HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
SECTION 8 SPECIAL PROGRAM OPERATIONS
Homeless Section 8 Program

APPLICATION COVERSHEET AND CHECKLIST

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
_____ 2. Transmittal form
_____ 3. Housing Intake and Needs Assessment, ***3 pgs*** **(DMH form)**
_____ 4. Authorization for Request or Use/Disclosure of Protected Health Information ***(MH 677 HMIS), 2 pgs*** **(DMH form)**
_____ 5. Authorization for Request or Use/Disclosure of Protected Health Information ***(MH 677 HACLA), 2 pgs*** **(DMH form)**
_____ 6. LACDMH Notice of Privacy Practices: Acknowledgement of Receipt ***(MH 601E)*** **(DMH form)**
_____ 7. Service Provider Responsibility Form, ***2 pgs*** **(DMH form)**
_____ 8. Homeless Section 8 Program Client Agreement **(DMH form)**
_____ 9. Request for Criminal History ***(RE-73 S8, 2/09)*** (5 years of background must be completed by all adults)
Use extra forms if needed **MUST BE PRINTED ON LEGAL SIZED PAPER**
_____ 10. Applicant Questionnaire ***(HAPP 13, 1/09)*** *for **all** adults 18 years of age and older*
MUST BE PRINTED ON LEGAL SIZED PAPER
_____ 11. Eligibility Questionnaire for Applicants ***(HAPP-27A, 1/09), 9 pgs*** (not on website, contact FHSU)
must be signed by all adults
_____ 12. Verification of Income (*Sign ONLY, HACLA will mail or fax out for verification)*
_____ Verification of DPSS Assistance **(*RE 29, 4/05*)** *for **all** adults 18 years of age and older*
MUST BE PRINTED ON LEGAL SIZED PAPER
_____ Certified Statement for Self-Employment ***(RE-46SE)*** *for **all** adults 18 years of age and older*
_____ Social Security Administration award Letter *for **all** adults 18 years of age and older*
_____ Notice of Action (TANF, CalWORKs, GR/FS) *for **all** adults 18 years of age and older*
_____ 13. Authorization to Release Information ***(HAPP-86A, 11/03)*** *for **all** adults 18 years of age and older*
_____ 14. Certification of Citizenship Status ***(NC-100A, 10/95)*** *for **all** adults 18 years of age and older*
_____ 15. Certification of Residence In Homeless Facility ***(RE-65)***
_____ 16. Certification of Homelessness ***(RE-65a)***
_____ 17. Debts Owed To Public Housing Agencies and Terminations ***(HUD-52675, 4/10), 2pgs***
*for **all** adults 18 years of age and older*
_____ 18. Authorization for the Release of Information ***(HUD-9886, 7/94), 2pgs*** *must be signed by all adults*
_____ 19. Section 8 Family Obligations ***(HAPP-149, 2/10), 2pgs*** *must be signed by all adults*
MUST BE PRINTED ON LEGAL SIZED PAPER
_____ 20. Reasonable Accommodation Questionnaire ***(S504-01B, 6/06)***
_____ 21. Fraud Information "Things You Should Know" ***(HUD-1140-OIG)*** *must be signed by all adults*
(Retain a copy for client)
_____ 22. Certification of No Social Security Number ***(HAPP-140, 1/09)*** *for **all** adults 18 years of age and older*
_____ 23. Certified Statement – Events that led to homelessness *for **all** adults 18 years of age and older*
_____ 24. Certified Statement – Yes/No questionnaire ***(ANC-19, 1/09)*** *for **all** adults 18 years of age and older*
_____ 25. Non-City Section 8 Applicants ***(NCLA/NC- 12, 7/95)***
_____ 26. Identification documents
_____ Current California ID Card or Driver's License *submit for **all** adults*
_____ Social Security Card *submit for **all** adults and minors*
_____ Birth Certificate *submit for **all** minors*
_____ 27. Certified Statement ***(RE-46, 9/10)*** ***filled by staff if assisting with forms***
_____ 28. Certified Statement ***(ANC-62, 5/99)*** *list all members in the household*
_____ 29. Supplement to Application For Federally Assisted Housing ***(form HUD-92006, 5/09)***

Client Name:_____ SS#:_____

Name of Agency:_____ 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:_____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

SECTION 8 HOMELESS PROGRAM

TRANSMITTAL FORM

(This form must accompany every application submitted to HACLA. Please retain a copy.)

TO: Housing Authority of the City of Los Angeles
Special Program Operations/Homeless Program
2500 Wilshire Boulevard, 4th Floor
Los Angeles, CA 90057
Attention: _____

FROM: LAC-DMH / _____
(CONTRACT AGENCY NAME ONLY)

SUBJECT: REFERRALS SUBMITTED FOR APPROVAL

DATE: _____

The following referrals are being submitted for approval to the Housing Authority of the City of Los Angeles for the Section 8 Homeless Program.

CLIENT'S NAME: _____

SSN: _____ SEX: _____ DOB: _____

Certification to be completed by the Referring Agency/NPO

This Referral has been reviewed and approved by:

_____
Name of Authorized Representative (NPO)

_____
Signature

( ) -_____
Telephone Number

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 #

_____
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:

_____ _____

Print Client Name IS #

_____

Agency/Program

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: _____

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 eligibly 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 City of Los Angeles (HACLA), Special Program Operations and 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 HACLA'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 eligibly 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 HACLA.

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:_____

LACDMH NOTICE OF PRIVACY PRACTICES: *Acknowledgement of Receipt*

Effective Date: April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Los Angeles County Department of Mental Health (LACDMH). 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://www.dmh.co.la.ca.us or on request from our Treatment Team.

I acknowledge receipt of the *Notice of Privacy Practices* of LACDMH.

Signature: _____ Date: _____
(client/parent/conservator/guardian)

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:

_____

_____

_____

_____

_____

_____

_____

Effective Date: **April 14, 2003**

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.

WHO WILL FOLLOW THIS NOTICE

This Notice describes LACDMH practices and that of:

- All employees, staff and other LACDMH personnel.
- Any member of a volunteer group we allow to help you while you are in the facility.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the facility. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the facility. As required and when appropriate, we will ensure that the minimum necessary information is released in the course of our duties.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations regarding the use and disclosure of medical information.

We are required by law to:

Keep your medical information, also known as "protected health information" or "PHI," private;

Give you this Notice of our legal duties and privacy practices with respect to your PHI; and

Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected health information. 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.

For Treatment

We create a record of the treatment and services you receive at our facilities. We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example, a doctor treating you for a chemical imbalance may need to know if you have problems with your heart because some

medications affect your blood pressure. We may share your PHI in order to coordinate the different things you need, such as prescriptions, blood pressure checks and lab tests, and to determine a correct diagnosis.

We also may disclose your PHI to people outside the facility who may be involved in your treatment, such as your case manager, or other persons for coordination and management of your health care. Your mental health information may only be released to health care professionals outside this facility without your authorization if they are responsible for your physical or mental health care.

For Payment

We may use and disclose your PHI in order to get paid for the treatment and services we have provided you. For example, we may need to give your health plan information about a medication, visit, or treatment session you received at the facility so your health plan will pay us. 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 your PHI to carry out activities that are necessary to run our facilities and to make sure that all of our clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many facility clients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other facility personnel for review and learning purposes.

Appointment Reminders

We may use and disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care at the facility.

Treatment Alternatives and Health-Related Products and Services

We may use and disclose your PHI to recommend possible treatment options or alternatives that may be of interest to you. Additionally, we may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you (for example, Medi-Cal eligibility or Social Security benefits).

Individuals Involved in Your Care or Payment for Your Care

We may disclose your PHI to a friend or family member who is involved in your medical care or payment related to your health care, provided that you agree to this disclosure, or we give you an opportunity to object to this disclosure. However, if you are not available or are unable to agree or object, we will use our professional judgment to decide whether this disclosure is in your best interest.

Disaster Relief Purposes

We may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. We will give you the opportunity to agree to this disclosure or object to this disclosure, unless we decide that we need to disclose your PHI in order to respond to the emergency circumstances.

USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU THAT DO NOT REQUIRE YOUR AUTHORIZATION

Research

We may disclose your PHI to medical researchers who request it for approved medical research projects; however, such disclosures must be cleared through a special approval process before any PHI is disclosed to the researchers who will be required to safeguard the PHI they receive.

As Required By Law

We will disclose your PHI when required to do so by federal, state or local law.

Workers' Compensation

We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose medical information about you for public health activities, such as those aimed at preventing or controlling disease, preventing injury or disability, and reporting the abuse or neglect of children, elders and dependent adults.

Health Oversight Activities

We may disclose your 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.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI 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 (which may include written notice to you) or to obtain an order protecting the PHI requested.

Law Enforcement

We may disclose PHI to government law enforcement agencies in the following circumstances:

- In response to a court order, warrant, subpoena, summons or similar process issued by a court.
- If a psychotherapist believes that it is likely that you present a serious danger of violence to another person.
- To report your discharge, if you were involuntarily detained after a peace officer initiated a 72-hour hold for evaluation and requested notification.

In certain circumstances, if you have been admitted to a facility and have disappeared or been transferred.

Coroners, Medical Examiners and Funeral Directors

We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about clients of the facility to funeral directors as necessary to carry out their duties.

Specialized Government Functions

We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates

If you are an inmate or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release 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.

Other Uses of Your Medical Information

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

RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI in our records:

Right to Inspect and Copy

With certain exceptions, you have the right to inspect and copy your PHI from our records. Usually, this includes treatment and billing records.

