles area, participate in one or more health information exchanges. An HIE is a community-wide information system used by participating health care providers to share health information about you for treatment purposes. Should you require treatment from a health care provider that participates in one of these exchanges who does not have your medical records or health information, that health care provider can use the system to gather your health information in order to treat you. For example he or she may be able to get laboratory or other tests that have already been performed or find out about the treatment that you have already received. We will include your PHI in this system.

For Research

Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, a research project may involve comparing the health and recovery of all clients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process, but we may, disclose PHI about you to people preparing to conduct a research project, for example, to help them look for clients with specific medical needs. We will always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

As Required By Law We will disclose PHI about you when required to do so by federal, State or local law, such as laws that require us to report abuse.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To Provide Breach Notification We may use and disclose your PHI, if necessary, to tell you and regulatory authorities or agencies of unlawful or unauthorized access to your PHI. For example, if your PHI is lost or stolen.

SPECIAL SITUATIONS WHEN WE MAY USE OR DISCLOSE PHI/PHI ABOUT YOU:

Workers' Compensation We may release PHI about you for workers' compensation or similar programs to comply with these and other similar legally established programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose PHI about you when required for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of product recalls of the products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect We may disclose PHI about you to a public health authority that is authorized by law to receive reports of child abuse or neglect. We may also disclose your PHI if we believe that you have been a victim of elder or dependent adult abuse or neglect provided the disclosure is authorized by law.

Lawsuits and Dispute If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the privacy of the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official:

- in response to a court order, court-issued subpoena, court- issued warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's authorization;
- about criminal conduct at LAC-DMH facilities; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities as required by law.

Protective Services for the President and Others We may disclose PHI about you to authorized federal or government law enforcement officials so they may provide protection to the President, other authorized or elected persons or foreign heads of state or to conduct special investigations.

Protection and Advocacy Services We may disclose PHI about you to the protection and advocacy agency established by law to investigate incidents of abuse and neglect and to otherwise protect the legal and civil rights of people with disabilities.

Inmates If you are an inmate of a correctional institution or under the custody of a law enforcement official we may disclose PHI about you to the correctional institution or law enforcement official. This disclosure would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING PHI ABOUT YOU

You have the following rights regarding PHI we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your PHI that is used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to the facility where you are receiving treatment/services. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If your health information is available electronically, under certain circumstances, you may be able to obtain this information in an electronic format. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to PHI, you may request, in writing, that the denial be reviewed. Another licensed health care professional chosen by LAC-DMH will review your request and the denial. The person conducting the review will not be the person who previously denied your request. We will comply with the outcome of the review.

Right to Amend If you feel that PHI we have about you is incorrect or incomplete, you may ask us to include additional information in your medical record. You have the right to request an amendment for as long as all of the information, both old and new, is kept by or for LAC-DMH. To request an amendment, your request must be made in writing and submitted to the LAC-DMH facility where the information is in question. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- is not part of the PHI kept by LAC-DMH;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of PHI about you, excluding disclosures for the purpose of treatment, payment or healthcare operations. To request this list or accounting of disclosures, you must submit your request in writing to LAC-DMH or we will provide you with a form to make your request. Your request must state a time period, which may not be more than six years prior to your request. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12- month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member. We will do our best to honor your request; however, except when you fully pay out-of-pocket as explained below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing or we will provide you with a form to make your request. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right To Restrict Disclosure of Information For Certain Services You have the right to restrict the disclosure of information regarding services for which you or someone else has paid in full or on an out-of-pocket basis (in other words you don't ask us to bill your health plan or health insurance company). If you or someone else has paid in full for a service, we must agree to your request and we will not share this information with your health plan without your written authorization, unless the law requires us to share your information.

Right to Request Confidential Communication You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to LAC-DMH or we will provide you with a form to make your request. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must tell us how or where you wish to be contacted. If you do not tell us how or where you wish to be contacted, we do not have to honor your request.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask any of our office staff. You may obtain a copy of this Notice at our website: http://dmh.lacounty.gov/

OTHER USES OF PHI

Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top right-hand corner, the effective date. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://dmh.lacounty.gov/ or you may request one from one of our facilities.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the U.S. Department of Health & Human Services. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, please contact:

Los Angeles County Department of Mental Health (LAC-DMH)
Patients' Rights Division
550 South Vermont Avenue
Los Angeles, CA 90020
(213) 738-4949

To file a complaint with Los Angeles County, contact:

Los Angeles County Auditor-Controller
HIPAA Compliance Unit
500 West Temple Street, Suite 515
Los Angeles, CA 90012
(213) 974-2164
Email: HIPAA@auditor.lacounty.gov

To file a complaint with the Federal Government, contact:

Region IX, Office for Civil Rights,
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (800) 537-7697

County of Los Angeles - Department of Mental Health
Countywide Housing, Employment, and Education Resource Development

HOUSING INTAKE AND NEEDS ASSESSMENT

Date of Assessment

Housing History:

What is client's current living situation?

☐ Motel ☐ Board and Care ☐ Streets, car, parks ☐ Transitional residential program
☐ Sober living home ☐ Friends/family ☐ Homeless shelter
☐ Apartment/SRO ☐ Other _____

Specify name or closest street: _____

Length of time in current situation? ☐ 0-3 months ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months ☐ 12 months or longer

How many people does client live with? _____

Who does client live with? _____

Does client share a room? ☐ Yes ☐ No If yes, with whom? _____

Does client pay rent? ☐ Yes ☐ No If yes, how much? _____

Does client have a key? ☐ Yes ☐ No Does client's unit have running water/electricity? ☐ Yes ☐ No

Does client have access to bathroom and cooking facilities? ☐ Yes ☐ No

What kind of agreement does client have to live there? (lease/informal agreement)

_____

Financial Situation:

What is client's total monthly income? _____

Source of Income: ☐ SSI ☐ GR ☐ VA ☐ SSDI ☐ SDI ☐ CALWORKs/TANF
☐ Food Stamps ☐ Child Support ☐ Employment ☐ Other (such as family support)
☐ Unemployment Insurance ☐ None

Is income expected in the future? ☐ Yes ☐ No If yes, how much? _____

Does client have a payee? ☐ Yes ☐ No Does client have a savings/checking account? ☐ Yes ☐ No

Has client ever served in the United States Military? ☐ Yes ☐ No

Is client eligible for Military/Veterans benefits? ☐ Yes ☐ No

Transportation:

Does client own a vehicle? ☐ Yes ☐ No Does client use public transportation? ☐ Yes ☐ No

Criminal Convictions:

	Client:	Other Household Members:	Date of Conviction:
Drug-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Production/manufacture of Methamphetamine?	☐ Yes ☐ No	☐ Yes ☐ No	
Violence-related?	☐ Yes ☐ No	☐ Yes ☐ No	
Registered as a sex offender?	☐ Yes ☐ No	☐ Yes ☐ No	
Arson?	☐ Yes ☐ No	☐ Yes ☐ No	

Print Client Name _____ IS # _____

DMH /

Agency/Program

Independent Living Supports/Assistance Needed:

Temporary	Ongoing	
☐	☐	Bathing
☐	☐	Care of personal hygiene
☐	☐	Cooking/preparing foods
☐	☐	Laundry
☐	☐	Housekeeping/cleaning
☐	☐	Making/keeping the home safe
☐	☐	Accessing healthcare and medical issues
☐	☐	Grocery shopping
☐	☐	Public/private transportation
☐	☐	Budgeting/banking/money management
☐	☐	Social skills/interpersonal relationships
☐	☐	Exhibiting appropriate behaviors as outlined in lease agreement
☐	☐	Accessing services in crowded places
☐	☐	Paying rent
☐	☐	Maintaining important personal documents and files
☐	☐	Walking a reasonable distance
☐	☐	Ability to wait in line for services
☐	☐	Using public facilities (i.e., post office)

Housing Plan:

How much can client afford to pay in rent? ☐ $0-$300 ☐ $301-$600 ☐ $601-$1,000 ☐ $1,001+

Who will live with the client? _____

_____ Number of minor children _____ Number of adults _____ Number/kind of pets

Does client have a poor credit history? ☐ Yes ☐ No

Does client have financial resources to pay for move-in expenses? ☐ Yes ☐ No

Does client need household furnishings/appliances? ☐ Yes ☐ No

Where does client want to live? Service Area: _____ City: _____

Does anyone in the client's family have physical limitations that would require accommodations? ☐ Yes ☐ No

If yes, what accommodations? _____

Mark all of the following housing situations that client would consider to be acceptable:

Co-Ed environment?	☐ Yes ☐ No	Sharing a unit/room with another family or individual?	☐ Yes ☐ No
Emergency shelter?	☐ Yes ☐ No	Shared or collaborative housing?	☐ Yes ☐ No
DMH Temporary Shelter Program?	☐ Yes ☐ No	Residential drug treatment program?	☐ Yes ☐ No
Sober living home?	☐ Yes ☐ No	Apartment unit/SRO?	☐ Yes ☐ No

In what ways does client need help in locating housing? ☐ Housing referrals ☐ Housing search ☐ Transportation ☐ Completing application ☐ Other _____

Has client ever been evicted from non-subsidized housing? ☐ Yes ☐ No

If yes, how many evictions has client had in the last 10 years? _____

Is client interested in applying for any of the following permanent housing options?

☐ Homeless Section 8 ☐ Shelter Plus Care (SPC) ☐ Section 8 ☐ Project Based Section 8/SPC housing

If yes, complete the questions on the following page:

Shelter Plus Care (SPC) or Homeless Section 8 Eligibility Assessment *(Only Complete If Applicable)*:

Does the client meet HUD homeless criteria (reside in a place not fit for human habitation such as the streets, a park, a car, abandoned buildings, etc., an emergency shelter, transitional housing for clients who originally came from the streets or an emergency shelter, any of these but is spending a short time in a hospital or other institution, residing in a hospital or institution longer than 30 days if there is no discharge plan and the person would be homeless upon discharge, living in a private dwelling and be within one week of a sheriff's eviction with no resources or subsequent residence identified)?