To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to your case manager or the person in charge of your treatment. A form will be provided to you for this request. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied the right to inspect and copy your PHI in our records, you may request that the denial be reviewed. With the exception of a few circumstances that are not subject to review, another licensed health care professional within LACDMH, who was not involved in the denial, will review the decision. We will comply with the outcome of the review.

Right to Request Amendment

If you feel that your PHI in our records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the PHI.

To request an amendment, ask for a "Request to Amend Protected Health Information" form, and complete and submit this form to your case manager or the person in charge of your treatment. 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 PHI that:

Was not created by us, unless you can provide us with a reasonable basis to believe that the person or entity that created the PHI is no longer available to make the amendment;

Is not part of the PHI kept by or for the facility;

Is not part of the PHI which you would be permitted to inspect and copy; or

Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a **Statement of Disagreement** form, with a description not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want this form to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

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 your PHI other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, ask for a "Request for an Accounting of Disclosures" form, and complete and submit this form to your case manager or the person in charge of your treatment. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. 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 that we follow additional, special restrictions when using or disclosing your PHI for treatment, payment or health care operations. You also have the right to request that we follow additional, special restrictions when using or disclosing your PHI to someone who is involved in your care or the payment for your health care, like a family member or friend. For example, you could ask that we not use or disclose that you are receiving services at this facility.

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, ask for a "Request for Additional Restrictions on Use or Disclosure of Protected Health Information," and complete and submit this form to your case manager or the person in charge of your treatment. 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 Request Confidential Communications

You have the right to request that we communicate with you about your appointments or other matters related to your treatment in a specific way or at a specific location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, ask for a "Request to Receive Confidential Communications by Alternative Means or at Alternative Locations" form, and complete and submit this form to your case manager or to the person in charge of your treatment. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

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.

You may obtain a copy of this Notice at our website: http://www.dmh.co.la.ca.us/

To obtain a paper copy of this Notice, please contact your Treatment Team.

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 medical information 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://www.dmh.co.la.ca.us/ or you may request one from your Treatment Team.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the Federal Government. 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, contact:

Los Angeles County Department of Mental Health (LACDMH)
Patient's 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
Chief HIPAA Privacy Officer
500 West Temple Street, Suite 410
Los Angeles, CA 90012
(213) 974-2164
Email: HIPAA@auditor.co.la.ca.u

To file a complaint with the Federal Government, contact:

Region IX, Office for Civil Rights,
U.S. Department of Health and Human Services
50 United Nations Plaza-Room 322
San Francisco, CA 94102.
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (415) 437-8311

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: _____

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 SPC.

Print Program/Agency Manager's Name: _____

Program/Agency Manager's Signature: _____

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: _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
REQUEST FOR CRIMINAL HISTORY

Date Submitted: _____ **Initial Interview Date:** _____

TO: Background Check Processing Personnel

FROM: S8 Admin APO I&C SPO SPA Serv. Delivery

Authorized Representative Signature_____

CLIENT NUMBER _____ MGR CODE _____ PROGRAM _____

Pursuant to California Penal Code Section 11105.03 the Housing Authority of the City of Los Angeles requests criminal history summary information on the individual whose name appears below. Please complete the reverse side of this form and return it to the requester within 14 days of receipt.

Information Sought

1) Whether the individual is required to register as a sex offender.

2) Whether the individual has ever been convicted for the manufacture or production of methamphetamine.

3) Whether the individual has a conviction while an adult during the last 10 years for a serious felony as defined in the California Penal Code 1192.7(c), of any offense punishable under California Penal Code Section 273.5, 422.6, 422.7, 422.75, 422.9, 1170.75, 12020, 12021 or 12021.1, a conviction under Section 273.6 that involves a violation of a protective order as defined in Section 6218 of the Family Code, or a conviction for any felony offense that involves controlled substances or alcoholic beverages, or any felony offense that involves any activity related to controlled substances or alcoholic beverages, or a conviction for any offence that involves domestic violence as defined in Section 13700 of the California Penal Code FURTHER LIMITED TO:

a) Convictions within the last 5 years for any drug related criminal activity including illegal use of a drug, and
b) Convictions within the last year for activity related to alcoholic beverages.

Adult Signature: _____ **Date:** _____

☐ Applicant ☐ Live-In Aide ☐ Adding to HH ☐ Participant Since _____

Last	First	M.I:	Sex

Social Security	Date of Birth (i.e. 12-03-08)	Driver License/ ID Number	State

Current Address (50058) How Long _____	City	State	Zip

Previous Address How Long _____	City	State	Zip

Descent	Hair	Eyes	Height	Weight

Other identifying information (Names, addresses, Etc.):
How Long _____

Other identifying information (Name, addresses, Etc.):
How Long _____

CLEARANCE REVIEW (Excludes HUD-VASH applicants)

Did the person receive housing assistance in the past? [Y|N]
If yes, where?_____From_____To_____.
Does the person have a record of any prior terminations from assisted housing for program violations? [Y|N]

If yes, Reason_____Termination Date_____Eviction Date_____
(Refer to Terminations & Denials Matrix) (if applicable)
Eligibility Date_____ Denied? [Y|N]

Attach copies of state issued ID and social security card to RE-73

☐ NO HITS ☐ NO RECORD MEETING CRITERIA
☐ NO EXACT MATCH ☐ MANUAL RECORD

Housing Authority of the City of Los Angeles
Applicant Questionnaire

Registrant's Name: _____ **Registration Number:** _____

Adult's Name: _____ **Date of Birth:** _____

California ID Number: _____ **Social Security Number:** _____

WARNING: Falsification or concealment of a material fact or submission of false, or fraudulent statements to any Department or Agency of the United States Government may result in a fine of not more than $10,000 or imprisonment for not more than five (5) years, or both. (18 U.S.C. 1001) **The Housing Authority has the right to request criminal history information from law enforcement agencies and information from HUD and public housing agencies to decide whether you are eligible for assistance.**

1. Please list all the States (in the U.S.A.) where you have lived since you were 18 years of age:

States: _____

2. Have you ever been convicted of making methamphetamine (speed)?	yes	no
3. Have you ever been required to register as a sex offender in any State?	yes	no
4. Within the last 5 years have you been convicted of any drug related criminal activity including illegal use of drugs or possession of illegal drugs? If yes, what were you convicted for: **Crime:** _____ **Date:** _____ _____ _____	yes	no
5. Within the last 5 years have you been convicted of any violent criminal activity? If yes, what were you convicted for: **Crime:** _____ **Date:** _____ _____ _____	yes	no
6. Within the last year have you been convicted of a crime that involved abuse of alcohol (such as drunk driving, driving under the influence, drunk and disorderly conduct)? If yes, what were you convicted for: **Crime:** _____ **Date:** _____ _____ _____	yes	no
7. During the last 5 years have you been on any Section 8 program? If yes, please provide the following information about the housing authority: Name of the housing authority: _____ State: _____ City: _____ Phone: _____ When did you leave the Section 8 program? Month: _____ Year: _____	yes	no
8. During the last 5 years have you lived in any other federally assisted housing? If yes, please provide the following information: Nameof the housing authority or owner: _____ State: _____ City: _____ Phone: _____ When did you leave assisted housing? Month: _____ Year: _____	yes	no
9. Were you removed from Section 8 or evicted from Section 8 or any other federally assisted housing within the last 5 years? Ifyes, when? _____ Why? _____	yes	no
10. Have you ever been told that you owe money to a housing authority or housing agency? If yes, what housing authority or agency? _____	yes	no
11. Have you ever been told you committed fraud while you were in Section 8 or any other assisted housing program? Ifyes, when: Month: _____ Year: _____ Where? _____	yes	no

I certify that all the above answers are correct. I understand that the HACLA has the right to request information from law enforcement and housing agencies to determine my eligibility.

Signature: _____ Date: _____ **HAPP-13 (1/09)**

PLACE HERE

To get a copy of the **HACLA Eligibility Questionnaire for Applicants – Homeless Section 8 Program (HAPP 27A)**, please contact Federal Housing Subsidies Unit (FHSU) to arrange pick up.

Please call:

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

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

VERIFICATION OF DEPARTMENT OF PUBLIC SOCIAL SERVICES (DPSS) ASSISTANCE

To: Los Angeles County Department of Social Services (DPSS)

Cal/Mgr Code: _____

Client No.: _____

Name: _____ SSN: _____

Case Name if Different: _____ Number in Assisted Household _____

Address: _____

Please provide the information requested below. I certify that this information will only be used for official Housing Authority business to determine the client's eligibility and rent. Please return this form to the Housing Authority (address below) in the enclosed self addressed envelope or fax to ( ) _____. **Do not return the form to the client**. Thank you for your assistance.

Name HACLA employee	Title	Phone	Signature	Date
		( )		

Return To:

Attn:

Client Certification: I hereby authorize DPSS to release the information requested below concerning my eligibility, the amount of benefits, and the reason for benefit reduction to the Housing Authority in writing, by telephone, or by computer matching. This authorization is valid for one year from the date below.

Signature: _____ Date: _____

TO BE COMPLETED BY DPSS EMPLOYEE (please do not use the check digit in the case number.)

A. DPSS Case #: [ ][ ][ ][ ][ ][ ][ ] -- [ ][ ] **B**. Aid Type _____

C. Date of most recent case opening: _____ **D**. Effective date of present grant: _____

E. Number of persons aided: _____ **F**. Number of persons in the home: _____

G. Maximum Allowable Grant: _____ **H**. Actual Grant: _____

I. Is the family receiving Food Stamps? **Yes** **No** - If "yes," what is the cash value? _____

J. Any special needs? **Yes** **No** - If "yes," what is the purpose_____ Amount: $ _____

K. REDUCTIONS IN BENEFITS:

1. Is there a current reduction in benefits due to fraud? **Yes** ○ **No** ○ When did it start? _____
   If "yes," what is the amount of the reduction? $ _____ When will it end? _____
   During what months/years did the fraud occur? _____
   During that period, what was the monthly amount the client actually received? $_____

2. Is there a current reduction in benefits because:
   - The family failed to participate in an economic self-sufficiency program? **Yes** ○ **No** ○
   - The family failed to comply with a work activities requirement? **Yes** ○ **No** ○

   If "yes" to either, what is the amount of the reduction? $_____ When did it start? _____
   When is the reduction (sanction) expected to end? _____

3. Is there a current reduction in benefits due to reasons other than fraud or non-compliance? **Yes** ○ **No** ○
   If "yes," what is the amount of the reduction? $ _____ When will it end? _____
   Please state the reason for the benefit reduction: _____

L. Additional income of the family (Wages, SSA/SSI, Child Support, Other):

Source	Amt	Source	Amt
	$		$
	$		$

M. If no longer assisted, what was the termination date: _____

N. Client address if different from above: _____

DPSS Employee Signature: _____ Date: _____

Please print name: _____ Phone: ( ) _____

File #: _____ District: _____

DPSS STAMP HERE

Please sign, date, and return this form to the Housing Authority only. Do not take or mail this form to any other agency, entity, or persons (including the client whose information is requested).

WARNING: 18 U.S.C. 1001 provides that whoever knowingly and willingly makes or uses a document or writing containing false, fictitious, or fraudulent statement or entry in any manner within the jurisdiction of any department or agency of the United States shall be fined or imprisoned for not more than five years or both.

HACLA USE ONLY

Date stamp receipt or document date, name, and title if oral verification

RE-29 4/2005

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OPPORTUNITY - AFFIRMATIVE ACTION EMPLOYER
2600 Wilshire Boulevard 4th Fl Los Angeles, California 90057 (213) 252-2500

CERTIFIED STATEMENT

Knowing the penalty for making a false statement under the United States Criminal Code, I hereby certify that the following is a true and full statement.

I, _____, am self employed.
I have listed by TOTAL EARNINGS for the past six (6) months from _____
To present as follows:

DATE (You were paid)	TYPE OF WORK	AMOUNT RECEIVED

(USE REVERSE SIDE FOR ADDITIONAL INCOME)

Date: _____ Signed: _____

Section 35A of the United States Criminal code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000 fine, to make false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction. The information given above was requested by the HOUSING AUTHORITY OF THE CITY OF LOS ANGELES in its capacity as a City, State and Federal Agency.

Housing Authority of the City of Los Angeles

Authorization to Release Information

CLIENT #: _____

I authorize the Housing Authority of the City of Los Angeles (HACLA) to release any requested information, to provide copies of any documents contained in my file, and to discuss any topic relevant to my application for or participation in a HACLA assisted housing program with the following and their agents or employees:

☐ Legal Aid Foundation or Neighborhood Legal Services

Attorney's Name: _____

☐ My congressperson or local elected representative

Representative's name: _____

☐ Other (please name): _____

Client's Name: _____

Signature: _____ Date: _____

Releasing Information to the Media:

The HACLA does not release information to the media (television, radio, newspapers, etc.) except as authorized by its Community Relations Division. This form cannot be used to authorize release of any information to the media other than to a specific media ombudsperson indicated above.

La Autoridad de La Vivienda de la Ciudad de Los Ángeles

Permiso de Autorización para Relevar Información

CLIENT #: _____

Autorizó a la Autoridad de la Vivienda de la Ciudad de Los Ángeles (HACLA – por sus siglas en inglés) que revele cualquier información pedida, para proporcionar copias de cualquier documento que contenga mi expediente, y de discutir cualquier tema relacionado con mi solicitud para o participación en un programa de asistencia de vivienda de HACLA con los siguientes representantes o empleados:

☐ Fundación de Asistencia Legal o Servicio Legal comunitario

Nombre del Abogado: _____

☐ Mi congresista o representante electo local

Nombre del representante: _____

☐ Otro (nombre por favor):_____

Nombre del Cliente: _____

Firma: _____ Fecha: _____

Revelando información a los medios de comunicación:

La HACLA no revela información a los medios de comunicación (televisión, radio, periódico, etc.) excepto como se autorice por el Departamento de Relaciones Comunitarios. Esta forma no se puede usar para autorizar la revelación de cualquier información a los medios de comunicación excepto al mediador en asuntos de interés público de un medio especifico de comunicación anteriormente señalado.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

CERTIFICATION OF CITIZENSHIP STATUS

INSTRUCTIONS: In order to be eligible to receive housing assistance, each resident/program applicant must be within the United States lawfully. Please read the certification carefully and return it as directed. Each family member who is age 18 or older must sign a Certification form The responsible adult who will be living in the unit must sign the Certification form for all family members under the age of 18.

I CERTIFY THAT, under the penalty of perjury, to the best of my knowledge, I am lawfully within the United States because (please check the appropriate boxes):

A. ☐ I am a citizen, naturalized citizen, or a national of the United States;
B. ☐ I have eligible immigration status.
Alien Registration No. _____

I CERTIFY THAT:

C. ☐ I do not have eligible immigrant status.
D. ☐ I choose not to state my immigrant status.
E. ☐ I am signing the Certification on behalf of minors(s):

Minor's Name	Birthdate	Relationship	Citizenship Status	Alien Registration
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	

F. ☐ I am signing the certification on behalf of adult family member(s) who do not have eligible immigration status or do not choose to state their immigration status *(head of household or spouse must be a citizen or have eligible immigration status)*:

Family Member's Name	Birthdate	Relationship	Citizenship Status (Circle)
			C D
			C D
			C D
			C D

Warning: 18 U.S.C. 1001 provides, among other things, that whoever knowingly and willfully makes or uses a documents or writing containing any false, fictitious, or fraudulent statement or entry, in any matter within the jurisdiction of any department or agency of the United States, shall be fined not more than $10,000 or imprisonment for not more than five years, or both.

_____ _____ _____
Print Name Signature Date

FOR OFFICE USE ONLY

Client No. _____ Registration No. _____

Office/Cal No. _____ Location _____ Manager Code _____

AUTORIDAD DE VIVIENDA DE LA CIUDAD DE LOS ÁNGELES

CERTIFICACIÓN DEL ESTADO DE CIUDADANÍA

INSTRUCCIONES: A fin de reunir los requisitos legales para continuar recibiendo asistencia de vivienda, cada residente o participante del programa debe radicar en los Estados Unidos legalmente. Favor de leer la certificación cuidadosamente y devuélvala como se indica. Todo miembro de la familia que sea mayor de 18 años de edad debe firmar un formulario de certificación. El adulto responsable que va a residir en la vivienda debe firmar el formulario de certificación por todos los miembros de la familia que sean menores de 18 años.

CERTIFICO QUE, bajo pena de perjurio y según mi leal saber y entender, radico legalmente en los Estados Unidos porque (favor de marcar las casillas pertinentes):

A. ☐ Soy ciudadano de los Estados Unidos, ciudadano naturalizado o por nacimiento.
B. ☐ Tengo una condición de inmigración que reúne los requisitos legales.
Número de cédula (registro) de inmigrante_____

CERTIFICO QUE:

D. ☐ No tengo una condición de inmigración que reúna los requisitos legales.
E. ☐ Opto por no declarar mi condición de inmigración.
F. ☐ Firmo la certificación por un menor de edad o por varios menores de edad:

Nombre del menor	Fecha de nacimiento	Parentesco	Estado de ciudadanía	Número de cédula
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	
			A B C D	

G. ☐ Firmo la certificación en nombre de adultos miembros de la familia que no tienen un estado de inmigración que reúna los requisitos legales o que optan por no declarar su estado de inmigración (el jefe de familia o cónyuge debe ser ciudadano o tener un estado de inmigración que reúna los requisitos legales):

Nombre del familiar	Fecha de nacimiento	Parentesco	Estado de inmigración (Circule)
			C D
			C D
			C D
			C D

Advertencia: El 18 U.S.C. 1001 estipula, entre otras cosas, que cualquier persona que a sabiendas y deliberadamente elabore o use un documento o escrito que contenga cualesquier declaración o dato falso, ficticio o fraudulento, de cualquier índole dentro de la jurisdicción de cualquier departamento o agencia de los Estados Unidos, será multada hasta con $10,000 o encarcelada hasta cinco años, o ambas.

_____ _____ _____
Nombre en letra de imprenta Firma Fecha

PARA USO EXCLUSIVO DE LA OFICINA

Client No. _____ Registration No. _____

Office/CAL No. _____ Location _____ Manager Code _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
HOMELESS PROGRAM
CERTIFICATION OF RESIDENCE IN HOMELESS FACILITY

To: Housing Authority City of L.A. Date: _____

Dear: _____

_____(Applicant) has applied to receive rent payment assistance through the Homeless Program provided by the Housing Authority of the City of Los Angeles. To qualify for the Homeless program, the application must be homeless, as defined by the Federal Program Regulations.

Please complete this certification. This information will be used only for the purpose of determining the homeless status for the above-named applicant. Thank you.