☐ Yes ☐ No

Has the client been HUD homeless for a continuous year or longer? ☐ Yes ☐ No

Has client ever been evicted from a Governmental subsidized housing program (Sec. 8, SPC etc.)? ☐ Yes ☐ No

If client is currently homeless, how many episodes of HUD homelessness has s/he had in the last three years?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Is client a US citizen or legal resident? ☐ Yes ☐ No

Does client reside in:

A place not meant for human habitation such as the streets, a car, abandoned buildings, parks, bus stations, doorways, etc.? ☐ Yes ☐ No

A homeless shelter? ☐ Yes ☐ No

Transitional or supportive housing for homeless persons who originally came from the streets or a homeless shelter? ☐ Yes ☐ No

Any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution and would otherwise sleep in the types of places described above? ☐ Yes ☐ No

A hospital or institution longer than 30 days if there are no resources available or discharge plan in place and the individual will be homeless when discharged? ☐ Yes ☐ No

A private dwelling and be within one week of a Sheriff's eviction (has eviction papers) with no subsequent residence identified, and lacks the resources and support networks to obtain housing? ☐ Yes ☐ No

Is client fleeing from domestic violence? ☐ Yes ☐ No

Shelter Plus Care is designed for clients who need intensive supportive services such as those in Full Service Partnerships (FSP).

Is the client expected to receive approximately $12,000/yr. worth of ongoing supportive services for at least 5 years? ☐ Yes ☐ No

If the client wants to apply for Homeless Section 8:

Will s/he be receiving supportive services for at least 1 year after lease up? ☐ Yes ☐ No

Is client willing to have at least 4 housing visits in the 1st year of occupancy? ☐ Yes ☐ No

What is the client's housing goal? _____

What have been/are barriers to permanent housing? _____

What are the steps/plan to help client achieve housing goal (include how barriers will be addressed)?

_____

_____

_____

_____

_____ _____

Print Client Name IS #

_____

Agency/Program

Provider Signature: _____ Client Signature: _____

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT

AFFORDABLE CARE ACT CERTIFICATION FORM

To be completed and signed by the Case Manager:

Our agency / program certifies that we are ensuring this program participant is assisted in applying for ACA Health Benefits, if appropriate (or officially opting out) and maintaining documentation indicating if the assistance was provided and completed on-site or if a referral was made to an off-site agency.

☐ Check here if participant already has health insurance such as Medi-Cal or Medicare

Name of Participant: _____

Name of Agency: _____

Print Case Manager's Name: _____

Case Manager's Signature: _____

Date: _____

HMIS Intake and Enrollment Form

Client Name / ID: _____

Name/Identification and Contact Information:

HMIS consent form signed? ☐ Yes ☐ No

Legal First Name: _____ Middle Name: _____

Legal Last Name: _____ Suffix: _____

Date of Birth/Code:	SSN/Code:	Last Known Permanent Address (If Known):
___/___/___ ☐ Full ☐ Partial ☐ Don't Know ☐ Refused	___-___-_____ ☐ Full ☐ Partial ☐ Don't Know ☐ Refused	Street: _____ Unit #: _____ City: _____ County: _____ State: _____ Zip: _____-_____ ☐ Full ☐ Don't Know ☐ Refused

Demographics:

Housing:	Family Type:	Relation:	Gender:
☐ Literally Homeless ☐ Imminently losing their housing ☐ Unstably housed and at-risk of losing their housing ☐ Stably Housed ☐ Don't Know ☐ Refused	☐ Unaccompanied ☐ Single Parent ☐ Two Parents ☐ Adults-no children	☐ Self ☐ Spouse ☐ Partner ☐ Child ☐ Stepchild ☐ Other	☐ Male ☐ Female ☐ Transgendered Female to Male ☐ Transgendered Male to Female ☐ Don't Know ☐ Refused ☐ Other

Disabled:	Veteran:	Ethnicity:	Education:	
☐ Yes ☐ No ☐ Don't Know ☐ Refused	☐ Yes ☐ No ☐ Don't Know ☐ Refused	☐ Non-Hispanic ☐ Hispanic ☐ Don't Know ☐ Refused	☐ No Schooling Completed ☐ Nursery School to 4th Grade ☐ 5th or 6th Grade ☐ 7th or 8th Grade ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade	☐ 12th Grade, no diploma ☐ High School Diploma ☐ GED ☐ Post-Secondary School ☐ 4-year College Degree ☐ Graduate School ☐ Unknown

Race (Check all that apply):				
			☐ Don't Know	☐ Refused
☐ Asian	☐ Black/African-American	☐ Native Hawaiian/Pacific Islander	☐ US Indian/Alaska Native	☐ White

Client Note:

Client Note (Optional):	
Type: ☐ Note ☐ Alert	
Private Customer: ☐ Yes ☐ No	
Note Date: ___/___/___	

HMIS Intake and Enrollment Form

Client Name / ID: _____

Income – Cash Sources:

Income Source (Check all that apply):	Stated Income:	Pay Interval:					
		Weekly	Every Other Week	Twice A Month	Monthly	Quarterly	Yearly
☐ No financial resources		☐	☐	☐	☐	☐	☐
☐ Earned Income		☐	☐	☐	☐	☐	☐
☐ Unemployment Insurance		☐	☐	☐	☐	☐	☐
☐ Supplemental Security Income (SSI)		☐	☐	☐	☐	☐	☐
☐ Social Security Disability (SSDI)		☐	☐	☐	☐	☐	☐
☐ Veteran's Disability Payment		☐	☐	☐	☐	☐	☐
☐ Private Disability Insurance		☐	☐	☐	☐	☐	☐
☐ Workers Compensation		☐	☐	☐	☐	☐	☐
☐ General Assistance (GA or GR)		☐	☐	☐	☐	☐	☐
☐ Retirement Income from Social Security		☐	☐	☐	☐	☐	☐
☐ Veteran's Pension		☐	☐	☐	☐	☐	☐
☐ Pension from a former job		☐	☐	☐	☐	☐	☐
☐ Child Support		☐	☐	☐	☐	☐	☐
☐ Alimony or other spousal support		☐	☐	☐	☐	☐	☐
☐ Other Source		☐	☐	☐	☐	☐	☐
☐ TANF		☐	☐	☐	☐	☐	☐
☐ Don't Know		☐	☐	☐	☐	☐	☐
☐ Refused		☐	☐	☐	☐	☐	☐

Income – Non-Cash Benefits:

Non-Cash Source (Check all that apply):			
☐ No	☐ Don't Know	☐ Refused	
☐ Food Stamps or Benefits Card (CalFresh)	☐ WIC	☐ MEDICAID	☐ CalWorks Child Care
☐ CalWorks Transportation	☐ MEDICARE	☐ Other CalWorks-Funded Services	☐ State Children's Health Insurance
☐ Temporary Rental Assistance	☐ VA Medical Services	☐ Section 8 or Rental Assistance	
☐ Other (Please Specify):			

Income – Notes:

Income Notes (Optional – Please specify which income source each note applies to):

HMIS Intake and Enrollment Form

Client Name / ID: _____

Program Entry:

Program Name: _____

Case Manager: _____ Program Entry Date: ____/____/____

Where did you sleep last night?	
☐ Emergency shelter	☐ Hotel or motel paid for without emergency shelter voucher
☐ Transitional housing for homeless persons	☐ Foster care home or foster care group home
☐ Permanent housing for formerly homeless persons	☐ Place not meant for habitation
☐ Psychiatric hospital or other psychiatric facility	☐ Other
☐ Substance abuse treatment facility or detox center	☐ Safe Haven
☐ Hospital (non-psychiatric)	☐ Rental by client, with VASH housing subsidy
☐ Jail, prison or juvenile detention facility	☐ Rental by client, with other (non-VASH) ongoing housing subsidy
☐ Rental by client, no ongoing housing subsidy	☐ Owned by client, with ongoing housing subsidy:
☐ Owned by client, no ongoing housing subsidy	☐ Don't Know
☐ Staying or living in a family member's room, apartment, or house	☐ Refused
☐ Staying or living in a friend's room, apartment, or house	

How long was your stay?	
☐ One week or less	☐ One year or longer
☐ More than one week, but less than one month	☐ Don't Know
☐ One to three months	☐ Refused
☐ More than three months, but less than one year	

Entry Questions – Homelessness (Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded):

Question	Check One Answer	Comments
Are you currently homeless?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Have you been continuously homeless for a year or more in a place not meant for human habitation, a safe haven, or in an emergency shelter?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
How many episodes of homelessness have you had in the past three (3) years?	☐ Less than 4 episodes ☐ At least 4 episodes	
What circumstances contributed to your current housing situation? (Choose any that apply)	☐ Change in Employment Income ☐ Death of a family member ☐ Divorce ☐ Domestic violence ☐ Emancipation ☐ Eviction ☐ Forced separation from family/household members ☐ Foreclosure ☐ Having been a victim of a natural disaster ☐ Having been a victim of sexual, physical, or emotional abuse ☐ Having been a victim of financial abuse ☐ Having disagreements with family/household members **Continued on next page →**	

← **Continued from previous page** What circumstances contributed to your current housing situation? (Choose any that apply)	☐ Health Problems – Mental ☐ Health Problems – Physical ☐ Injury ☐ Loss or Decrease of Mainstream Benefits ☐ Lost Job/Layoff ☐ No friends or family available ☐ Post-traumatic stress disorder (PTSD) ☐ Release from hospital/institution ☐ Release from jail/prison ☐ Substance Abuse ☐ Time out/left previous housing program ☐ Underemployed or don't make enough money ☐ Other (Comment needed)	

Entry Questions – Youth (Head of Households aged 17 and under only, required questions are shaded):

Question	Check One Answer	Comments
Are you a runaway youth?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	

Entry Questions – Transition Age Youth (TAY) (Head of Households aged 16 to 24 only, required questions are shaded):

Question	Check One Answer	Comments
Are you a current or former foster care youth?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Have you ever been in the juvenile justice system?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Have you ever been on adult probation?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Which of the following best represents how you think about yourself?	☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Transgender ☐ Questioning ☐ Don't Know ☐ Refused	

HMIS Intake and Enrollment Form

Client Name / ID: _____

Entry Questions – Domestic Violence (All clients, required questions are shaded):

Question	Check One Answer	Comments
Have you been a victim of domestic or intimate partner violence?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
If you experienced domestic or intimate partner violence, how long ago did you have this experience? **(Required if previous question is Yes)**	☐ Within the past three months ☐ Three to six months ago ☐ From six to twelve months ago ☐ More than a year ago ☐ Don't Know ☐ Refused	

Entry Questions – Disability (All clients, required questions are shaded):

Question	Check One Answer	Comments
Do you have a physical disability?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
If yes, are you currently receiving services or treatment for this condition? **(Required if previous question is Yes)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Do you have a developmental disability?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
If yes, are you currently receiving services or treatment for this condition? **(Required if previous question is Yes)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Have you been diagnosed with AIDS or have you tested positive for HIV?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
If yes, are you currently receiving services or treatment for this condition? **(Required if previous question is Yes)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Do you feel you have a mental health problem?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	