Sincerely,

_____
(Signature)

_____
(Title)

I hereby authorize the release of the requested information.

_____
(Signature of Applicant)

CERTIFICATION

I certify that:

_____ is staying at _____from
(applicant's name) (name of facility)

_____ to _____.

Before coming to the facility, the applicant resided at _____

_____.
(staff person at facility's signature)

The names of all family members in the shelter are _____
_____.

If some members of the family are not in the shelter, please explain why: _____
_____
_____.

When will they have to vacate? _____.

If they have already vacated, where did they move to? _____
_____.

Title_____ Date _____

Address of Facility _____.

Type of Facility:

____ Emergency Shelter
____ Transitional Housing

Housing Authority of the City of Los Angeles

Certification of Homelessness

To: ________________________________ Date: ______________________

____

____

Dear ________________________________

______________________________ ("Applicant"), Social Security No. ______________ has applied for housing assisted by this agency and has indicated that:

[ ] He/she lacks a fixed, regular, and adequate nighttime residence; and

[ ] He/she has primary nighttime residence that is: a supervised publicly or privately operated shelter designed to provide temporary living accommodations or; an institution that provides a temporary residence for persons intended to be institutionalized; or a public or private place not designed for, or ordinarily, used as, a regular sleeping accommodation for human beings.

One of the qualification requirements for participation in the Section 8 Homeless Program is that the Applicant meet one or more parts of the homeless status definition in the Federal Program regulations. Therefore, we would appreciate your completing the certification below and returning this form to us in the enclosed envelope. This information will be used only for the purpose of determining the homeless status for the above-named Applicant.

Sincerely,

____
Signature

____
Title

I hereby authorize the release of the requested information.

____
Applicant's Signature

* *

CERTIFICATION

I certify that ____ *[check appropriate box(es) below]*
(Applicant Name)

[ ] Lacks a fixed, regular, and adequate nighttime residence; and

[ ] Has primary nighttime residence that is:
- [ ] A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare/voucher hotels, congregate shelters, or transitional housing designed for homeless persons);
- [ ] An institution that provides a temporary residence for persons intended to be institutionalized; or
- [ ] A public or private place not designed for, or ordinarily, used as, a regular sleeping accommodation for human beings.

______________________________ ______________________________
Agency Name Signature

______________________________ ______________________________
Agency address Print Name

______________________________ ______________________________
Professional Title

______________________________ ______________________________
Date Phone Number

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: The information collection requirements contained in this notice have been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3520) and assigned OMB control number 2577-0266. In accordance with the Paperwork Reduction Act, HUD may not conduct or sponsor, and a person is not required to respond to a collection of information unless the collection displays a current valid OMB control number.

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, your current rental assistance may be terminated and your future request for HUD rental assistance may be denied for a period of up to ten years from the date you moved out of an assisted unit or were terminated from a HUD rental assistance program.

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.
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?
You should contact the PHA, who has reported this information about you, in writing, if you disagree with the reported information. 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. Disputes must be made within three years from the end of participation date. Otherwise the debt and termination information is 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:**
Housing Authority City of LA S8 SPA 2500 Wilshire Blvd Suite PH Los Angeles, CA 90057	**Signature** **Date** **Printed Name**

Authorization for the Release of Information/ Privacy Act Notice

to the U.S. Department of Housing and Urban Development (HUD) and the Housing Agency/Authority (HA)

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing

OMB CONTROL NUMBER: 2501-0014

exp. 1/31/2014

PHA requesting release of information; **(Cross out space if none)** (Full address, name of contact person, and date)	IHA requesting release of information: **(Cross out space if none)** (Full address, name of contact person, and date)

Authority: Section 904 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, as amended by Section 903 of the Housing and Community Development Act of 1992 and Section 3003 of the Omnibus Budget Reconciliation Act of 1993. This law is found at 42 U.S.C. 3544.

This law requires that you sign a consent form authorizing: (1) HUD and the Housing Agency/Authority (HA) to request verification of salary and wages from current or previous employers; (2) HUD and the HA to request wage and unemployment compensation claim information from the state agency responsible for keeping that information; (3) HUD to request certain tax return information from the U.S. Social Security Administration and the U.S. Internal Revenue Service. The law also requires independent verification of income information. Therefore, HUD or the HA may request information from financial institutions to verify your eligibility and level of benefits.

Purpose: In signing this consent form, you are authorizing HUD and the above-named HA to request income information from the sources listed on the form. HUD and the HA need this information to verify your household's income, in order to ensure that you are eligible for assisted housing benefits and that these benefits are set at the correct level. HUD and the HA may participate in computer matching programs with these sources in order to verify your eligibility and level of benefits.

Uses of Information to be Obtained: HUD is required to protect the income information it obtains in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. HUD may disclose information (other than tax return information) for certain routine uses, such as to other government agencies for law enforcement purposes, to Federal agencies for employment suitability purposes and to HAs for the purpose of determining housing assistance. The HA is also required to protect the income information it obtains in accordance with any applicable State privacy law. HUD and HA employees may be subject to penalties for unauthorized disclosures or improper uses of the income information that is obtained based on the consent form. **Private owners may not request or receive information authorized by this form.**

Who Must Sign the Consent Form: Each member of your household who is 18 years of age or older must sign the consent form. Additional signatures must be obtained from new adult members joining the household or whenever members of the household become 18 years of age.

Persons who apply for or receive assistance under the following programs are required to sign this consent form:

- PHA-owned rental public housing
- Turnkey III Homeownership Opportunities
- Mutual Help Homeownership Opportunity
- Section 23 and 19(c) leased housing
- Section 23 Housing Assistance Payments
- HA-owned rental Indian housing
- Section 8 Rental Certificate
- Section 8 Rental Voucher
- Section 8 Moderate Rehabilitation

Failure to Sign Consent Form: Your failure to sign the consent form may result in the denial of eligibility or termination of assisted housing benefits, or both. Denial of eligibility or termination of benefits is subject to the HA's grievance procedures and Section 8 informal hearing procedures.

Sources of Information To Be Obtained

State Wage Information Collection Agencies. (This consent is limited to wages and unemployment compensation I have received during period(s) within the last 5 years when I have received assisted housing benefits.)

U.S. Social Security Administration (HUD only) (This consent is limited to the wage and self employment information and payments of retirement income as referenced at Section 6103(l)(7)(A) of the Internal Revenue Code.)

U.S. Internal Revenue Service (HUD only) (This consent is limited to unearned income [i.e., interest and dividends].)

Information may also be obtained directly from: (a) current and former employers concerning salary and wages and (b) financial institutions concerning unearned income (i.e., interest and dividends). I understand that income information obtained from these sources will be used to verify information that I provide in determining eligibility for assisted housing programs and the level of benefits. Therefore, this consent form only authorizes release directly from employers and financial institutions of information regarding any period(s) within the last 5 years when I have received assisted housing benefits.

Consent: I consent to allow HUD or the HA to request and obtain income information from the sources listed on this form for the purpose of verifying my eligibility and level of benefits under HUD's assisted housing programs. I understand that HAs that receive income information under this consent form cannot use it to deny, reduce or terminate assistance without first independently verifying what the amount was, whether I actually had access to the funds and when the funds were received. In addition, I must be given an opportunity to contest those determinations.

This consent form expires 15 months after signed.

Signatures:

Head of Household	Date		
Social Security Number (if any) of Head of Household		Other Family Member over age 18	Date
Spouse	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date
Other Family Member over age 18	Date	Other Family Member over age 18	Date

Privacy Act Notice. Authority: The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the Social Security Number of each household member who is six years old or older. Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities. Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate Federal, State, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law. Penalty: You must provide all of the information requested by the HA, including all Social Security Numbers you, and all other household members age six years and older, have and use. Giving the Social Security Numbers of all household members six years of age and older is mandatory, and not providing the Social Security Numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

Penalties for Misusing this Consent:

HUD, the HA and any owner (or any employee of HUD, the HA or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form.

Use of the information collected based on the form HUD 9886 is restricted to the purposes cited on the form HUD 9886. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000.

Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD, the HA or the owner responsible for the unauthorized disclosure or improper use.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OPPORTUNITY-AFFIRMATIVE ACTION EMPLOYER
2600 Wilshire Boulevard • Los Angeles, California 90057 • (213) 252-2500

COMMISSIONERS:
OZIE B. GONZAQUE, Chairperson

EXECUTIVE DIRECTOR
DONALD J. SMITH

NOTICE TO APPLICANTS APPLYING FOR HOUSING ASSISTANCE

The Federal regulation regarding the restrictions on housing assistance for non-citizens was effective on June 19,1995. This means that the eligibility for housing assistance is dependent upon the submission of evidence of citizenship or eligible immigration status.

The evidence required for all family members, regardless of age, is:

1. For citizens or nationals: a signed declaration of U.S. Citizenship (whether by birth or naturalization).

2. For non-citizens: a signed declaration of eligible immigration status, the original immigration documents(s), and a signed verification consent form. The original immigration document(s) will be photocopied and returned to you immediately.

   The Housing Authority will verify the immigration status of a family member with the Immigration and Naturalization Service ***only*** *if the family member claims eligible immigration status and signs a consent form.*

The evidence of citizenship or eligible immigration status must be submitted at the time of your interview. If applicable, please bring the **original** documents to your interview appointment.

The attached "Fact Sheet of Questions and Answers for Applicants" addresses the common questions asked about this rule and the impact it may have on your family. It is a part of this notice.

Your application for housing assistance may be denied, after all appeals are exhausted, if no member of your family is a citizen or has eligible immigration status. If some members of your family are citizens or have eligible immigration status and some do not, the amount of housing assistance will be calculated according to the number of family members who have eligible status.

Please feel free to discuss your questions or concerns with the interviewer.

Housing Authority Management

Attachment

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
SECTION 8 ASSISTED HOUSING PROGRAM

SECTION 8 FAMILY OBLIGATIONS

When your unit is approved and the Housing Assistance Payments (HAP) contract is signed, your family must follow the rules listed below.

A. THE FAMILY MUST:

1. Provide CORRECT AND ACCURATE INFORMATION, including proof of CITIZENSHIP or eligible IMMIGRATION status, and records about your INCOME and the income of all family members living with you. You must report all income such as wages, unemployment benefits, child support, Social Security, SSI, pensions and all ASSETS such as bank accounts, stocks, bonds, property ownership, whether or not you have income from them. (Live-in aides are exempt from providing information regarding income)

2. Provide any INFORMATION that the Housing Authority or HUD tells you is needed for any reexamination of family income and composition. You and all adult family members must sign forms that allow us to verify income, asset and other information required by the Housing Authority. (Live-in aides are exempt from providing income information.)

3. Provide and verify SOCIAL SECURITY NUMBERS for all members of your family including live-in aide. This requirement does not apply to individuals who do not contend eligible immigration status.

4. Provide TRUE and COMPLETE information.

5. PAY gas, electric, water or any other utility bill for which you are responsible. PROVIDE and keep in repair any appliances such as a stove or refrigerator which the owner does not provide. REPAIR or pay for damage to the unit caused by any household member or guest. Pay your portion of the rent on time.

6. Allow the Housing Authority to INSPECT your unit at reasonable times after reasonable notice. We will inspect your unit at least once a year.

7. NOTIFY the Housing Authority and the owner IN WRITING before moving out of the unit, or ending the lease. You must get a new voucher before you can move with Section 8. You must give at least 30 days WRITTEN NOTICE if you plan to move from your unit.

8. Immediately give the Housing Authority a copy of any EVICTION NOTICE.

9. Use the section 8 unit as a place to live and ALLOW ONLY THE PEOPLE AUTHORIZED BY THE HOUSING AUTHORITY TO LIVE THERE. The unit must be a family's only place of living.

10. Immediately TELL the Housing Authority of the birth, adoption or court-awarded custody of a child. You must ask for and get WRITTEN APPROVAL before any other person (including family members, foster children or live-in aides) can live with you.

11. Immediately NOTIFY the Housing Authority IN WRITING if someone moves out or no longer lives in the unit.

12. Give the Housing Authority any information needed to prove that you or other family members are living in the unit or have moved out of the unit. (You must NOTIFY the Housing Authority of any time that you are away from the unit or expect to be away for more than thirty days.)

B. THE FAMILY MUST NOT:

1. COMMIT any serious or repeated VIOLATION OF THE LEASE.

2. Use your unit mainly as a place of business rather than as a place to live.

3. SIGN OVER the lease to someone else or GIVE the unit to someone else.

4. SUBLEASE or LEASE or charge someone else rent for the unit or a part of the unit.

5. BE AN OWNER of the unit you are living in (unless it is a mobile home) or have any interest in the unit.

6. Commit any FRAUD, bribery or any other corrupt or criminal act in connection with the program.
   Section 487i of the California Penal Code states that any person who defrauds a housing program of a public housing authority of more than four hundred dollars ($400) is guilty of grand theft.

CONTINUED ON BACK

All members of your family 18 years of age or older must sign this form.

_____	_____	_____
Signature	Signature	Signature
_____	_____	_____
Date	Date	Date

THE FAMILY MUST NOT (continued):

7. GIVE THE LANDLORD any secret or "under-the-table" money or pay more rent than the Housing Authority allows. If a landlord asks you to pay extra rent, notify your Section 8 Advisor at once.

8. USE DRUGS or take part in other DRUG-RELATED CRIMINAL ACTIVITY or in VIOLENT CRIMINAL ACTIVITY. The family must not participate in any other criminal activity that threatens the health, safety or right to peaceful enjoyment of other residents and persons residing in the area near your unit. This applies to your entire household, whether or not you personally take part in the activity or even know about it.

9. ABUSE ALCOHOL in a way that threatens the health, safety or right to peaceful enjoyment of other residents and persons residing near your unit.

10. RECEIVE ANY OTHER HOUSING ASSISTANCE (SUBSIDY) either to live in YOUR UNIT or to LIVE ELSEWHERE while you have Section 8 with us.

GROUNDS FOR DENIAL OR TERMINATION OF ASSISTANCE

The Housing Authority may deny or take away your Section 8 for any of the following:

1. If you and the members of your household do not follow the family obligations listed above.

2. If as an applicant you or any member of your household is required to have a criminal history record check, but does not sign the consent form or refuses to provide fingerprints if needed.

3. If you or any member of your household must register as a sex offender in any State.

4. If you or any member of your household ever produced or manufactured methamphetamine on the premises of federally assisted housing.

5. If you or any member of your household currently illegally uses drugs, or has a pattern of illegal use that may threaten the health, safety or right to peaceful enjoyment of the premises by other residents, or if you are evicted or convicted for drug related criminal activity.

6. If you or any member of your household abuses alcohol or has a pattern of abuse that threatens the health, safety or right to peaceful enjoyment of the premises by other residents, or if you are evicted for reasons related to alcohol abuse.

7. If you or any member of your household was evicted or removed for good reason from any of our assisted housing programs (including Section 8) within 5 years of your application interview.

8. If you or any member of your household commits fraud, bribery or any other corrupt or criminal act in connection with any federal housing program or has done such things within 10 years of your application interview.

9. If you or any household member owes rent or other amounts to any housing authority in connection with Section 8 or public housing assistance or has not repaid a housing authority for money paid to an owner under a Housing Assistance Payments Contract for rent, damages to the unit or other amounts owed under the lease.

10. If your family breaks a repayment agreement with this or any other housing authority to pay amounts you owe to the housing authority.

11. If you or any member of your household is abusive or violent or makes threats against any Housing Authority employee.

12. If you are in the Family Self Sufficiency (FSS) Program and, for no good reason, you do not follow the rules of your FSS contract.

13. If you are in the Welfare to Work Program and willfully and continually fail to meet your responsibilities under that program.

14. If you or any member of your family does not immediately give the Housing Authority a copy of any letter or notice from HUD that gives information about the amount of income you receive or about verifying family income.

15. If you do not move to another unit when the Housing Authority tells you that your family is too large for the Section 8 unit you are living in (or that your family is too small for its unit in the HOPWA and Shelter Plus Care programs).

16. If you do not accept an offer of assistance with conditions (that provides assistance to some family members but forbids others to live in the unit), or if any adult member of your family does not sign the statement of assistance with conditions, or if you violate the conditions.

AUTORIDAD DE LA VIVIENDA DE LA CIUDAD DE LOS ANGELES
PROGRAMA DE ASISTENCIA DE VIVIENDA DE SECCION 8

OBLIGACIONES DE LA FAMILIA EN SECCION 8

Cuando su unidad es aprobada y el contrato de asistencia de vivienda (HAP, por sus siglas en inglés) es firmado, su familia debe de seguir las regulaciones enlistadas a continuación.

A. LA FAMILIA DEBE:

1. Proveer INFORMACION CORRECTA Y PRECISA, incluyendo prueba de CIUDADANIA o de un estado INMIGRATORIO elegible, y datos acerca de su INGRESO y de los ingresos de todos los miembros de su familia que viven con usted. Usted debe reportar todos los ingresos como por ejemplo salarios, beneficio por desempleo, Seguro Social, pensiones y todos los BIENES como cuentas de banco, acciones, bonos, títulos de propiedades, ya sea o no que usted obtenga ingresos de ellos. (Los prestadores de servicios auxiliares a domicilio están exentos de proporcionar información relacionada con su ingreso)

2. Proveer cualquier INFORMACION que la Autoridad de la Vivienda o el Departamento de Vivienda y Desarrollo Urbano (HUD por sus siglas en inglés) le diga que se necesita para una reexaminación de los ingresos y la composición familiar. Usted y todos los miembros adultos de su familia deben firmar formas que nos permitan verificar los ingresos, bienes y otra información requerida por la Autoridad de la Vivienda. (Los prestadores de servicios auxiliares a domicilio están exentos de proporcionar información relacionada con su ingreso.)

3. Proveer y verificar NUMEROS DE SEGURO SOCIAL para todos los miembros de su familia incluyendo al prestador de servicios auxiliares. Este requerimiento no es necesario si decide no declarar su estado inmigratorio.

4. Proveer información COMPLETA y VERDADERA.

5. PAGAR las cuentas de gas, electricidad, agua o cualquier otro recibo por servicios públicos por los cuales usted es responsable. PROVEER y mantener en buenas condiciones cualquier electrodoméstico tal como estufa o refrigerador el cual no ha sido proveído por el propietario. REPARAR o pagar por los daños a la unidad ocasionados por cualquier miembro del hogar o invitado. Pagar su porción del alquiler a tiempo.

6. Permitir a la Autoridad de la Vivienda INSPECCIONAR su unidad en un horario razonable después de notificaciones razonables. Inspeccionaremos su unidad por lo menos una vez al año.

7. NOTIFICAR a la Autoridad de la Vivienda y al propietario POR ESCRITO antes de que se mude de la unidad, o cancele el contrato de alquiler. Usted debe obtener un vale nuevo antes de que se pueda mudar con Sección 8. Usted debe de dar un AVISO POR ESCRITO con 30 días de anticipación si usted tiene planes de mudarse de su unidad.