HMIS Intake and Enrollment Form

Client Name / ID: _____

Mental health problem: Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently **(Required if previous question is Yes)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
If yes, are you currently receiving services or treatment for this condition? **(Required if mental health question is Yes)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Do you have a drug or alcohol problem?	☐ Drug ☐ Alcohol ☐ Both drug and alcohol ☐ No ☐ Don't Know ☐ Refused	
Substance Abuse: Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently **(Required if previous question is Yes)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
If yes, are you currently receiving services or treatment for this condition? **(Required if substance abuse question is Yes)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Chronic Health Condition	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
If yes, are you currently receiving services or treatment for this condition? **(Required if previous question is Yes)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	

Entry Questions – General Health (All clients, required questions are shaded):

Question	Check One Answer	Comments
Do you have any other special needs?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Compare to other people your age, would you say your health is excellent, very good, fair, or poor?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor	

HMIS Intake and Enrollment Form

Client Name / ID: _____

Entry Questions – Pregnancy (Women aged 15 and older only, required questions are shaded):

Question	Check One Answer	Comments
Are you pregnant?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
What is your due date?	___/___/_____	

Entry Questions – Chronic Homelessness (Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded):

Question	Check One Answer	Comments
Client is chronically homeless?	☐ Yes ☐ No	

Entry Questions – Veteran (US Veterans only, required questions are shaded):

Question	Check One Answer	Comments
What branch of the military did you serve in?	☐ Army ☐ Air Force ☐ Navy ☐ Marines ☐ Other ☐ Don't Know ☐ Refused	
In which military service eras did you serve? (Choose all that apply)	☐ Post September 11, 2001 (September 11, 2001 -Present) ☐ Persian Gulf Era (August 1991 – September 10, 2001) ☐ Post-Vietnam (May 1975 – July 1991) ☐ Vietnam Era (August 1964 – April 1975) ☐ Between Korean and Vietnam War (February 1955– July 1964) ☐ Korean War (June 1950 – January 1955) ☐ Between WWII and Korean War (August 1947 – May 1950) ☐ World War II (September 1940 – July 1947) ☐ Between WW1 & WW2 (Dec 1918-Aug 1940) ☐ WW1 (Apr 1914-Nov 1918) ☐ Don't know ☐ Refused	
What type of discharge did you receive?	☐ Honorable ☐ General ☐ Medical ☐ Bad Conduct ☐ Dishonorable ☐ Other ☐ Don't Know ☐ Refused	
How many months did you serve on active duty in the military?	_____ months	

Did you serve in a war zone?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
What war zone(s)? (Choose all that apply)	☐ Europe ☐ North Africa ☐ Vietnam ☐ Laos & Cambodia ☐ South China Sea ☐ China / Burma / India ☐ Korea ☐ South Pacific ☐ Persian Gulf ☐ Afghanistan ☐ Other ☐ Don't Know ☐ Refused	
What was the number of months served in a war zone?	_____ months	
Did you ever receive hostile or friendly fire in a war zone?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	

Entry Questions – Employment (Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded):

Question	Check One Answer	Comments
Are you currently employed?	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
If the client is not currently employed, is the client looking for work? **(Required if previous question is No, Don't know, or Refused)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
Employment Tenure: **(Required if employment question is Yes)**	☐ Permanent ☐ Temporary ☐ Seasonal	
If employed, is the client looking for additional employment or increased hours at their current job? **(Required if employment question is Yes)**	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
If currently working, number of hours worked in the past week? **(Required if employment question is Yes)**	_____ Hours	

HMIS Intake and Enrollment Form

Client Name / ID: _____

Entry Questions – Income (Adults aged 18 and older having no financial resources only, required questions are shaded):

Question	Check One Answer	Comments
If you have no income, why are you not on general relief?	□ Sanctioned □ Time Limits □ Employment □ Other □ N/A	

Entry Questions – Education (Adults aged 18 and older, required questions are shaded):

Question	Check One Answer	Comments
Currently in school or working on any degree or certificate	□ Yes □ No □ Don't Know □ Refused	
Received vocational training or apprenticeship certificates	□ Yes □ No □ Don't Know □ Refused	
If client has received a high school diploma, GED, or enrolled in post-secondary education, what degrees has the client earned?	□ None □ Associates Degree □ Bachelors □ Masters □ Doctorate □ Other Graduate/Professional Degree □ Certificate of advanced training or skilled artisan □ Don't Know □ Refused	

Entry Questions – Children's Education (Adults aged 18 and older, required questions are shaded):

Question	Check One Answer	Comments
Is your child currently enrolled in school?	□ Yes □ No □ Don't Know □ Refused □ N/A	
If not enrolled, identify the problems in enrolling your child. I am going to read a list of problems that you may have had getting your child into a school. Please tell me if you have experienced any of these problems for your child?	□ None □ Residency Requirements □ Availability of School Records □ Birth Certificates □ Legal Guardianship Requirements □ Transportation □ Lack of Available Preschool Programs □ Immunization Requirements	

HMIS Intake and Enrollment Form

Client Name / ID: _____

← **Continued from previous page** Please tell me if you have experienced any of these problems for your child?	☐ Physical Examination Records **Continued on next page →** ☐ Other ☐ Don't Know ☐ Refused	
What is the name of the child's school(s)?	_____	
Was/is the child connected to Mckinney-Vento homeless Assistance Act school liaison.	☐ Yes ☐ No ☐ Don't Know ☐ Refused	
What type of school is it? Is it a public or private school?	☐ Public school ☐ Parochial or other private school ☐ Don't Know ☐ Refused	
When was (child) last enrolled in school? If not enrolled, what is the date of the child's last school enrollment?	____/____/_____	

_____ _____ _____

Client Signature Site Date

_____ _____ _____

Agency Staff Signature Site Date

DO NOT WRITE IN BOX BELOW – DATA ENTRY PERSONNEL ONLY (Optional):

Date entered into HMIS: _____/_____/_____

Question	Answer	Initials of Staff completion	Comments
Was the hard copy intake form completely filled out correctly?	☐ Yes ☐ No		
Was client's picture taken for an ID Card?	☐ Yes ☐ No		
Was client's ID Card printed?	☐ Yes ☐ No		
Were services assigned to client for first day in the program?	☐ Yes ☐ No		

Staff Name (verifying completion of Data Entry): _____

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
FEDERAL HOUSING SUBSIDIES UNIT
HACoLA HOMELESS SECTION 8 PROGRAM

Sample Format for Case Manager / Housing Liaison Referral Letter

Must be on Agency letterhead.

First Paragraph

- Just one or two sentences describing your agency's program(s) (Attaching an agency brochure helps.)
- Applicant's entry date into your agency's program
- Applicant's exit date from your agency's program. (If applicable, explain why the Applicant is leaving your agency's program, and identify the linkage schedule and the next provider to whom Applicant will be linked--agency name, case manager name and phone number.)
- Say where the applicant is living at the present time.
    - If he or she is in a shelter or transitional living program, ask the shelter to write a letter on their letterhead (and add their pamphlet, if available).
    - If the applicant is living on the "streets," include information specifying where he or she can be found (e.g., "Ms. Jones resides in the alley directly behind the Baja Fresh Restaurant located at 6043 Hollywood Boulevard, Hollywood, CA 90028. I have met with her for case management at this location on the following dates: 01/23/04, 02/06/04, 03/10/04, and 04/13/04. She was noted by police citation for sleeping in this alley on the flowing dates: 05/23/04, and 05/30/04."

Troubleshooting

- If exit date at shelter or transitional living program has passed, then explain why the Applicant is still in the program.
- *Example*: "Even though Mr. Smith's residential time at Hugh Heffner's Transitional Living Center has expired, we received permission to allow him to stay here until he is approved for a HACoLA Homeless Section 8 voucher. "
- Be mindful if you allow an Applicant to stay at your facility past their expiration date (i.e., identify why and for how long).

Second Paragraph

- Narrative outline of the Applicant's homeless history, with **NO** time gaps.
- Identify time periods Applicant can't recall, if any.
- This detailed history should begin from when Applicant began seeing the case manager. If that time is less than two years, then the case manager should include the Applicant's recollection of their homelessness prior to engagement.
- Include (1) the specific date Applicant first became homeless and (2) the event that caused Applicant's to become homeless. If the event is documented (e.g.,

eviction papers, motel receipts, etc.) reference them here and include them in the application.
- Identify and explain **all** Applicant telephone numbers and addresses disclosed **anywhere** in the application package, including the address on the Applicant's CDL or other photo ID.
- Explain why Applicant cannot live at / return to these addresses

Third Paragraph
- Explain why you think this Applicant meets target population for Homeless Section 8
- Mental illness should only be mentioned (e.g., "Mr. Doe has a mental illness, attends all appointments regularly at the clinic, and is medication compliant.")
- Explain your Applicant's experience with your program
- Always include strengths and positive points concerning the applicant
- Mention Independent Living Skills, especially money management. (Place the person you have chosen for a Homeless Section 8 Program into a Community Living Program or Independent Living Skills class.)

Fourth Paragraph
- If children are involved, please state: (1) where they are, (2) who is supporting them, and (3) if the child is in placement, attach court paperwork indicating who has custody and a letter from the Children's Social Worker indicating that the child will be allowed to reside with the applicant in the apartment.
- Criminal Background Checks: Criminal background checks are required for all adult family members (18 years and over) that will be residing with the applicant. Provide information concerning the following:
    - If the adult family member has been convicted of any drug or alcohol related offense, explain and document what treatment (including residential and out patient substance abuse treatment, 12-step meetings, etc.) he or she has been involved in and completed.
    - If the adult family member has been convicted of a violent offence, explain and document what treatment (including anger management classes, and individual therapy, etc.) he or she has been involved in and completed.

Fifth Paragraph
- Closing remarks and contact information for referring clinician or case manager.

Salutation,

Signature
Title

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

SAMPLE REFERRAL LETTER

January 21, 2006

Eligibility Interviewer
Housing Authority of the County of Los Angeles
700 W. Main Street
Alhambra, CA 91801

RE: Jane Doe, SS# 123-45-6789

Housing Authority of the County of Los Angeles:

I am writing this letter in support of Jane Doe's Homeless Section 8 application. Jane has been a client of the ACTION program since October 18, 2000. ACTION is an assertive community treatment program that assists dually diagnosed consumers with psychotherapy, case management, and psychiatry. Jane has a mental illness and has maintained all scheduled appointments with me for counseling and sees her psychiatrist regularly despite her lack of a fixed nightly residence.

Jane became homeless on January 8, 2001 after fleeing from a domestic violence situation. For the past four years, Jane has lived in inpatient psychiatric hospitals, on the street, crisis residential facilities, LAHSA cold/wet weather shelters, and a garage. We recently met and reviewed her psychiatric treatment history and compiled the following list of dates and locations of Jane's living arrangements. Because of the client's cognitive deficits and memory loss, the following represents the best history this client can recollect:

01/08/2001 to 02/07/2001: 1736 Crisis House, Torrance
02/08/2001 to 03/15/2001: New Image Emergency Shelter, Los Angeles
03/16/2001 to 06/31/2001: Shady Lady Motel, 3434 Sunset Blvd., Hollywood
07/01/2001 to 08/31/2001: Client does not remember where she resided
09/01/2001 to 10/25/2001: Twin Towers Correctional Facility
10/26/2005 to 12/15/2002: "Streets" – Sidewalk at 4th and Los Angeles, Los Angeles
12/16/2002 to 12/19/2002: BHC Alhambra Hospital, Psychiatric Unit, Rosemead
12/20/2002 to 01/19/2003: Excelsior House Crisis Residential Treatment, Los Angeles
01/20/2003 to 04/01/2003: "Streets" – Car parked at 1720 E 120th St., Los Angeles (Car was towed)
04/02/2003 to 04/15/2003: "Streets" – Alley between Augustus Hawkins MHC and King Drew Medical Center, Los Angeles
04/16/2003 to 06/20/2003: Help is on the Way Shelter, Los Angeles

06/21/2003 to 07/26/2003: Client does not remember where she resided
07/27/2003 to 08/05/2003: Brotman Medical Center, Psychiatric Unit
08/06/2003 to 12/15/2003: "Streets" – 2nd and Broadway, Santa Monica
12/16/2003 to 03/15/2004: New Directions Emergency Shelter, West Los Angeles
03/16/2004 to 04/10/2004: Weingart Center Shelter, Los Angeles
04/11/2004 to 08/04/2004: "Streets" – Sidewalk at 4th and Los Angeles, Los Angeles
08/05/2004 to 08/08/2004: Robert F. Kennedy, Psychiatric Unit
08/09/2004 to 02/09/2005: Daybreak Transitional Living Program, Santa Monica
02/10/2005 to 05/06/2005: Garage/Abandoned Home - 1796 Raymond St., Los Angeles. The garage lacked cooking facilities, a restroom or shower, running water, electricity, and insulation to keep warm. The roof often leaked when it rains.
05/07/2005 to 05/22/2005: Twin Towers Correctional Facility – Arrested for trespassing
05/23/2005 to 06/15/2005: "Streets" – near Cherokee and Hollywood Blvd., Hollywood
06/15/2005 to 09/15/2005: Jan Clayton Center Residential Substance Abuse Treatment, Hollywood
09/16/2005 to present: PATH Specialized Shelter Bed Program, Los Angeles

Jane is an appropriate candidate for the Homeless Section 8 program because she is now medication compliant, has completed courses in parenting, independent living skills, and money management. In the past, Jane successfully maintained a residence and has good independent living skills. Jane is a part of the Money Management Program at Hollywood Mental Health Center, which will also continue to provide the intensive case management that will allow her to maintain independence in the community. In addition, Jane has completed a 90-day residential substance abuse treatment program and continues to maintain a relationship to her facility by attending outpatient groups. Jane also attends 12 Step groups for support and fellowship in recovery.

Jane has an 8-year-old daughter (Sheila Jones) who will live with her mother once she is in a stable living situation. Presently, Sheila resides with client's mother (Marie Doe) at 6703 67th Street, Los Angeles. A letter from client's DCFS social worker indicating the child's current location and the social worker's intent to place the child with client at her new residence is attached.

I appreciate your time in reviewing this case. A Homeless Section 8 voucher would provide an avenue of stability for Jane. If you have any questions or concerns, please feel free to call me at 213-637-5555.

Sincerely,

John Smith, MSW
Psychiatric Social Worker

PLACE HERE

To get a copy of the **HACoLA Application for Rental Assistance – Homeless Section 8 Program**, please contact Federal Housing Subsidies Unit (FHSU) to arrange pick up.

Please call:

Julian Tasev @ 213-251-6518
(jtasev@dmh.lacounty.gov)

or

Jessica Jones-Montgomery
@ 213-251-6560
(jjonesmontgomery@dmh.lacounty.gov)

HOUSING AUTHORITY
of the County of Los Angeles
ASSISTED HOUSING DIVISION
700 W. Main Street • Alhambra, CA 91801
Tel:626.262.4510 -- TDD:855.892.6095 • www.hacola.org

Gloria Molina
Mark Ridley-Thomas
Zev Yaroslavsky
Don Knabe
Michael D. Antonovich
Commissioners

Sean Rogan
Executive Director

• •

PROGRAM REFERRAL FORM
HOMELESS

This referral MUST be completed by the public agency or by the social service agency contracted with the Housing Authority of the County of Los Angeles (HACoLA).

CLIENT NAME: _____

SSN: _____ DOB: _____

REFERRING AGENCY NAME: DMH /

AGENCY CONTACT: _____

AGENCY ADDRESS: 695 S. Vermont Ave., 10th Fl
City / State / Zip: Los Angeles, CA 90005

AGENCY PHONE: _____

DATE REFFERAL SUBMITTED TO HOUSING AUTHORITY: _____

_____ _____
AGENCY CONTACT SIGNATURE CLIENT SIGNATURE

_____ _____
DATE DATE

Please affix agency stamp or business card of Agency Contact completing this form in the box below:

Affix agency stamp or business card:

HOMELESS Program Application Checklist

Applicant Name:________________________ Social Security #_____________________

CASE MANAGEMENT

- ☐ Case Management Agreement (copy)
- ☐ Out of Service Agreement
- ☐ Readiness Evaluation Form
- ☐ Applicant Eligibility Worksheet**/**Homeless Condition Certification (Sections I-III)
- ☐ Verification of Disability (if applicable)
- ☐ Copy of Statement of Veteran & Family Responsibility (VASH only)

HA office Use Only
Missing Item(s):
____
____
____
____

VERIFICATION OF INCOME

- ☐ Application Packet
- ☐ Cal-Works/GR Notice of Action
- ☐ Social Security Award Letter
- ☐ Employment Letter (original) or 3 pay stubs (copies)
- ☐ Unemployment Award letter or 3 pay stubs (copies)
- ☐ School Verification (for adults over 18 years of age)
- ☐ Bank Statement (copy)
- ☐ Retirement Pension Award Letter
- ☐ 1040/1040A (Self employment) or Notarized Statement
- ☐ Other_____________________________________

HA office Use Only
Missing Item(s):
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FAMILY IDENTIFICATION (copies)

☐ **Valid** California Identification/DL	☐ Social Security	☐ Birth Certificate
☐ **Valid** California Identification/DL	☐ Social Security	☐ Birth Certificate
☐ **Valid** California Identification/DL	☐ Social Security	☐ Birth Certificate
☐ **Valid** California Identification/DL	☐ Social Security	☐ Birth Certificate
☐ **Valid** California Identification/DL	☐ Social Security	☐ Birth Certificate
☐ **Valid** California Identification/DL	☐ Social Security	☐ Birth Certificate
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☐ **Valid** California Identification/DL	☐ Social Security	☐ Birth Certificate
☐ **Valid** California Identification/DL	☐ Social Security	☐ Birth Certificate
☐ **Valid** California Identification/DL	☐ Social Security	☐ Birth Certificate

HA office Use Only
Missing Item(s):
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I _________________________________ certify that all the attached documents have been
Designated Agency Contact Name (Print)

reviewed for completeness and their contents are true and correct.

______________________________ ________________________ ___________
Designated Agency Contact Name (Signature) Name of Agency Date

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
700 W. MAIN STREET, ALHAMBRA, CA 91801

READINESS EVALUATION

Referral Agency: DMH /

Agency Address: _____

Client Name: _____

Date: _____

Please answer the following questions to determine if the client has been appropriately evaluated, provided services and is ready to live independently:

1. **ARE YOU CURRENTLY PROVIDING CASE MANAGEMENT SERVICES TO THE CLIENT?**
   ☐ **YES** ☐ **NO**

2. **AT THIS TIME, DO YOU HAVE A CASE MANAGEMENT PLAN IN PLACE?**
   ☐ **Yes** ☐ **No**

3. **HAVE YOU ASSESSED THE CLIENT TO DETERMINE IF HE/SHE IS READY TO LIVE INDEPENDENTLY?**
   ☐ **YES** ☐ **NO**

4. **IS HE/SHE READY TO LIVE INDEPENDENTLY?**
   ☐ **YES** ☐ **NO**

5. **HAVE YOU CONNECTED YOUR CLIENT TO ALL APPROPRIATE SERVICES (AS DETERMINED IN YOUR CASE MANAGEMENT PLAN) THAT WOULD ASSURE THEY ARE READY TO LIVE INDEPENDENTLY (MEDICAL, MENTAL HEALTH, LIFE SKILLS, ETC.)?**
   ☐ **YES** ☐ **NO**

   IF NO, PLEASE EXPLAIN:

   _____

   _____

   _____

_____ _____
Name of Evaluator Date

Housing Authority of the County of Los Angeles

HOMELESS CONDITION CERTIFICATION
(MUST ONLY BE COMPLETED BY REFERRING AGENCY)

Section I & II **MUST** be completed by the referring agency. Both sections **MUST** be completed in order for the application to be considered.

REFERRING AGENCY NAME:_____

APPLICANT NAME:_____

APPLICANT'S CURRENT RESIDENT ADDRESS:

_____

(**PO BOX IS NOT ACCEPTABLE)**

Section I. CHECK THE APPROPRIATE HOMELESS STATUS AND ATTACH THE REQUIRED HOMELESSNESS VERIFICATION TO THIS WORKSHEET.