8. Proporcionar inmediatamente a la Autoridad de la Vivienda copia de cualquier AVISO DE DESALOJO.

9. Usar la unidad de Sección 8 como un lugar de residencia y SOLO PERMITIR RESIDIR EN LA VIVIENDA A LAS PERSONAS AUTORIZADAS POR LA AUTORIDAD DE LA VIVIENDA. La unidad debe ser el único lugar de residencia de la familia.

10. Inmediatamente NOTIFIQUE a la Autoridad de la Vivienda del nacimiento, adopción o custodia de un menor otorgada por una corte. Usted debe pedir y recibir una APROBACION POR ESCRITO antes de que cualquier persona (incluyendo familiares, o niños de crianza temporal o prestador auxiliar de servicio que vivan en casa) pueda residir con usted.

11. Inmediatamente NOTIFIQUE a la Autoridad de la Vivienda POR ESCRITO si alguien se muda o ya no reside en la unidad.

12. Proporcionar a la Autoridad de la Vivienda cualquier información necesaria para probar que usted o cualquier otro miembro de su familia están residiendo en la unidad o se han mudado de ella. (Usted debe NOTIFICAR a la Autoridad de la Vivienda sobre cualquier período de tiempo que usted se encuentre fuera o que planee estar ausente de su unidad por más de treinta días.)

B. LA FAMILIA NO DEBE:

1. COMETER ninguna VIOLACION DEL CONTRATO DE ALQUILER que sea seria o repetida.

2. Usar su unidad principalmente como un lugar negocio en vez de residencia.

3. FIRMAR PARA ALGUIEN MAS el contrato de alquiler o DARLE la unidad a alguien más.

4. SUBARRENDAR o ARRENDAR o cobrar a alguien alquiler por la unidad o por una porción de la unidad.

5. SER EL PROPIETARIO de la unidad en que usted reside (a menos que sea una casa movible) o que tenga algún provecho en la unidad.

6. Cometer cualquier tipo de FRAUDE, soborno o cualquier otro acto corrupto o criminal en relación con el programa. El artículo 487i del Código Penal del Estado de California establece que toda persona que defraude más de cuatrocientos dólares ($400.00) a un programa de una Autoridad de Vivienda es culpable de robo.

CONTINUA AL REVERSO

Todos los miembros de su familia que son de 18 años de edad o mayores deben firmar este formulario.

_____	_____	_____
Firma	Firma	Firma
_____	_____	_____
Fecha	Fecha	Fecha

LA FAMILIA NO DEBE (continuación):

7. DARLE AL PROPIETARIO cualquier dinero secreto o “por debajo de la mesa” o pagar mas alquiler que el que la Autoridad de la Vivienda le permite. Si un propietario le pide que usted pague extra alquiler notifique a su consejero de la Sección 8 inmediatamente.

8. USAR DROGAS o tomar parte en otra ACTIVIDAD CRIMINAL RELACIONADA CON DROGAS o en una ACTIVIDAD CRIMINAL VIOLENTA. La familia no debe participar en ninguna otra actividad criminal que atente con la salud, seguridad o el derecho de disfrutar pacíficamente de otros residentes y personas que vivan en un área cercana a su unidad. Esto aplica a todo su grupo familiar ya sea o no que usted tome parte de las actividades o que tenga conocimiento de ellas.

9. ABUSO DE ALCOHOL de una manera que atente contra la salud, seguridad o el derecho de disfrutar pacíficamente de otros residentes y personas que vivan en un área cercana a su unidad.

10. RECIBIR CUALQUIER OTRA ASISTENCIA A LA VIVIENDA (SUBSIDIO) ya sea para vivir en SU UNIDAD o para VIVIR EN ALGUN OTRO LUGAR mientras usted tiene Sección 8 con nosotros.

MOTIVOS PARA NEGACION O CANCELACION DE LA ASISTENCIA

La Autoridad de la Vivienda puede negar o quitarle su Sección 8 por cualquiera de las siguientes razones:

1. Si usted y los miembros de su grupo familiar no siguen las obligaciones familiares enlistadas anteriormente.

2. Si como solicitante a usted o a cualquier miembro de su grupo familiar se le requiere verificar el historial criminal, pero no firma los formularios de consentimiento o se rehúsa a proveer las huellas digitales si es necesario.

3. Si usted o cualquier miembro de su grupo familiar está registrado como un agresor sexual en cualquier estado de los Estados Unidos.

4. Si usted o cualquier miembro de su grupo familiar han producido o manufacturado metanfetamina en las instalaciones de vivienda que reciben asistencia federal.

5. Si usted o cualquier miembro de su grupo familiar se encuentran usando ilegalmente drogas o tienen un habito del uso ilegal que pueda atentar con la salud, seguridad o el derecho de disfrutar pacíficamente de otros residentes y personas que vivan en un área cercana a su unidad, o si usted ha sido desalojado o condenado por actividades criminales relacionadas con drogas.

6. Si usted o cualquier miembro de su grupo familiar abusa el alcohol o tiene el hábito de abusarlo y que pueda atentar con la salud, seguridad o el derecho de disfrutar pacíficamente de otros residentes y personas que vivan en un área cercana a su unidad, o si usted ha sido desalojado o condenado por actividades criminales relacionadas con el abuso del alcohol.

7. Si usted o cualquier miembro de su grupo familiar ha sido desalojado o retirado con buena razón de cualquiera de nuestros programas de asistencia a la vivienda (incluyendo Sección 8) durante los últimos 5 años de su entrevista como solicitante.

8. Si usted o cualquier miembro de su grupo familiar comete fraude, soborno o cualquier otro acto corrupto o criminal en conexión con cualquier programa de vivienda federal o ha cometido dichas actividades durante los últimos 10 años de su entrevista como solicitante.

9. Si usted o cualquier miembro de su grupo familiar debe alquiler u otra cantidad a cualquiera Autoridad de la Vivienda en conexión con Sección 8 o asistencia de vivienda pública o no ha pagado a alguna Autoridad de la Vivienda por dinero pagado a algún propietario bajo un contrato de Pagos de Asistencia de Vivienda por alquiler, daños a la unidad u otros adeudos relacionados con el contrato de alquiler.

10. Si su familia no cumple con un acuerdo de reembolso con esta o cualquier otra autoridad de la vivienda de pagar las cantidades que debe a la autoridad de la vivienda.

11. Si usted o cualquier miembro de su grupo familiar es abusivo o violento o hace amenazas en contra de cualquier empleado de la Autoridad de la Vivienda.

12. Si usted participa en el Programa de Autosuficiencia Familiar (FSS por sus siglas en inglés) y sin tener una buena razón, usted no sigue las regulaciones de su contrato de FSS.

13. Si usted participa en el Programa de Asistencia Pública para Trabajar (Welfare to Work, por su nombre en inglés) y premeditadamente y constantemente falla en cumplir con sus responsabilidades bajo este programa.

14. Si usted o cualquier miembro de su grupo familiar no entrega inmediatamente a la Autoridad de la Vivienda una copia de cualquier carta o notificación de HUD (Departamento Federal de Vivienda y Desarrollo Urbano) que de información acerca de la cantidad de ingreso que usted recibe o verificación acerca de los ingresos familiares.

15. Si usted no se muda a otra unidad cuando la Autoridad de la Vivienda le dice que su familia es muy grande para la unidad de Sección 8 donde usted está viviendo (o que su familia es muy pequeña para esa unidad en los programas de HOPWA (Oportunidades de Vivienda Para Personas con SIDA) y Shelter Plus Care (Programa de Alojamiento y Cuidado).

16. Si usted no acepta una oferta de asistencia con condiciones (que proporciona asistencia a algunos miembros de la familia pero prohíbe a otros que vivan en la unidad) o si algún otro adulto de la familia no firma la declaración de asistencia con condiciones, o si usted quebranta las condiciones.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES

NOTICE OF NONDISCRIMINATION BASED ON DISABILITY AND REASONABLE ACCOMMODATION POLICY

The Housing Authority of the City of Los Angeles (HACLA) strives to provide equal opportunity for all individuals to participate in and benefit from its programs in compliance with state and federal fair housing laws. An individual with a physical or mental disability may request a change, exception, or adjustment to a HACLA rule, policy, service, or modification to a dwelling unit or common space also known as a ***Reasonable Accommodation*** to obtain equal access to the HACLA programs.

A request can be submitted at any time. Request for services, such as sign language interpretation for a meeting, must be made orally or in writing at least five (5) business days in advance of the need.

A reasonable accommodation can only be granted if there is a ***verified*** disability-related need for the accommodation. HACLA may require verification as to the disability and/or the relationship to the accommodation requested if the disability and/or accommodation requested is not apparent or otherwise known to the HACLA. The HACLA will not inquire about diagnosis or other medical details. You are only required to disclose a disability to the HACLA if you request an accommodation or claim a deduction or eligibility preference for admission to a program based on disability.

Verifications may be provided by an individual who is in position to know of the disability and the need requested such as (but not limited to): a licensed physician, physical therapist, psychiatrist, social worker, caseworker, or counselor.