Homeless Category	Homeless Status	Type of Verification Required
Category 1: **Literally Homeless**	☐ Persons living on the street.	**Preferred order:** **1.** Third party verification: Written referral by another housing or service provider certifying the applicant's homelessness status (including efforts made to obtain housing); **or** **2.** Intake worker observation: A letter from the *referring agency* certifying the outreach or intake worker's observation of the applicant/family's homelessness condition (living on the streets) including efforts made to obtain housing. The verification letter must be signed and dated; **or** **3.** Self certification: Certification by the individual/head of household stating that (s)he was living on the streets; **-OR-** An HMIS printout documenting receipt of one of the above listed forms of verification. The HMIS printout should reflect the name of the person who entered the data, the date of entry, **and** clearly document how the applicant's living condition was verified.
Category 1: **Literally Homeless**	☐ Persons coming from an emergency shelter, transitional housing, hotel/motel paid	**Preferred order:** **1.** Third party verification: Written referral by another housing or service provider certifying the applicant's homelessness status–as that of one who is living in an emergency shelter, transitional housing or hotels/motels paid for by charitable organizations or federal, state or local

	for by charitable organizations, or federal/state/local government programs for low-income individuals.	government programs for low income individuals. The certification must be signed and dated and include information on where the housing was located, which organization provided the funding, and include efforts made to obtain housing; **or** **2.** Intake worker observation: (If certification from the original referring agency cannot be provided), A letter from the *referring* agency certifying the intake worker's firsthand knowledge of the individual/family living in emergency shelter, transitional housing or hotels/motels paid for by charitable organizations or federal, state or local government programs for low income individuals. The certification must be signed and dated, include information on where the housing was located, which organization provided the funding, and include efforts made to obtain housing; **or** **3.** Self certification: Certification by the individual/head of household stating that (s)he was living in an emergency shelter, transitional housing or hotels/motels paid for by charitable organizations or federal, state or local government programs for low income individuals. The certification must be signed and dated, include information on where the housing was located, which organization provided the funding, and include efforts made to obtain housing; **-OR-** An HMIS printout documenting receipt of one of the above listed forms of verification. The HMIS printout should reflect the name of the person who entered the data, the date of entry, **and** clearly document how the applicant's living condition was verified.
Category 1: **Literally Homeless**	☐ Persons coming from an institution where he/she stayed for 90 days or less **and** resided in an emergency shelter or was on the street immediately before entering	**Preferred order:** **1.** Third party verification: Written referral by another housing or service provider certifying the applicant's homelessness status as that of one who is exiting an institution where living arrangements cannot be provided. The referral must be signed and dated, include the location of the institution, and the efforts made to obtain housing; **or** **2.** Intake worker observation (If certification from the original referring agency cannot be provided): A letter from the intake worker at the

	the institution.	*referring* agency certifying his or her firsthand knowledge of the individual/family living in an emergency shelter or on the streets before entering the institution. The certification must be signed and dated, include the location of the institution, and the efforts made to obtain housing; **or** **3.** Self certification: Certification by the individual/head of household stating that (s)he was living in an institution. The certification must be signed and dated, include the location of the institution, and include efforts made to obtain housing; **-OR-** An HMIS printout documenting receipt of one of the above listed forms of verification. The HMIS printout should reflect the name of the person who entered the data, the date of entry, **and** clearly document how the applicant's living condition was verified. **And one of the following:** 1. Discharge paperwork from the institution, **or** a written statement from appropriate official of the institution disclosing the dates of stay **or** an oral statement recorded in writing by the **referring agency**. The oral statement must be certified by the intake worker from the **referring agency**. 2. If the intake worker from the **referring agency** is unable to obtain this documentation from an official at the institution, the **referring agency** must provide documentation of the intake worker's due diligence in attempting to obtain the information **and** the applicant's self-certification that he or she is exiting or just exited an institution where he or she resided for 90 days or less.
Category 2: **Imminent Risk of Homeless**	☐ Persons who will imminently lose their housing.	☐ **Eviction:** A court order resulting from an eviction action or notice to terminate tenancy, notifying the individual or family that they must leave the residence within 14 days from the date of application for homeless assistance; **-OR-** ☐ **Hotel/Motel:** Evidence that an individual/family living in a hotel/motel ***not*** paid for by a charitable organizations or government programs lacks the financial resources to continue to reside there for more than 14 days

		from the date of application for homeless assistance; **-OR-** ☐ **House Sharing/Couch Surfing:** Oral statement by the applicant that the owner or leaseholder will not allow them to stay for more than 14 days from the date of application for homeless assistance. The oral statement must be recorded in writing and certified to be found credible by the intake worker of the *referring agency*. **The certification must include documentation of verification with the owner or leaseholder <u>or</u> documentation of the intake worker's attempts to verify the statement with the owner or leaseholder.** **<u>And</u>** A certification by the applicant indicating that no subsequent residence has been identified and the applicant lacks the financial resources and support networks to obtain other permanent housing.
Category 3: **Homeless under other Federal Statutes**	☐Unaccompanied youth (under age 25yrs of age) or families with children or youth, who are defined as homeless under other listed Federal statutes or section 725(2) of the McKinney - Vento Homeless Assistance Act but do not otherwise qualify under the homeless definition. **Note: Eligibility under this category requires HUD written approval.*	Certification that the applicant meets the definition of homelessness under one of the following federal statutes by an official from a nonprofit or government agency that administers assistance under: 1. Runaway and Homeless Youth Act 2. Head Start Act 3. Subtitle N of the Violence Against Women Act 4. Section 330 of the Public Health Service Act 5. Food and Nutrition Act 6. Section 17 of the Child Nutrition Act of 1966 7. Subtitle B of title VII of the McKinney-Vento Homeless Assistance Act. **<u>And</u>** A signed and dated general certification from an intake worker or the applicant verifying that the person or family has not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days preceding the homeless assistance application. **<u>And</u>** A signed and dated general certification from the applicant and any supporting documentation verifying that the person or family has moved at least twice during the 60 days preceding the homeless assistance application.

		If supporting documentation is unobtainable, the intake worker from the **referring agency** must provide documentation of efforts to obtain appropriate statements or records. If the moves were to flee from domestic violence, dating violence, sexual assault or stalking, the intake worker may provide instead a signed and dated general certification from the applicant, attesting that the applicant was fleeing from that situation and that they resided at their former address. Applicant and **referring agency** must sign/date certification. **And** A signed and dated general certification from the applicant along with the following supporting documentation verifying that the person or family can be expected to continue in such status for an extended period of time due to special needs or barriers: 1. Written diagnosis from a professional who is licensed by the state to diagnose and treat that condition (chronic disability, chronic physical or mental health conditions, or substance addiction); or 2. Intake staff-recorded observation of disability that within 45-days of the date of application for assistance is confirmed by a professional who is licensed by the state to diagnose that condition; or 3. Other reasonable documentation that proves: a. History of domestic violence, dating violence, sexual assault or stalking; or b. Presence of a disabled child/youth; or c. Two or more barriers to employment (illiteracy, low English proficiency, lack of diploma or GED, history of incarceration or detention for criminal activity, or history of unstable employment).
Category 4: **Fleeing/ Attempting to Flee Domestic Violence**	☐ Person or family who is fleeing or attempting to flee from domestic violence, dating violence, sexual assault,	A signed and dated self-certification or certification made by the victim service provider's intake worker, attesting that the applicant was fleeing from that situation, that no subsequent residence has been identified, and that applicant lacks the resources and support networks to obtain other permanent housing.

	stalking, or other dangerous or life-threatening conditions related to violence (that has taken place in the person or family's primary nighttime residence or has made them afraid to return to the primary nighttime residence).	If the person or family is not admitted to a domestic violence or shelter receiving services from a victims service provider, a self-certification should be accompanied by a written observation from the intake worker or the referring agency (other social service, law enforcement or legal agency, pastoral counselor or any other organization that the person or family has sought assistance from) attesting that the applicant was fleeing from that situation, that no subsequent residence has been identified, and the applicant lacks the resources and support networks to obtain other permanent housing. *If obtaining third party verification will jeopardize the applicant's safety, self or head of household certification shall be obtained instead.*

Section II. REFERRING AGENCIES SUMMARY

How did applicant become homeless?_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The above applicant has been homeless since:_____
(INITIAL DATE OF HOMELESSNESS)

HISTORY: Since the initial date of homelessness, the above applicant's homeless history has been as follows: (include explanations on addresses if different from the shelter address).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is Applicant Chronically Homeless? Yes ☐ No ☐

<u>If applicant is Chronically Homeless</u>, this section MUST be completed. Please include complete addresses of where the applicant has been staying (if on the streets, include city name and street name).

<u>Name of Shelter/address</u>	**<u>Entry Date</u>**	**<u>Exit Date</u>**
1._____		
2._____		
3._____		
4._____		
5._____		

Note: All written verification provided from the emergency shelters, transitional housing and referring agency must be the original document and on the respective agency's letterhead. Letter must include facility address, phone number, and contact person's name.

I certify that all the information provided is true and correct to the best of my knowledge.

_____ _____
Applicant's Signature Date

_____ _____
Referring Case Manager's Signature Date

_____
Referring Agency Address

Affix Office Stamp or Business Card

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
700 W. Main Street • PO Box 1510 • Alhambra, CA 91801

VERIFICATION OF DISABILITY

ID#:

The individual below signed a release of information giving you permission to supply our agency with information to verify their reported disability. Written documentation that a person's disability meets one the program definitions must come from a professional trained to make such a determination.

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize the release of information concerning my disability to the Housing Authority of the County of Los Angeles. I understand that the information provided on this certification is required for determining my eligibility for the program or for reasonable accommodation and level of assistance.

Applicant /Participant Name (print) _____ (SS#) _____

Applicant/Participant Signature (If minor, Parent/Guardian of person listed above) _____ Date _____

1. Does the individual meet the U.S. Department of Housing and Urban Development (HUD) Definition of a Person with Disabilities below? ☐ YES ☐ NO (If "NO," go to #2 below)

(1.1) A disabled person is one with an inability to engage in any substantial gainful activity because of any physical or mental impairment that is expected to result in death or has lasted or can be expected to last continuously for at least 12 months; or for a blind person at least 55 years old, inability because of blindness to engage in any substantial gainful activities comparable to those in which the person was previously engaged with some regularity and over a substantial period.

(1.2) A developmentally disabled person is one with a severe chronic disability that:
- (a) is attributable to a mental and/or physical impairment;
- (b) has manifested before age 22;
- (c) is likely to continue indefinitely;
- (d) results in substantial functional limitations in three or more of the following areas: capacity for independent living, self-care, receptive and expressive language; learning, mobility, self direction, and economic self-sufficiency AND
- (e) requires special interdisciplinary or generic care treatment, or other services which are of extended or lifelong duration and are individually planned or coordinated.

(1.3) A disabled person is also one who has a physical, emotional or mental impairment that:
- (a) is expected to be of long-continued or indefinite duration;
- (b) substantially impedes the person's ability to live independently;
- (c) is such that the person's ability to live independently could be improved by more suitable housing conditions.

2. Does the individual above meet the Fair Housing Act definition of a person with disabilities? ☐ YES ☐ NO

(2.1) An individual with a mental or physical impairment that limits one or more major life activities, or
(2.2) An individual who is regarded as having such an impairment; or
(2.3) An individual who has a record of such impairment.

The term "major life activity" includes, but is not limited to, those activities that are of central importance to daily life, such as seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, learning and speaking.

CERTIFICATION

I _____ CERTIFY THAT _____, THE PERSON STATED ABOVE, SHOULD BE CONSIDERED DISABLED IN ACCORDANCE WITH DEFINITION NUMBER _____ AS STATED ABOVE.

By signing below, I certify that the foregoing information is true and correct to the best of my professional knowledge.

Warning: Any person who signs this statement and who willingly states as true, any matter which (s)he knows to be false, is subject to the penalties prescribed for perjury in Section 118 of the California Penal Code and Section 11054 of the Welfare and Institutions Code.

Printed Name	Title	License Number
Name of Agency or Department	Signature	Date
Address	City, State, Zip	Telephone Number

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
700 W. MAIN STREET, ALHAMBRA, CA 91801

HOMELESS PROGRAM
OUT OF SERVICE AREA AGREEMENT

You have been identified as a possible candidate to participate in the Homeless program. However, your current home and/or employment address is outside of the area regularly serviced by the Housing Authority of the County of Los Angeles (HACoLA).

While HACoLA is able to assist families that live or work outside of its regular boundaries, such families must live in HACoLA's jurisdiction for at least the first twelve months of assistance.

If, given this requirement, you continue to be interested in the Homeless program, please read, sign and date the statement below.

I certify that I have been advised that my current home and/or work address are not within HACoLA's regular service area. I have also been advised that if I am selected for admission into the Homeless program, I will be required to live in HACoLA's jurisdiction (service area), for at minimum, the first twelve months of assistance.

Upon receipt of my Homeless voucher, I agree to find a unit within HACoLA's jurisdiction for a period of one year.

_____
Print Name

_____
Participant Signature

_____
Date

HOUSING AUTHORITY
COUNTY OF LOS ANGELES
Assisted Housing Division - P.O. Box 1510, Alhambra, CA 91802

DECLARATION FOR _____ Name of Head of Household: _____

Social Security Number:_____

Contract Number:_____

DECLARATION OF ELIGIBILITY FOR ASSISTED HOUSING PROGRAMS

SECTION ONE	**DECLARATION INSTRUCTIONS** 1) If the person named above is a citizen, national or eligible non-citizen, check the box for Declaration A or B as applicable. Only one Declaration box should be checked. 2) Print the name of the person on the blank line in the Declaration statement you choose. Then proceed to complete Section Two. Both Sections One and Two must be completed. **NOTE: Do not complete this declaration for individuals who: 1) are not U.S. citizens or nationals; 2) are not eligible non-citizens or 3) do not wish to disclose their citizenship status.** For these individuals, the head of Household should complete the enclosed "Listing of Non-Contending Family Members" and sign and date it. If the form does not apply for the individual named above, mark this form "does not apply" and return it. **Each member of the family MUST either complete a Declaration or be named on the Listing of Non-Contending Family Members.**

☐ **A. DECLARATION OF U.S. CITIZEN OR U.S. NATIONAL**

I declare that _____ is a U. S. citizen or national.

☐ **B. DECLARATION OF ELIGIBLE NON-CITIZEN STATUS**

I declare that _____ is an eligible non-citizen and can provide documentation to verify one of the non-citizen categories shown below.

IF STATUS "B" IS CHECKED, AN APPOINTMENT WILL BE MADE AT WHICH YOU WILL BE REQUIRED TO SUBMIT AN ORIGINAL IMMIGRATION AND NATURALIZATION SERVICE DOCUMENT VERIFYING ELIGIBLE STATUS.

A lawfully admitted permanent resident, immigrant or special agricultural worker, granted temporary resident status.

A non-citizen who entered the U.S. before 1/1/72, and has lived in the U.S. continuously. I am not ineligible for citizenship, and has been deemed lawfully admitted for permanent residence under section 210 or 21OA of the INA.

A non-citizen with lawful Refugee status, Asylum status, or under conditional entry because of persecution or fear of persecution or because of being uprooted by catastrophic national calamity.

A non-citizen lawfully present in the U.S. under Parole status.

A person lawfully present in the U.S. as a result of the Attorney General's withholding deportation. (Threat to life or freedom)

A non-citizen admitted to the U.S. under Amnesty provisions.

A non-citizen who was 62 years of age or older **and** was receiving federal housing assistance under a covered program on June 19, 1995. (Proof of age and participation on a federal housing program required)

SECTION TWO	**CERTIFICATION AND SIGNATURE** **Persons over eighteen must sign their own declaration below; the adult in the household who is completing a declaration for a child must sign the adult's name below to complete a child's declaration.**

I declare, under penalty of perjury under the laws of the State of California, that the above declaration is true and correct. I understand that false statements or misrepresentation of citizenship status may result in cancellation or termination of assistance.

Executed the _____ day of _____ , 20 _____ at _____ , California.
[Date] [Month] [Year] [City]

APPLICANT/RESIDENT SIGNATURE X_____

Housing Authority of the County of Los Angeles
Assisted Housing Division
P. O. Box 1510, Alhambra, CA 91802

Tenant Name: _____
HOH Social Security #: ___ - ___ - ____

VERIFICATION CONSENT FORM

A Verification Consent Form must be completed by each adult who declares eligible immigration status. Please read the form carefully, then sign and return the form to the Housing Authority within ten (10) days of the date of this form. For each child, this form must be signed by an adult member living in the household.

I understand that the evidence of eligible immigration status submitted to the Housing Authority for the person named below may be released by the Housing Authority to the U.S. Department of Housing and Urban Development (HUD) or to the Immigration and Naturalization Service (INS) for purposes of verification of the immigration status without responsibility for the further use or transmission of the evidence by the entity receiving the information.

I understand that HUD may release evidence of eligible immigration status to the INS for purposes of establishing eligibility for financial assistance and level of benefits under HUD's Conventional Housing Programs and not for any other purpose. HUD is not responsible for the further use or transmission of the evidence or other information by the INS.

_____ - -
Print NAME OF PERSON SS#

_____
Relationship to Head of Household

_____
APPLICANT/RESIDENT SIGNATURE DATE

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
Assisted Housing Division – P.O. Box 1510 – Alhambra, CA 91802

Name of Head of Household: _____

Social Security Number: _____

Contact Number: _____

LISTING OF NON-CONTENDING FAMILY MEMBERS

When to use this form: If some members of the family decide not to claim that they have eligible immigrant status, but other members of the family establish their citizenship or eligible immigrant status, the family may be considered for assistance. The head of household must provide the names of all family members who do not contend that they have eligible immigrant status and who will not submit either a Declaration or documentation of eligible immigrant status.

Instructions:

1) In the space below, type or legibly print the names of all family members who do not contend that they have eligible immigrant status and who will not submit either a Declaration or documentation of eligible immigrant status.

2) The form must be signed and dated by either a Head of Household or a Co-head/Spouse.

I, _____ , certify under penalty of perjury that the persons listed
(Head of Household/Co-head/Spouse)

below are members of my household who have elected not to contend that he or she has eligible immigration status.

_____
(First Name, Middle Initial(s), Last Name)

_____
(First Name, Middle Initial(s), Last Name)

_____
(First Name, Middle Initial(s), Last Name)

_____
(First Name, Middle Initial(s), Last Name)

_____
(First Name, Middle Initial(s), Last Name)

_____ _____
Signature of Head of Household/Co-head/Spouse Date

*If there are additional names to be listed, please list them on the back of this form.

MOVE IN NOTIFICATION AGREEMENT

To be read and signed by applicant and case manager:

Name of Applicant_____

Name of Clinic/Agency DMH /_____

I certify that I have been advised and understand that if I move into a unit before:

- It passes inspection,
- The Housing Authority – County of Los Angeles (HaCoLa), the owner of the property and I have signed the contract,
- I receive authorization from the Housing Authority to move in.

I may subject myself to the following:

- Being financially responsible for the rent until the unit passes inspection, the contract is signed, and housing authority gives gives authorization to move in,
- ~~Moving out of the unit if it does not pass inspection, or if the contract is~~ not signed,
- Being responsible for any expenses/damages incurred during the time I occupied the unit,
- Being responsible for paying relocation costs,
- Being responsible for locating another unit with the assistance of my case manager if the voucher/certificate has not expired.

I, the case manager, advised_____of the
Applicant

above terms and agreements.

_____ _____
Applicant Signature Date

_____ _____
Case Manager Signature Date

SPE:spb
Revised 3/29/06

ATTACHMENT B

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES

REASONABLE ACCOMMODATION CERTIFICATION

Release of Information Authorization (completed by household member)

I hereby authorize the release of information regarding the need for a reasonable accommodation. I understand that the information the Housing Authority obtains will be kept confidential and used solely to determine if an accommodation should be provided.

Printed Name of Household Member | Date | Tenant ID/SSN

Household Member Signature | Signature of Adult Household Member (if request is for a minor)

Certification (completed by care provider)

The Housing Authority grants reasonable accommodation requests to meet needs dictated by a verified disability. The above-named individual has requested to accommodate their disability. This form may be completed by a qualified professional who has direct experience with the individual's disability, or as a self-certification. By signing above, the individual authorizes you to release this information to the Housing Authority.

Please complete the information below and return this form to ___ at the Housing Authority of the County of Los Angeles, 12131 Telegraph Road, Santa Fe Springs, CA 90670. Since you may be called for verification, please keep a record of this form on file. You may use the back of this form if necessary.

1. A disability is defined as a physical, mental or emotional impairment which limits one or more of a person's major life activities, a record of having such an impairment, or being regarded as having such an impairment. Does the individual have a disability?

No ☐▶ Skip to Question 5.

Yes ☐▶ *Please describe your direct experience with the individual and their disability. (If self-certifying, write "self.")*

2. Does the individual, because of this disability, need an extra bedroom, in order to have equal opportunity to use and enjoy their home?

No ☐▶ Skip to Question 5.

Yes ☐▶ *Please describe why an extra bedroom is necessary due to the disability.*

3. Is this request related to an extra bedroom?

No ☐▶ Go to the next question.

Yes ☐▶ *The program allows the living room to be used as a sleeping area. Please provide an explanation for any reason(s) associated with the disability that the living room cannot serve the purpose presented by the disability.*

4. Do you recommend this type of accommodation for individuals with similar impairments?

No ☐▶ *Please explain your answer.*

Yes ☐▶ Go to the next question.