A. Examples of Exceptions to Services, Policies or Procedures include, but are not limited to:

- Rescheduling an interview appointment and/or a non-office visit (e.g.: home visit)
- Providing sign language interpreters for meetings or interviews
- Using a text telephone (TTY) for telephone calls or e-mail with hearing or speech impaired persons
- Permitting a person with disabilities to have outside assistance to meet program requirements
- Meeting clients in wheelchair-accessible areas or providing space to accommodate a service animal

B. Examples of Modifications to Dwelling Units and Common Areas include, but are not limited to:

- Installing grab bars, handrails, wheelchair ramps or lever hardware for a mobility-impaired person
- Modifying units for hearing-impaired and vision-impaired persons (i.e., providing appropriate doorbells, etc.)

HACLA-owned units Residents of HACLA-owned units can request modifications to a unit or common area. The HACLA pays for most modifications to HACLA-owned units.

Section 8 Programs A tenant with a disability *must get the unit owner's permission* to modify a unit (preferably in writing) - *the owner may ask for verification of need.* Depending on the building the tenant or the landlord may have to pay for unit modifications - for additional information, go to www.hacla.org/504.

You may request an accommodation from the HACLA orally to your worker or in writing, preferably using HACLA's, "*Reasonable Accommodation Questionnaire*" form (S504-02). The form is available at our offices, on the HACLA website, or call (213) 252-1879 to request one be mailed to you. HACLA staff may assist in the completion of the form(s) upon request. Persons with speech or hearing impairments may use the TTY number or email address below or California Relay to contact our office. The HACLA responds to requests within 30 days of receipt of request. HACLA will contact the requestor if more information is needed. The HACLA Reasonable Accommodation policy and related forms are also available on the HACLA website www.hacla.org/504.

If you believe that you have experienced discrimination in a Housing Authority program due to a disability, complete and submit a *Reasonable Accommodation or Disability Discrimination Grievance* form (S504-08). Denial of a reasonable accommodation request does not necessarily constitute discrimination.

Accessibility (Section 504) Coordinator
Housing Authority of the City of Los Angeles – Planning Department
2600 Wilshire Boulevard, 3rd Floor, Los Angeles, CA 90057
Telephone: (213) 252-1879 TTY: (213) 252- 5313 E-mail: coordinator@hacla.org

Print

Clear Form

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
REASONABLE ACCOMMODATION QUESTIONNAIRE

Print form on Legal Size Paper (8 1/2 x 14)

A person with a disability(ies) may request a change, exception or adjustment to HACLA's rules, policies, practices, procedures or modifications to its housing units or common areas as a reasonable accommodation. Requesting an accommodation does not affect participation in the program. **This form is to be completed and returned to the HACLA as part of the application and annual review process but can be requested and submitted at any time as needed.**
Contact your HACLA worker if assistance is needed in completing this form.

Head of Household Name: _____ Reg # / Client # _____

Address: _____ Phone # _____

Other preferred contact information: _____

Please check the appropriate box, provide the information as necessary, sign the bottom, and submit to the HACLA.

1. Does anyone in your household need a reasonable accommodation?

   ☐ No - If **No**, complete number 3 below

   ☐ Yes - If **Yes**, complete numbers 1a, 1b, 1c, 2, and 3 below

1a. Print the name of the family member requiring the accommodation _____

1b. Describe the accommodation needed _____

_____

_____

1c. Is this request to rescind a negative action taken by HACLA because the family did not comply with program requirements and the reason for not complying was due to a household member's disability? ☐ No ☐ Yes

If **Yes**, how did the disability prevent compliance with the rules and requirements of the program? *(Include any applicable dates)* _____

_____

_____

_____

2. Person who can verify the disability and the disability-related need for the accommodation, such as (but not limited to): a licensed physician, physical therapist, psychiatrist, social worker, caseworker, or counselor).

Name: _____

Agency (if applicable): _____

Address: _____

Phone number: (_____ Fax number: _____

E-mail (if known): _____

3. Signature: I certify the above information is correct:

_____ _____
Signature of Head of Household or Cohead Date

Please submit the completed form to the HACLA

For HACLA use only

Received by: _____ Date _____

Notes:

Cal/Manager Code _____
Unit No._____
Reg./Client No._____
Review Month _____

THINGS YOU SHOULD KNOW

Don't risk your chances for Federally assisted housing by providing false, incomplete, or inaccurate information on your application and recertification forms.

Purpose

This is to inform you that there is certain information you must provide when applying for assisted housing. There are penalties that apply if you knowingly omit information or give false information.

Penalties for Committing Fraud

The United States Department of Housing and Urban development (HUD) places a high priority on preventing fraud. If your application or recertification forms contain false or incomplete information, you may be:

- Evicted from your apartment or house;
- Required to repay all overpaid rental assistance you received;
- Fined up to $10,000;
- Imprisoned for up to 5 years; and/or
- Prohibited from receiving future assistance.

Your State and local governments may have other laws and penalties as well.

Asking Questions

When you sit down with the person who fills out your application, you should know what is expected of you. If you do not understand something, say so. That person can answer your question or find out what the answer is.

Completing the Application

When you give your answers to application questions, you must include the following information:

Income

- All sources of money you and any family member receive (wages, welfare payments, alimony, social security, pension, donations from others, etc.);
- Any money you receive on behalf of your children (child support, social security for children, donations, etc.);
- Income from assets (interest from a savings account, credit union, or certificate of deposit dividends from stocks, bonds, etc.);
- Earnings from a second job or part-time job or self employment;
- Any anticipated income (such as a bonus or pay raise you expect to receive).

Assets

- All bank accounts, savings bonds, certificates of deposit, stocks, bonds, real estate, etc., that are owned by you or any member of your family/household who will be living with you.
- Any business or asset you sold in the last 2 years for less than its full value, such as selling your home to your children.

Signature	Signature	Signature
Date	Date	Date

Continued on Back

- **Family/Household Members**
- The names of all the people (adults and children) who will actually be living with you, whether or not they are related to you.

Signing the Application

- Do not sign any form unless you have read it, understand it, and are sure everything is complete and accurate.
- When you sign the application and certificate forms, you are claiming that they are complete to the best of your knowledge and belief. **You are committing fraud if you sign a form knowing that it contains misleading or inaccurate information.**
- Information you give on your application will be verified by your housing agency. In addition, HUD may do computer matches of the income you report with various Federal, State or private agencies to verify that it is correct.

Recertifications - also called Annual Reexaminations

You must provide updated information at least once a year. Some programs require that you report any changes in income or family/household composition immediately. Be sure to ask when you must recertify. You must report on recertification forms:

- All income changes, such as pay increases or benefits, change of job, loss of job, loss of benefits, added benefits etc., for all family/household members;
- Any family/household member who has moved in or out;
- All assets that you or your family/household members own and any asset that was sold in the last 2 years for less than its full value.

Beware of Fraud

You should be aware of the following fraud schemes:

- Do not pay any money to file an application.
- Do not pay any money to move up on the waiting list.
- Do not pay any money for anything not covered by your lease.
- Get a receipt for any money you pay.
- Get a written explanation if you are required to pay any money other than rent (such as maintenance charges or charges for parking or storage).

Reporting Abuse

If you are aware of anyone who has falsified an application, or if anyone tries to persuade you to make false statements, report them to the manager of your project and to the Housing Authority. If you cannot report to the manager or the Housing Authority, call the local HUD office or the HUD Hotline on (202) 472-4200. This is **not** a toll free number. You can also write to the HUD HOTLINE, Room 8254, 451 Seventh Street S.W. Washington, DC 20410.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
CERTIFICATION OF NO SOCIAL SECURITY NUMBER

Client No.: ____________________

Family Head: ____________________

Household Member: ____________________

I, ______________________________ hereby certify/state as a true and full statement that I do not have a social security number assigned to me. I do not have a social security number for the following reason(s):____

____

____

I, ______________________________ hereby certify state that ____________________, ______________________________, a household member under the age of 18, does not have a social security number assigned to him/her. He/she does not have a social security number for the following reason(s): ____

____

____

I understand that any false statement regarding a social security number that has been assigned will result in termination and/or denial of Housing Authority benefits.

I also authorize the release of information to the Housing Authority by the Social Security Administration

______________________________ ____________________

APPLICANT/PARTICIPANT SIGNATURE DATE

WARNING: 24 CFR REQUIRES EACH MEMBER OF AN APPLICANT'S/PARTICIPANT'S FAMILY WHO IS AT LEAST SIX YEARS OF AGE TO PROVIDE DOCUMENTATION OF A SOCIAL SECURITY NUMBER ASSIGNED TO THE FAMILY MEMBER. FAILURE TO PROVIDE DOCUMENTATION OF AN ASSIGNED SOCIAL SECURITY NUMBER OR CERTIFY THAT NO SOCIAL SECURITY NUMBER IS ASSIGNED MAY RESULT IN THE LOSS OF HOUSING AUTHORITY BENEFITS.

SECTION 4871 OF THE CALIFORNIA PENAL CODE STATES THAT ANY PERSON WHO DEFRAUDS A HOUSING PROGRAM OF A PUBLIC HOUSING AUTHORITY OF MORE THAN FOUR HUNDRED DOLLARS ($400) IS GUILTY OF GRAND THEFT.

____

Initials

= =

Statement Received By: ______________________________ DATE: ____________________

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
SECTION 8 HOMELESS PROGRAM

CERTIFIED STATEMENT
EVENTS THAT LED TO HOMELESSNESS

Knowing the penalty for making a false statement under United States Criminal Code, I hereby certify that the following is a true and full statement.