5. If necessary, would you be willing to testify under oath to the information provided on this form?

No ☐▶ Complete the signature certification below.

Yes ☐▶ Complete the signature certification below.

6. You may attach any supporting documentation to this form.

I hereby certify that the foregoing information is true and correct to the best of my knowledge. I understand that I may be called for verification of the information I submit. Warning: Any person who signs this statement and who willingly states as true, any matter which (s)he knows to be false, is subject to the penalties prescribed for perjury in Section 118 of the California Penal Code and Section 11054 of the Welfare and Institutions Code.

Printed Name | Signature | Date

Name of Practice/Organization | Title/Occupation | Telephone Number

Address | City/State/Zip | Telephone Number

INTERNAL USE ONLY BELOW THIS LINE

Care Provider Phone Verification: | Date(s) contact attempted | Date contact made

1	2	3	4	5				
					Supervisor Recommendation:	☐ Approve	☐ Disapprove	Signature / Date:
					Manager Determination:	☐ Approve	☐ Disapprove	Signature / Date:

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES

CRIMINAL BACKGROUND SCREENING POLICY FACT SHEET

On May 24, 2001, the U.S. Department of Housing and Urban Development (HUD) issued the "Screening and Eviction for Drug Abuse and other Criminal Activity; Final Rule." This rule gave Public Housing Agencies (PHA's) the tools to adopt and implement fair, effective and comprehensive policies for screening out Section 8 program applicants who engage in illegal drug use or other criminal activity. The Rule required PHA's to screen applicants for specific criminal activity and, were allowed, the discretion to establish their own requirements for others.

In response, the Housing Authority for the County of Los Angeles (HACoLA) established policies and procedures to effectively and fairly screen prospective program participants, which are summarized below:

A prospective participant **WILL** be denied Section 8 assistance for any of the following reasons:

- Currently on probation or parole (including summary probation)
- Has been evicted from federally assisted housing for drug related criminal activity for a period of three years following the eviction
- Subject to a lifetime sex offender registration requirement
- Has engaged in fraud or bribery or any other corrupt or criminal act in connection with any federal housing program
- Has been convicted for the manufacture of methamphetamine on the premises of federally assisted housing
- There is reasonable cause to believe that there is a pattern of abuse of alcohol that may threaten the health, safety, or peaceful enjoyment of the premises

A prospective participant **MAY** be denied Section 8 assistance for any of the following reasons:

- Drug-related criminal activity
- Violent criminal activity
- Other criminal activity which may threaten the health, safety, or right to peaceful enjoyment of the premises by other residents or persons residing in the immediate vicinity
- Other criminal activity that would threaten the health or safety of the owner or Housing Authority staff, contractors, subcontractors or vendors

The following are answers to some frequently asked questions, to further assist you in understanding our policies and procedures:

Q. Who must go through the criminal background screening process?

A. All adult household members 18 years of age or older, including live-in attendants, all new adult household members being added to a currently assisted households and all incoming families, porting into HACoLA's jurisdiction. In addition, all minors 13 years of age and older will be screened for lifetime sex offender registration requirement.

Q. What is involved in the criminal background screening process?

A. The screening process includes completing a Criminal Background Consent form. It may also include **fingerprinting** to ensure positive identification and request for additional documents to verify status of arrest or convictions.

Q. How long does it take to complete the criminal background screening process?

A. The criminal background screening process can take approximately 1 week to 3 months to complete, depending on each individual case.

Q. Are there any other factors that will be taken into consideration prior to the final determination?

A. Yes, factors such as disclosure, completion of rehabilitative treatment for drug related offenses, and type and longevity of the conviction will be considered. A criminal conviction alone may not necessarily result in the denial of assistance.

Q. If a prospective participant is denied is there any recourse?

A. All prospective participants who are denied assistance based on criminal background screening are allowed an opportunity for an Informal Review of the determination.

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES

CRIMINAL BACKGROUND SCREENING POLICY ACKNOWLEDGEMENT

The Housing Authority of the County of Los Angeles (HACoLA) is mandated by the U.S. Department of Housing and Urban Development (HUD) to conduct criminal background screenings as part of the Section 8 Rental Assistance Program. All new prospective participants are required to complete a criminal background screening.

Our policies and procedures have been established to effectively and fairly screen prospective program participants who engage in illegal criminal activities.

A prospective participant **WILL** be denied Section 8 assistance for any of the following reasons:

- Currently on probation or parole (including summary probation)
- Has been evicted from federally assisted housing for drug related criminal activity for a period of three years following the eviction
- Subject to a lifetime sex offender registration requirement
- Has engaged in fraud, bribery or any other corrupt or criminal act in connection with any federal housing program
- Has been convicted for the manufacture of methamphetamine on the premises of federally assisted housing
- There is reasonable cause to believe that there is a pattern of abuse of alcohol that may threaten the health, safety, or peaceful enjoyment of the premises

A prospective participant **MAY** be denied Section 8 assistance for any of the following reasons:

- Drug-related criminal activity
- Violent criminal activity
- Other criminal activity which may threaten the health, safety, or right to peaceful enjoyment of the premises by other residents or persons residing in the immediate vicinity
- Other criminal activity that would threaten the health or safety of the owner or HACoLA staff, contractors, subcontractors or vendors

The following are answers to some frequently asked questions, to assist you in understanding our policies and procedures.

Q. Who must go through the criminal background screening process?

A. All adult household members 18 years of age or older, including live-in attendants, all new adult household members being added to a currently assisted households and all incoming families, porting into HACoLA's jurisdiction. In addition, all minors 13 years of age and older will be screened for lifetime sex offender registration requirement.

Q. What is involved in the criminal background screening process?

A. The screening process includes completing a Criminal Background Consent form. It may also include **fingerprinting** to ensure positive identification and request for additional documents to verify status of arrest or convictions.

Q. How long does it take to complete the criminal background screening process?

A. The criminal background screening process can take approximately 1 week to 3 months to complete depending on each individual case.

Q. Are there any other factors that will be taken into consideration prior to the final determination?

A. Yes, factors such as disclosure, completion of rehabilitative treatment for drug related offenses, and type and longevity of the conviction will be considered. A criminal conviction alone may not necessarily result in the denial of assistance.

Q. If a prospective participant is denied, is there any recourse?

A. All prospective participants who are denied assistance based on criminal background screening are allowed an opportunity for an Informal Review of the determination.

⬇ TO BE COMPLETED BY HEAD OF HOUSEHOLD ⬇

I have read and understood the above, and I further understand that if any member of my family is found ineligible to participate in HACoLA's Section 8 Rental Assistance Program, I may not be issued a voucher or allowed to add an additional family member. If I am transferring to HACoLA's jurisdiction I may be required to return to the originating PHA, exclude a culpable household member, including myself or I may be terminated from the program.

Head of Household Print Name	Head of Household Signature	Date	Social Security #

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
ASSISTED HOUSING DIVISION
700 W. MAIN STREET • ALHAMBRA • CA 91801

CRIMINAL BACKGROUND CONSENT

INSTRUCTIONS: Please copy this form and complete for each household member age 18 and older.

The Housing Authority of the County of Los Angeles (HACoLA) is asking for a criminal background check for all adult household members (including live-in aides) 18 years of age or older who are applicants for the Section 8 Rental Assistance Program in order to comply with HUD requirements. A criminal conviction alone may not necessarily result in the denial of assistance. Other factors such as telling the Housing Authority about past criminal activity, completion of a drug or alcohol rehabilitation program, type of the conviction and how long ago it took place, may also be taken into consideration. A conviction is any plea of guilty, no contest, or a verdict of guilty. An applicant who fails to provide complete and true information as requested may not receive rental assistance.

I) ☐ **By initialing here, I am certifying that I have read and understood the previous paragraph.**

AUTHORIZATION TO CONDUCT CRIMINAL BACKGROUND INVESTIGATION

Last Name: _____ First Name: _____

Middle Name: _____ Jr/Sr: _____ Social Security #: _____-_____-_____

CA Driver's License #: _____ CA Identification #: _____

Date of Birth (DOB): _____/_____/_____ Sex: Female ☐ Male ☐

Please initial only one of the following boxes below. You must SIGN and DATE the form REGARDLESS of box checked.

II) ☐ **I, the undersigned, do not authorize the release of criminal history information to the Housing Authority of the County of Los Angeles and hereby voluntarily notify the Housing Authority of the County of Los Angeles that I no longer would like to be considered for participation in HACoLA's Section 8 Rental Assistance Program and in doing so, waive my rights to the hearing process.**

III) ☐ **I, the undersigned, do hereby authorize the release of criminal history information pursuant to Section 11105.03 of the Penal Code and 42 USC 1437 of the Federal Law to the Los Angeles County Sheriff's Department and/or Housing Authority of the County of Los Angeles. The use of this information is limited to the screening of prospective participants of HACoLA's Section 8 Rental Assistance Program. All information obtained from a criminal background investigation will be kept confidential and used for the sole purpose of admissions to HACoLA's Section 8 Rental Assistance Program. The information provided will be destroyed no more then 30 days after a final decision is made.**

CRIMINAL BACKGROUND DISCLOSURE

*If you initialed **BOX III**, print legibly or type the following information. Do not leave any sections blank. If it does not apply, write "N/A".*

Current Phone Number	Other Number (message, pager, cell phone)
( )	( )

Current Residence Address

				Present
Street	City	State/Zip Code	From	To

CRIMINAL BACKGROUND DISCLOSURE (continued)

Write the addresses you have lived at, in the **last 3 years**. If necessary, please add an attachment.

Street	City	State/Zip Code	From	To

1. Have you ever been known by another name? If yes, list all other names (Also Known As – A.K.A.):

   A.K.A.: _____ A.K.A.: _____

2. Are you currently on parole or probation for **any criminal offense** (including summary probation)?

   Yes____ No____ If yes, please give dates and charges: _____

   _____

3. Have you ever been arrested, charged or convicted for **any drug-related criminal activity**?

   Yes____ No____ If yes, please give dates, charges, city and state: _____

   _____

4. Have you ever been evicted from federally assisted housing (i.e., public housing) for drug related criminal activity?

   Yes____ No____ If yes, please give dates, charges, city and state: _____

   _____

5. Have you ever been arrested, charged or convicted for **any criminal activity**?

   Yes____ No____ If yes, please give dates, charges, city and state: _____

   _____

6. Have you ever been arrested, charged or convicted for any violent criminal activity in which you used, or you attempted to use, or threatened to use physical force against a person or property of another?