1. How long have you been homeless?

_____

2. What circumstances led to you becoming homeless?

_____
_____
_____
_____
_____
_____

3. What is your current situation? (If employed, indicate employer & occupation. If in school, include name of school, training occupation &estimate date of Training completion)

_____
_____
_____
_____
_____

4. What is your career objective? (Where do you see yourself five years from now?

_____
_____
_____
_____

Signature _____ Date _____

Section 35A of the United States Criminal Code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000 fine or both, to make a false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction.

Print Form

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OP PORTUN I TY - AF F I RMAT I VE ACT I ON EMPLOYER
2600 Wilshire Blvd, 4th floor - Los Angeles, California 90057 *(213) 252- 2500*
www.hacla.org *TTY (213) 252-5313*

CERTIFIED STATEMENT

Knowing the penalty for making a false statement under the United States Criminal Code, I hereby certify that the following is a true statement.

My name is _____

My Social Security number is _____

I live at _____

Write YES or NO to each of the statements as they apply to you.

1. I am working at the present time. _____
2. I have worked in the past 12 months. _____
3. I am self-employed (including babysitting, laborer, sales). _____
4. I attend high school, trade school or college. _____
5. I receive welfare (AFDC, General Relief). _____
6. I receive unemployment or disability benefits. _____
7. I receive contributions or child support. _____
8. I receive SSI, Social Security, and/or Private Pension _____
9. I have a bank account. _____
10. I receive income from assets (real estate, stocks, and bonds). _____
11. I receive income from the Veterans Administration. _____

Additional comments or information _____
_____

Signature _____ Date _____

Section 35A of the United States Criminal Code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000.00 fine, or both, to make a false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction.

Section 487i of the California Penal Code states that any person who defrauds a housing program of a public housing authority of more than four hundred dollars ($400) is guilty of grand theft.

ANC-19 (1-09)

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
SECTION 8 HOMELESS PROGRAM
NON-CITY SECTION 8 APPLICANTS

APPLICANT AGREEMENT TO LIVE IN THE CITY OF LOS ANGELES

I understand that I have been determined to be a non-city resident of the City of Los Angeles for the Section 8 Homeless Program. I understand that, if I am approved for the Section 8 Homeless Program of the Housing Authority of the City of Los Angeles, I will be required to live within the city limits of Los Angeles during my first year on the Section 8 Homeless Program. I understand that under no circumstances may I live in any area that is not part of the City of Los Angeles.

I, _____(Head)
(Please Print)

_____(Co-Head/Spouse)
(Please Print)

AGREE to participate in the program if approved, knowing the restriction of having to live within the City of Los Angeles under the Section 8 Homeless Program for at **one (1)** year from the date on my initial lease for a unit under the program. I further understand and agree that if I am approved I will not be eligible to transfer to any other city within or outside the State of California during my initial twelve months on the program.

_____ _____
(Signature of Head) (Date)

_____ _____
(Co-Head/Spouse) (Date)

(To be completed by HACLA Office personnel)

Date: _____

Applicant Name: _____(Head)

_____(Co-Head/Spouse)

Non-City Address: _____

City: _____ State: _____ Zip Code: _____

_____ _____
(HACLA Employee Signature) (Date)

NCLA/NC-12 (07/95)

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.

Also…

If there are minors in the house, you will also need to include their birth certificate.

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OPPORTUNITY – AFFIRMATIVE ACTION EMPLOYER
2600 Wilshire Blvd, 4th floor – Los Angeles, California 90057 (213)252-2500
www.hacla.org *TTY (213) 252-5313*

CERTIFIED STATEMENT

Manager Code _____
Client No. _____

My name is JOHN DOE

I live at Homeless on the streets on the corner of 1st St. and Main St. in Los Angeles, CA 99999

-OR- address of current residence

Warning: Title 18, Section 1001 of the United States code, states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. Making false statements is a felony under California State Law (penal code sections: 115, 118, 487, 532) and may result in criminal charges including perjury, grand theft, filing false documents with a public office, and obtaining money under false pretenses.
Section 35(A) of the United States Criminal code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000 fine or both, to make a false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction. The information given above was requested by the HOUSING AUTHORITY OF THE CITY OF ANGELES in its capacity as a City, State, and Federal Agency.

Knowing the penalty for making a false statement under the United States Code, I hereby certify that the following is a true, correct, and complete statement.

On this form, please have the applicant describe the following in his/her own words and writing:

1) explain how you became homeless

2) explain the reason that the address on your CA ID/DL is different from your current residence

3) explain the reason that the address on your Income Verification Letter is different from your current residence

4) explain the reason that the address on your Bank Statement is different from your current residence

5) indicate your income source and amount

6) explain discrepancies throughout the application (if any)

This statement was completed, signed and dated knowingly, freely, and voluntarily, without threats or duress from anyone to obtain my statement.

Signature _____ Date _____

Witnessed By: _____ Date: _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OPPORTUNITY – AFFIRMATIVE ACTION EMPLOYER
2600 Wilshire Blvd, 4th floor – Los Angeles, California 90057 (213)252-2500
www.hacla.org *TTY (213) 252-5313*

CERTIFIED STATEMENT

Manager Code _____
Client No. _____

My name is _____

I live at _____

Warning: Title 18, Section 1001 of the United States code, states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. Making false statements is a felony under California State Law (penal code sections: 115, 118, 487, 532) and may result in criminal charges including perjury, grand theft, filing false documents with a public office, and obtaining money under false pretenses.
Section 35(A) of the United States Criminal code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000 fine or both, to make a false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction. The information given above was requested by the HOUSING AUTHORITY OF THE CITY OF ANGELES in its capacity as a City, State, and Federal Agency.

Knowing the penalty for making a false statement under the United States Code, I hereby certify that the following is a true, correct, and complete statement.

_____

_____

_____

_____

_____

_____

_____

_____

_____

This statement was completed, signed and dated knowingly, freely, and voluntarily, without threats or duress from anyone to obtain my statement.

Signature _____ Date _____

Witnessed By: _____ Date: _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OPPORTUNITY – AFFIRMATIVE ACTION EMPLOYER
2600 Wilshire Blvd, 4th floor – Los Angeles, California 90057 (213)252-2500
www.hacla.org *TTY (213) 252-5313*

DECLARACION CERTIFICADA

Nombre: _____

Domicilio:_____

ADVERTENCIA: El Título 18, Sección 1001 del Código de los Estados Unidos establece que una persona es culpable de un delito grave si a sabiendas y por voluntad propia hace declaraciones falsas o fraudulentas a un departamento u oficina de los Estados Unidos. Hacer declaraciones falsas es un delito grave bajo la ley del Estado de California (Código Penal Secciones: 115, 118, 487 y 532) y puede traer como consecuencia cargos penales, como perjurio, hurto mayor, entregar documentos falsos a una oficina pública y obtener dinero de manera fraudulenta.
La sección 35 (A) del Código penal de los Estados Unidos considera una ofensa criminal, con pena máxima de encarcelamiento por 10 años, multa de $10,000 dólares o ambos, el hacer una declaración falsa o representación a cualquier Departamento de los Estados Unidos en cualquier asunto dentro de su jurisdicción. La información proporcionada arriba fue solicitada por la AUTORIDAD DE VIVIENDA DE LA CIUDAD DE LOS ÁNGELES en su capacidad como una Ciudad, Estado, y Agencia Federal.

Conociendo la pena bajo el Código de Los Estados Unidos por hacer declaraciones falsas, por el presente doy fe que la siguiente es una declaración verdadera, cierta y completa:

_____

_____

_____

_____

_____

_____

_____

Esta declaración fue terminada, firmada y fechada con conocimiento, libremente, y voluntariamente, sin amenazas o la compulsión de cualquier persona para obtener mi declaración.

Firma _____ Fecha _____

Testimonio de _____ Fecha _____

HOUSING AUTHORITY OF THE CITY OF LOS ANGELES
AN EQUAL EMPLOYMENT OPPORTUNITY-AFFIRMATIVE ACTION EMPLOYER
2600 Wilshire Boulevard • Los Angeles, California 90057 • (213) 252-2500

COMMISSIONERS:
OZIE B. GONZAQUE, Chairperson

EXECUTIVE DIRECTOR
DONALD J. SMITH

CERTIFIED STATEMENT

Knowing the penalty for making a false statement under the United States Criminal Code, I hereby certify that the following is a true and full statement.

Fill in the blanks:

I _____ certify that the only person(s) who will be living with me is (are):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

I understand that I should report to my Section 8 worker at the Housing Authority any changes in my family composition and/or changes in my family income.

Signature _____ Date _____

Section 35A of the United States Criminal Code makes it a criminal offense, punishable by a maximum of 10 years imprisonment, $10,000.00 fine, or both, to make a false statement or representation to any Department or Agency of the United States as to any matter within their jurisdiction. The information given above was requested by the HOUSING AUTHORITY OF THE CITY OF LOS ANGELES in its capacity as a City, State and Federal Agency.

OMB Control # 2502-0581
Exp. (07/31/2012)

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

Applicant Name:	
Mailing Address:	
Telephone No:	**Cell Phone No:**
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	**Cell Phone No:**
E-Mail Address (if applicable):	
Relationship to Applicant:	

Reason for Contact: (Check all that apply)

- ☐ Emergency
- ☐ Unable to contact you
- ☐ Termination of rental assistance
- ☐ Eviction from unit
- ☐ Late payment of rent
- ☐ Assist with Recertification Process
- ☐ Change in lease terms
- ☐ Change in house rules
- ☐ Other: _____

Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.

Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.

Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.

☐ Check this box if you choose not to provide the contact information.

Signature of Applicant **Date**

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

Privacy Statement: Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.