   Yes____ No____ If yes, give dates, charges, city and state: _____

   _____

7. Have you ever been arrested, charged or convicted for **any sex-related criminal activity**?

   Yes____ No____ If yes, please explain and provide incident dates: _____

8. Are you subject to a lifetime registration under a State Sex Offender Registration Program?

   Yes____ No____ If yes, please explain and provide incident dates: _____

SIGNATURE REQUIRED: *By signing below, I certify that the above information is true and correct to the best of my knowledge*.

Signature:_____ Date: _____

Please Do Not Write Below This Line

Office Use Only

Section A (Completed by HACoLA staff)

Head of household name: _____ Head of household SS#: - -

Program	Unit	Return to (Print HACoLA staff name)

☐ Applicant ☐ Participant | Port-in? ☐ Yes ☐ No | Initial PHA: _____ ☐ Absorb ☐ Bill

Section B (Completed by Program Integrity Unit)

Final Disposition: ☐ Suitable ☐ Denied ☐ Denied N/S ☐ Cancel off W/L

Submit FP card	Fingerprinted	F/P card submitted	FBI report rec'd	Hearing Date
☐ Yes ☐ No				

Reviewed By: _____ Date: _____

HOUSING AUTHORITY OF THE COUNTY OF LOS ANGELES
ASSISTED HOUSING DIVISION
700 W. MAIN STREET • ALHAMBRA • CA 91801

PARENT/GUARDIAN AUTHORIZATION FOR HOUSING AUTHORITY TO OBTAIN SEX OFFENDER REGISTRATION INFORMATION OF A MINOR

Please complete this form for each household member between the *ages of 13 through 17 years old.*

In accordance with Section 982.553(2)(i) of Title 24 of the Code of Federal Regulations and Section 2.8.2 of the Administrative Plan for the Housing Authority of the County of Los Angeles (HACoLA), HACoLA will deny admission into the Section 8 program to any applicant, including **minors between the ages of 13 to 17 years of age**, who is subject to lifetime registration under a state sex offender registration program. In order to identify any such applicants, HACoLA is authorized to obtain sex offender registration information from the State of California Department of Justice.

By completing this form and signing below, you are authorizing HACoLA to obtain sex offender registration information from the State of California Department of Justice with respect to a member of your household (identified below) between the ***ages of 13 and 17 years of age***. The information obtained by HACoLA is maintained confidentially and will solely be used for the purpose of determining admissions to HACoLA's Section 8 Rental Assistance Program. The information obtained will be destroyed no more than 30 days after a final decision is made, including completion of any administrative reviews and/or legal challenges.

Section I: Parent/Guardian Authorization

Parent/Guardian Name (Print): _____ **SSN:** _____

Parent/Guardian Signature: _____ **Date:** _____

Section II: To be Completed With Minor's Information Only

Last Name: _____ First Name: _____

Middle Name: _____ Social Security #: ___-___-___

Address: _____

CA Driver's License #: _____ CA Identification #: _____

Date of Birth (DOB): ___/___/___ Sex: Female ☐ Male ☐

Has she/he been licensed to drive in another state? ☐ Yes ☐ No

If yes, which state? _____ When? ___/___/___

Has she/he ever been known by another name? ☐ Yes ☐ No

If yes, please list all other names (a.k.a.):

1. _____ 3. _____
2. _____ 4. _____

Is the minor subject to a lifetime registration requirement under a state sex offender registration program?

☐ Yes ☐ No If yes, please explain and provide incident dates: _____

_____

Please Do Not Write Below This Line

Office Use Only

Head of household name:		Head of household SS#:	- -
Program	Unit	Return to (Print HACoLA staff name)	

☐ Applicant ☐ Participant	Port-in? ☐ Yes ☐ No	Initial PHA:		☐ Absorb ☐ Bill
Final Disposition:	☐ Suitable ☐ Denied			

Reviewed By: **Date**

U.S. Department of Housing and Urban Development

Office of Public and Indian Housing

DEBTS OWED TO PUBLIC HOUSING AGENCIES AND TERMINATIONS

Paperwork Reduction Notice: Public reporting burden for this collection of information is estimated to average 7 minutes per response. This includes the time for respondents to read the document and certify, and any recordkeeping burden. This information will be used in the processing of a tenancy. Response to this request for information is required to receive benefits. The agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number. The OMB Number is 2577-0266, and expires 08/31/2016.

NOTICE TO APPLICANTS AND PARTICIPANTS OF THE FOLLOWING HUD RENTAL ASSISTANCE PROGRAMS:

- Public Housing (24 CFR 960)
- Section 8 Housing Choice Voucher, including the Disaster Housing Assistance Program (24 CFR 982)
- Section 8 Moderate Rehabilitation (24 CFR 882)
- Project-Based Voucher (24 CFR 983)

The U.S. Department of Housing and Urban Development maintains a national repository of debts owed to Public Housing Agencies (PHAs) or Section 8 landlords and adverse information of former participants who have voluntarily or involuntarily terminated participation in one of the above-listed HUD rental assistance programs. This information is maintained within HUD's Enterprise Income Verification (EIV) system, which is used by Public Housing Agencies (PHAs) and their management agents to verify employment and income information of program participants, as well as, to reduce administrative and rental assistance payment errors. The EIV system is designed to assist PHAs and HUD in ensuring that families are eligible to participate in HUD rental assistance programs and determining the correct amount of rental assistance a family is eligible for. All PHAs are required to use this system in accordance with HUD regulations at 24 CFR 5.233.

HUD requires PHAs, which administers the above-listed rental housing programs, to report certain information at the conclusion of your participation in a HUD rental assistance program. This notice provides you with information on what information the PHA is required to provide HUD, who will have access to this information, how this information is used and your rights. PHAs are required to provide this notice to all applicants and program participants and you are required to acknowledge receipt of this notice by signing page 2. Each adult household member must sign this form.

What information about you and your tenancy does HUD collect from the PHA?

The following information is collected about each member of your household (family composition): full name, date of birth, and Social Security Number.

The following adverse information is collected once your participation in the housing program has ended, whether you voluntarily or involuntarily move out of an assisted unit:

1. Amount of any balance you owe the PHA or Section 8 landlord (up to $500,000) and explanation for balance owed (i.e. unpaid rent, retroactive rent (due to unreported income and/ or change in family composition) or other charges such as damages, utility charges, etc.); and
2. Whether or not you have entered into a repayment agreement for the amount that you owe the PHA; and
3. Whether or not you have defaulted on a repayment agreement; and
4. Whether or not the PHA has obtained a judgment against you; and
5. Whether or not you have filed for bankruptcy; and
6. The negative reason(s) for your end of participation or any negative status (i.e., abandoned unit, fraud, lease violations, criminal activity, etc.) as of the end of participation date.

Who will have access to the information collected?
This information will be available to HUD employees, PHA employees, and contractors of HUD and PHAs.

How will this information be used?
PHAs will have access to this information during the time of application for rental assistance and reexamination of family income and composition for existing participants. PHAs will be able to access this information to determine a family's suitability for initial or continued rental assistance, and avoid providing limited Federal housing assistance to families who have previously been unable to comply with HUD program requirements. If the reported information is accurate, a PHA may terminate your current rental assistance and deny your future request for HUD rental assistance, subject to PHA policy.

How long is the debt owed and termination information maintained in EIV?
Debt owed and termination information will be maintained in EIV for a period of up to ten (10) years from the end of participation date.

What are my rights?
In accordance with the Federal Privacy Act of 1974, as amended (5 USC 552a) and HUD regulations pertaining to its implementation of the Federal Privacy Act of 1974 (24 CFR Part 16), you have the following rights:

1. To have access to your records maintained by HUD, subject to 24 CFR Part 16.
2. To have an administrative review of HUD's initial denial of your request to have access to your records maintained by HUD.
3. To have incorrect information in your record corrected upon written request.
4. To file an appeal request of an initial adverse determination on correction or amendment of record request within 30 calendar days after the issuance of the written denial.
5. To have your record disclosed to a third party upon receipt of your written and signed request.

What do I do if I dispute the debt or termination information reported about me?
If you disagree with the reported information, you should contact in writing the PHA who has reported this information about you. The PHA's name, address, and telephone numbers are listed on the Debts Owed and Termination Report. You have a right to request and obtain a copy of this report from the PHA. Inform the PHA why you dispute the information and provide any documentation that supports your dispute. HUD's record retention policies at 24 CFR Part 908 and 24 CFR Part 982 provide that the PHA may destroy your records three years from the date your participation in the program ends. To ensure the availability of your records, disputes of the original debt or termination information must be made within three years from the end of participation date; otherwise the debt and termination information will be presumed correct. Only the PHA who reported the adverse information about you can delete or correct your record.

Your filing of bankruptcy will not result in the removal of debt owed or termination information from HUD's EIV system. However, if you have included this debt in your bankruptcy filing and/or this debt has been discharged by the bankruptcy court, your record will be updated to include the bankruptcy indicator, when you provide the PHA with documentation of your bankruptcy status.

The PHA will notify you in writing of its action regarding your dispute within 30 days of receiving your written dispute. If the PHA determines that the disputed information is incorrect, the PHA will update or delete the record. If the PHA determines that the disputed information is correct, the PHA will provide an explanation as to why the information is correct.

This Notice was provided by the below-listed PHA:	**I hereby acknowledge that the PHA provided me with the *Debts Owed to PHAs & Termination N*otice:**
	Signature **Date**
	Printed Name

PLACE HERE

INCOME VERIFICATION including the following:

- Verification of Employment and Earnings (3 months of pay stubs) (if applicable)
- Verification of DPSS Assistance (Notice of Action)
- Verification of Social Security Benefits
- Unemployment / State Disability Insurance Award Letter & 3 consecutive check stubs
- Child Support Payment History Chart & 3 consecutive check stubs
- Adoption / Foster Care / Kin-Gap Assistance Payment Letter
- Self-Employment – all pages of most recent year Tax Returns, W'2s & 1099s
- Bank Verification of Income and Assets (1 month bank statement) *for* ***every*** *household bank account*
- Verification of Contributions Received
- Retirement Income Verification Letter
- Life Insurance
- Pension / Annuity Award Letter

PLACE HERE

Copy of each household member's California Identification Card (ID) or Driver's License. **If the CA ID/DL expires before the client is housed, the application will be withdrawn;** therefore, if the ID/DL is within 6 months of expiration, ask the client to renew their ID at the DMV. Submit a copy of the DMV application/receipt with the HACoLA application.

-and-

Copy of each household member's **signed** Social Security Card. If it is not signed, the application will be returned to the clinic/agency that submitted it.